



# VIRGINIA

## REGISTER OF REGULATIONS

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### TABLE OF CONTENTS

<b>Register Information Page</b> .....	1617
<b>Publication Schedule and Deadlines</b> .....	1618
<b>Petitions for Rulemaking</b> .....	1619
<b>Notices of Intended Regulatory Action</b> .....	1620
<b>Regulations</b> .....	1621
6VAC20-140. McGruff House Program Regulations (Final) .....	1621
8VAC20-720. Regulations Governing Local School Boards and School Divisions (Fast-Track) .....	1621
9VAC5-10. General Definitions (Rev. D13) (Fast-Track) .....	1624
9VAC5-80. Permits for Stationary Sources (Rev. G13) (Fast-Track) .....	1633
9VAC20-60. Virginia Hazardous Waste Management Regulations (Final) .....	1642
9VAC20-110. Regulations Governing the Transportation of Hazardous Materials (Final) .....	1643
12VAC30-120. Waivered Services (Final) .....	1643
12VAC30-60. Standards Established and Methods Used to Assure High Quality Care (Fast-Track) .....	1671
12VAC30-120. Waivered Services (Fast-Track) .....	1671
12VAC30-141. Family Access to Medical Insurance Security Plan (Fast-Track) .....	1671
22VAC15-51. Background Checks for Licensed Child Day Centers (Fast-Track) .....	1697
<b>Governor</b> .....	1699
<b>General Notices/Errata</b> .....	1700

Virginia Code Commission

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# VIRGINIA REGISTER INFORMATION PAGE

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

## **ADOPTION, AMENDMENT, AND REPEAL OF REGULATIONS**

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

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

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

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

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

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

A regulation becomes effective at the conclusion of the 30-day final adoption period, or at any other later date specified by the promulgating agency, unless (i) a legislative objection has been filed, in which event the regulation, unless withdrawn, becomes effective on the date specified, which shall be after the expiration of the 21-day objection period; (ii) the Governor exercises his authority to require the agency to provide for additional public comment, in which event the regulation,

unless withdrawn, becomes effective on the date specified, which shall be after the expiration of the period for which the Governor has provided for additional public comment; (iii) the Governor and the General Assembly exercise their authority to suspend the effective date of a regulation until the end of the next regular legislative session; or (iv) the agency suspends the regulatory process, in which event the regulation, unless withdrawn, becomes effective on the date specified, which shall be after the expiration of the 30-day public comment period and no earlier than 15 days from publication of the readopted action.

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

## **FAST-TRACK RULEMAKING PROCESS**

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

## **EMERGENCY REGULATIONS**

Pursuant to § 2.2-4011 of the Code of Virginia, an agency, upon consultation with the Attorney General, and at the discretion of the Governor, may adopt emergency regulations that are necessitated by an emergency situation. An agency may also adopt an emergency regulation when Virginia statutory law or the appropriation act or federal law or federal regulation requires that a regulation be effective in 280 days or less from its enactment. The emergency regulation becomes operative upon its adoption and filing with the Registrar of Regulations, unless a later date is specified. Emergency regulations are limited to no more than 18 months in duration; however, may be extended for six months under certain circumstances as provided for in § 2.2-4011 D. Emergency regulations are published as soon as possible in the *Register*. During the time the emergency status is in effect, the agency may proceed with the adoption of permanent regulations through the usual procedures. To begin promulgating the replacement regulation, the agency must (i) file the Notice of Intended Regulatory Action with the Registrar within 60 days of the effective date of the emergency regulation and (ii) file the proposed regulation with the Registrar within 180 days of the effective date of the emergency regulation. If the agency chooses not to adopt the regulations, the emergency status ends when the prescribed time limit expires.

## **STATEMENT**

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

## **CITATION TO THE VIRGINIA REGISTER**

The *Virginia Register* is cited by volume, issue, page number, and date. **29:5 VA.R. 1075-1192 November 5, 2012**, refers to Volume 29, Issue 5, pages 1075 through 1192 of the *Virginia Register* issued on November 5, 2012.

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

Members of the Virginia Code Commission: **John S. Edwards**, Chairman; **Gregory D. Habeeb**; **James M. LeMunyon**; **Ryan T. McDougle**; **Robert L. Calhoun**; **E.M. Miller, Jr.**; **Thomas M. Moncure, Jr.**; **Wesley G. Russell, Jr.**; **Charles S. Sharp**; **Robert L. Tavenner**; **Christopher R. Nolen**; **J. Jasen Eige**.

Staff of the Virginia Register: **Jane D. Chaffin**, Registrar of Regulations; **Karen Perrine**, Assistant Registrar; **Anne Bloomsburg**, Regulations Analyst; **Rhonda Dyer**, Publications Assistant; **Terri Edwards**, Operations Staff Assistant.

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# PUBLICATION SCHEDULE AND DEADLINES

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

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## February 2014 through March 2015

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

\*Filing deadlines are Wednesdays unless otherwise specified.

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# PETITIONS FOR RULEMAKING

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## TITLE 18. PROFESSIONAL AND OCCUPATIONAL LICENSING

### BOARD OF MEDICINE

#### Initial Agency Notice

Title of Regulation: **18VAC85-110. Regulations Governing the Practice of Licensed Acupuncturists.**

Statutory Authority: §§ 54.1-2400 and 54.1-2956.9 of the Code of Virginia.

Name of Petitioner: Leslie Stone.

Nature of Petitioner's Request: To amend requirements for graduates of nonaccredited educational programs in acupuncture to allow consideration of transcripts from acupuncture programs in the United States that are not accredited by the Accreditation Commission for Acupuncture and Oriental Medicine.

Agency Plan for Disposition of Request: The board will receive public comment on the petition from February 10, 2014, to March 10, 2014. At the Executive Committee meeting, scheduled for April 4, 2014, the board will consider the petition and any comments received and make a decision about rulemaking.

Public Comment Deadline: March 10, 2014.

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

VA.R. Doc. No. R14-11; Filed January 21, 2014, 3:17 p.m.

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# NOTICES OF INTENDED REGULATORY ACTION

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## TITLE 12. HEALTH

864-7455, FAX (804) 864-7475, TTY (800) 828-1120, or  
email [gary.hagy@vdh.virginia.gov](mailto:gary.hagy@vdh.virginia.gov).

VA.R. Doc. No. R11-1631; Filed January 15, 2014, 9:25 a.m.

### STATE BOARD OF HEALTH

#### **Withdrawal of Notice of Intended Regulatory Action**

Notice is hereby given in accordance with § 2.2-4007.01 of the Code of Virginia that the State Board of Health has WITHDRAWN the Notice of Intended Regulatory Action (NOIRA) for amending **12VAC5-440, Regulations for Summer Camps**, which was published in [27:13 VA.R. 1480 \(February 28, 2011\)](#). The NOIRA is nearly three years old, and action to draft proposed amendments has not been completed. The State Board of Health will file a new NOIRA.

Statutory Authority: §§ 35.1-11 and 35.1-16 of the Code of Virginia.

Agency Contact: Gary Hagy, Department of Health, 109 Governor Street, Richmond, VA 23219, telephone (804) 864-7455, FAX (804) 864-7475, TTY (800) 828-1120, or email [gary.hagy@vdh.virginia.gov](mailto:gary.hagy@vdh.virginia.gov).

VA.R. Doc. No. R11-2711; Filed January 15, 2014, 9:21 a.m.

#### **Withdrawal of Notice of Intended Regulatory Action**

Notice is hereby given in accordance with § 2.2-4007.01 of the Code of Virginia that the State Board of Health has WITHDRAWN the Notice of Intended Regulatory Action (NOIRA) for amending **12VAC5-460, Regulations Governing Tourist Establishment Swimming Pools and Other Public Pools**, which was published in [27:13 VA.R. 1480 \(February 28, 2011\)](#). The NOIRA is nearly three years old, and action to draft proposed amendments has not been completed. The State Board of Health will file a new NOIRA.

Statutory Authority: § 35.1-11 of the Code of Virginia.

Agency Contact: Gary Hagy, Department of Health, 109 Governor Street, Richmond, VA 23219, telephone (804) 864-7455, FAX (804) 864-7475, TTY (800) 828-1120, or email [gary.hagy@vdh.virginia.gov](mailto:gary.hagy@vdh.virginia.gov).

VA.R. Doc. No. R11-2712; Filed January 15, 2014, 9:24 a.m.

#### **Withdrawal of Notice of Intended Regulatory Action**

Notice is hereby given in accordance with § 2.2-4007.01 of the Code of Virginia that the State Board of Health has WITHDRAWN the Notice of Intended Regulatory Action (NOIRA) for amending **12VAC5-462, Swimming Pool Regulations Governing the Posting of Water Quality Tests Results**, which was published in [27:13 VA.R. 1481 \(February 28, 2011\)](#). The NOIRA is nearly three years old, and action to draft proposed amendments has not been completed. The State Board of Health will file a new NOIRA.

Statutory Authority: §§ 32.1-12 and 32.1-248.1 of the Code of Virginia.

Agency Contact: Gary Hagy, Department of Health, 109 Governor Street, Richmond, VA 23219, telephone (804)

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# REGULATIONS

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

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## 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.

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## TITLE 6. CRIMINAL JUSTICE AND CORRECTIONS

### CRIMINAL JUSTICE SERVICES BOARD

#### Final Regulation

**REGISTRAR'S NOTICE:** The Criminal Justice Services Board is claiming an exclusion from Article 2 of the Administrative Process Act in accordance with § 2.2-4006 A 4 a of the Code of Virginia, which excludes regulations that are necessary to conform to changes in Virginia statutory law where no agency discretion is involved. The Criminal Justice Services Board will receive, consider, and respond to petitions by any interested person at any time with respect to reconsideration or revision.

**Title of Regulation:** **6VAC20-140. McGruff House Program Regulations (repealing 6VAC20-140-10 through 6VAC20-140-90).**

**Statutory Authority:** § 9.1-102 of the Code of Virginia.

**Effective Date:** March 12, 2014.

**Agency Contact:** Stephanie Morton, Law Enforcement Program Coordinator, Department of Criminal Justice Services, 1100 Bank Street, Richmond, VA 23219, telephone (804) 786-8003, FAX (804) 786-0410, or email stephanie.morton@dcjs.virginia.gov.

**Summary:**

*Chapters 821 and 854 of the 2011 Acts of Assembly repealed §§ 9.1-159 and 9.1-160 of the Code of Virginia pertaining to the McGruff House Program; therefore, this chapter is obsolete and is repealed.*

VA.R. Doc. No. R14-3814; Filed January 8, 2014, 12:17 p.m.



## TITLE 8. EDUCATION

### STATE BOARD OF EDUCATION

#### Fast-Track Regulation

**Title of Regulation:** **8VAC20-720. Regulations Governing Local School Boards and School Divisions (amending 8VAC20-720-170).**

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

**Public Hearing Information:** No public hearings are scheduled.

**Public Comment Deadline:** March 12, 2014.

**Effective Date:** March 27, 2014.

**Agency Contact:** Anne Wescott, Assistant Superintendent for Policy and Communication, Department of Education, P.O. Box 2120, Richmond, VA 23218, telephone (804) 225-2403, or email anne.wescott@doe.virginia.gov.

**Basis:** Article VIII of the Constitution of Virginia authorizes the Board of Education to approve textbooks and instructional aids and materials for use in courses in the public schools of the Commonwealth. Section 22.1-16 of the Code of Virginia authorizes the Board of Education to promulgate such regulations as may be necessary to carry out its powers and duties and the provisions of Title 22.1 of the Code of Virginia.

**Purpose:** On September 22, 2011, the Board of Education adopted Guidelines for Local Textbook Approval to assist school divisions as they review and approve textbooks at the local level. The guidelines encourage local school boards that opt to use a textbook that has not been approved by the Board of Education to conduct a local textbook review that includes components similar to the state level review. Revisions to the Regulations Governing Local School Boards and School Divisions include provisions of the Board of Education's Guidelines for Local Textbook Approval, thus changing them from optional guidelines to required regulations. Amending the regulations will impact public welfare in that textbooks not approved by the Board of Education will now undergo a similar review to ensure quality and accurate information. The amendments will have no impact on public health and safety.

**Rationale for Using Fast-Track Process:** The Board of Education is adding to existing regulations content from guidelines it has already reviewed and approved. Therefore, the department does not expect this addition to be controversial.

**Substance:** The changes in the regulations would require local school boards that opt to use a textbook that has not been approved by the Board of Education to conduct a local textbook review that includes components similar to the state level review. Such components include a correlation with the Standards of Learning for the particular subject area, if they exist, and a review of strengths and weaknesses in instructional planning and support. Additionally, the publisher of the textbook must certify the accuracy of the content of the textbook and sign an agreement to correct all factual and editing errors found in a textbook, at its expense. Finally, the publisher must certify that the books meet other requirements of the Code of Virginia related to textbooks.

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# Regulations

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Issues: The Regulations Governing Local School Boards and School Divisions set forth the requirements for local school boards and school divisions to review and approve instructional materials and textbooks. The primary advantage of the review of the regulations to the public, the department, and the Commonwealth is that they address the quality of materials used in Virginia's classrooms and will ensure textbooks not approved by the Board of Education will still undergo a review of their accuracy and correlation to the Standards of Learning. Additionally, local school divisions will receive written agreement from publishers that the publishers will correct errors at no cost to the division. While this is advantageous to school divisions, it may be disadvantageous to publishers. The amendment may limit the choice of textbooks for local school divisions if publishers are unwilling to sign such agreements.

Department of Planning and Budget's Economic Impact Analysis:

Summary of the Proposed Amendments to Regulation. On September 22, 2011, the Virginia Board of Education (Board) adopted Guidelines for Local Textbook Approval (Guidelines) to assist local school divisions as they review and approve textbooks at the local level. The Guidelines encourage local school boards that opt to use a textbook that has not been approved by the Board to conduct a local textbook review that includes components similar to the state level review. The Board proposes to add provisions of the Guidelines to these regulations, thus changing those provisions from optional guidelines to required regulations.

Result of Analysis. The proposed amendments are beneficial for some entities and moderately costly for others.

Estimated Economic Impact. The new proposed language includes the following concerning local school board selection of textbooks other than those approved by the Board:

"3. The publisher of such textbooks shall:

- a. provide to the local school board a certification that the content of the textbook is accurate; and
- b. sign an agreement with the local school board to correct all factual and editing errors found in a textbook, at its own expense."

Presumably a publisher seeking to sell textbooks to a local school board that had not been approved by the state Board would be willing to state in writing that the product they are selling is accurate. A written agreement that the publisher would at its own expense correct all factual and editing errors found in a textbook would be to the advantage of the local school board. A small school division would not normally have much negotiating leverage with a publisher. The backing of state law that the publisher must agree to correct errors would likely add negotiating leverage. Thus the proposal to add the new language to these regulations would be beneficial to local school divisions in that respect. The placing of the

requirement in state law would commensurately reduce negotiating leverage for the publishers and would be commensurately disadvantageous.

If a local school board wished to use a textbook that has not been approved by the Board and the publisher refused to state in writing that it would at its own expense correct all factual and editing errors, then the local school division would not be able to use that textbook. So in this respect, the proposal to add the new language to these regulations could reduce choice for local school divisions.

Businesses and Entities Affected. The proposed amendments potentially affect the 132 public school divisions in the Commonwealth and textbook publishers. Approximately 20 publishing companies are listed as having one or more books on the list of textbooks approved by the Board of Education. There are numerous other publishing houses that may market their materials directly to local school divisions.

Localities Particularly Affected. The proposed regulations will affect all localities that opt to adopt textbooks that are not on the list of textbooks approved by the Board of Education.

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

Effects on the Use and Value of Private Property. Some publishers may lose some leverage in contracts with local school divisions. This may have a very small impact on their value.

Small Businesses: Costs and Other Effects. Some small textbook publishers may lose some negotiating leverage in contracts with local school divisions.

Small Businesses: Alternative Method that Minimizes Adverse Impact. There is no apparent alternative method that would reduce the potential small negative impact of reduced negotiating leverage for some small publishers, while still accomplishing the intended policy goal.

Real Estate Development Costs. The proposed amendments will not affect 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 agency concurs with the economic impact analysis completed by the Department of Planning and Budget.

Summary:

*The amendments require local school boards that opt to use a textbook that has not been approved by the Board of Education to conduct a local textbook review that includes components similar to the state level review.*

**8VAC20-720-170. Textbooks.**

A. Textbook approval.

1. The Board of Education shall have the authority to approve textbooks for use in the public schools of Virginia.
2. In approving basal textbooks for reading in kindergarten and first grade, the ~~board~~ Board of Education shall report to local school boards those textbooks with a minimum decodability standard based on words that students can correctly read by properly attaching speech sounds to each letter to formulate the word at 70% or above for such textbooks in accordance with § 22.1-239 of the Code of Virginia.
3. Any local school board may use textbooks not approved by the ~~board~~ Board of Education provided the local school board selects such books in accordance with this chapter.
4. Contracts and purchase orders with publishers of textbooks approved by the ~~board~~ Board of Education for use in grades 6-12 shall allow for the purchase of printed textbooks, printed textbooks with electronic files, or electronic textbooks separate and apart from printed versions of the same textbook. Each local school board shall have the authority to purchase an assortment of textbooks in any of the three forms listed in this subdivision.

B. ~~Selection~~ Procedures for selection of textbooks by local school boards. Local school boards shall adopt procedures for the selection of textbooks. These procedures shall include, at a minimum, the following:

1. Appointment of evaluation committees by the local school board to review and evaluate textbooks in each of the subject areas.
2. Notice to parents that textbooks under consideration for approval will be listed on the school division's website and made available at designated locations for review by any interested citizens.

3. Opportunities for those reviewing such textbooks to present their comments and observations, if any, to the local school board through locally approved procedures.
4. Procedures to ensure appropriate consideration of citizen comments and observations.
5. Selection criteria.

C. Local school board selection of textbooks other than those approved by the Board of Education.

1. The selection process for non-Board of Education approved textbooks is subject to the procedures outlined in subsection B of this section.
2. The selection process for such textbooks pertaining to Virginia Standards of Learning subjects shall include at the local level a correlation of the content to the Virginia Standards of Learning in the content area and an analysis of strengths and weaknesses of the textbook in terms of instructional planning and support.
3. The publisher of such textbooks shall:
  - a. Provide to the local school board a certification that the content of the textbook is accurate; and
  - b. Sign an agreement with the local school board to correct all factual and editing errors found in a textbook at its own expense.

D. Purchasing Board of Education approved textbooks.

1. Local school divisions shall purchase textbooks approved by the Board of Education directly from the publishers of the textbooks by either entering into written term contracts or issuing purchase orders on an as-needed basis in accordance with § 22.1-241 of the Code of Virginia.
2. Such written contracts or purchase orders shall be exempt from the Virginia Public Procurement Act (§ 2.2-4300 et seq. of the Code of Virginia).

~~D. E.~~ Purchasing non-Board of Education approved textbooks. The purchase of textbooks other than those approved by the ~~board~~ Board of Education is not exempt from the Virginia Public Procurement Act.

~~E. F.~~ Distribution of textbooks. Each local school board shall provide, free of charge, such textbooks required for courses of instruction for each child attending public schools.

~~F. G.~~ Certifications.

1. The division superintendent and chairperson of the local school board shall annually certify to the Virginia Department of Education that:
  - a. All textbooks were selected and purchased in accordance with this chapter; and
  - b. The price paid for each textbook in accordance with § 22.1-241 of the Code of Virginia.
2. The certification shall include a list of all textbooks adopted by the local school board.

VA.R. Doc. No. R14-3621; Filed January 13, 2014, 11:04 a.m.



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## TITLE 9. ENVIRONMENT

### STATE AIR POLLUTION CONTROL BOARD

#### Fast-Track Regulation

**Title of Regulation: 9VAC5-10. General Definitions (Rev. D13) (amending 9VAC5-10-20).**

**Statutory Authority:** § 10.1-1308 of the Code of Virginia; federal Clean Air Act (§§ 110, 111, 123, 129, 171, 172, and 182); 40 CFR Parts 51 and 60.

**Public Hearing Information:** No public hearings are scheduled.

**Public Comment Deadline:** March 12, 2014.

**Effective Date:** March 27, 2014.

**Agency Contact:** Karen G. Sabasteanski, Department of Environmental Quality, 629 East Main Street, P.O. Box 1105, Richmond, VA 23218, telephone (804) 698-4426, FAX (804) 698-4510, TTY (804) 698-4021, or email karen.sabasteanski@deq.virginia.gov.

**Basis:** Section 10.1-1308 of the Virginia Air Pollution Control Law (Chapter 13 (§ 10.1-1300 et seq.) of Title 10.1 of the Code of Virginia) authorizes the State Air Pollution Control Board to promulgate regulations abating, controlling, and prohibiting air pollution in order to protect public health and welfare. Written assurance from the Office of the Attorney General that the State Air Pollution Control Board possesses the statutory authority to promulgate the proposed regulation amendments is available upon request.

**Federal Requirements.** Section 109 (a) of the federal Clean Air Act requires the U.S. Environmental Protection Agency (EPA) to prescribe national ambient air quality standards (NAAQS) to protect public health. Section 110 mandates that each state adopt and submit to EPA a state implementation plan (SIP) that provides for the implementation, maintenance, and enforcement of the NAAQS. Ozone, one of the pollutants for which there is a NAAQS, is in part created by emissions of VOCs. Therefore, in order to control ozone, VOCs must be addressed in Virginia's SIP.

40 CFR Part 51 sets out requirements for the preparation, adoption, and submittal of SIPs. Subpart F of Part 51, Procedural Requirements, includes § 51.100, which consists of a list of definitions. 40 CFR 51.100 contains a definition of VOC. This definition is revised by EPA to add or remove VOCs as necessary. If, for example, it can be demonstrated that a particular VOC is "negligibly reactive"--that is, if it can be shown that a VOC is not as reactive and therefore does not have a significant effect on ground-level or upper atmospheric ozone--then EPA may remove that substance from the definition of VOC.

On February 12, 2013 (78 FR 9823), EPA revised the definition of VOC in 40 CFR 51.100 to exclude HCF<sub>2</sub>OCF<sub>2</sub>H (HFE-134); HCF<sub>2</sub>OCF<sub>2</sub>OCF<sub>2</sub>H (HFE-236cal2); HCF<sub>2</sub>OCF<sub>2</sub>CF<sub>2</sub>OCF<sub>2</sub>H (HFE-338pcc13); and HCF<sub>2</sub>OCF<sub>2</sub>OCF<sub>2</sub>CF<sub>2</sub>OCF<sub>2</sub>H (H-Galden 1040x or H-Galden ZT 130 (or 150 or 180)) from the definition of VOC. These exclusions are accomplished by adding the substances to a list of substances not considered to be a VOC. Additionally, EPA corrected the citation for 1,1,1,2,2,3,4,5,5,5-decafluoro-3-methoxy-4-trifluoromethyl-pentane (HFE-7300). These changes to the exemption list became effective on March 14, 2013.

**State Requirements.** These specific amendments are not required by state mandate. Rather, Virginia's Air Pollution Control Law gives the State Air Pollution Control Board the discretionary authority to promulgate regulations "abating, controlling and prohibiting air pollution throughout or in any part of the Commonwealth" (§ 10.1-1308 A of the Code of Virginia). The law defines such air pollution as "the presence in the outdoor atmosphere of one or more substances which are or may be harmful or injurious to human health, welfare or safety, to animal or plant life, or to property, or which unreasonably interfere with the enjoyment by the people or life or property" (§ 10.1-1300 of the Code of Virginia).

**Purpose:** The purpose of the regulation (general definitions) is not to impose any regulatory requirements in and of itself, but to provide a basis for and support to other provisions of the Regulations for the Control and Abatement of Air Pollution, which are in place in order to protect public health and welfare. The proposed amendments are being made to ensure that the definition of VOC, which is crucial to most of the regulations, is up-to-date and scientifically accurate, as well as consistent with the overall EPA requirements under which the regulations operate.

**Rationale for Using Fast-Track Process:** The definition is being revised to add less-reactive substances to the list of compounds not considered to be VOCs and to make a correction. As discussed elsewhere, this revision is not expected to affect a significant number of sources or have any significant impact, other than a positive one, on air quality overall. Additionally, removal of the substances at the federal level was accompanied by detailed scientific review and public comment, and no negative comments were received during the federal public comment period. Therefore, no additional information on the reactivity of these substances or the appropriateness of their removal is anticipated.

**Substance:** The general definitions impose no regulatory requirements in and of themselves but provide support to other provisions of the Regulations for the Control and Abatement of Air Pollution. The list of substances not considered to be VOCs in Virginia has been revised to include HCF<sub>2</sub>OCF<sub>2</sub>H (HFE-134); HCF<sub>2</sub>OCF<sub>2</sub>OCF<sub>2</sub>H (HFE-236cal2); HCF<sub>2</sub>OCF<sub>2</sub>CF<sub>2</sub>OCF<sub>2</sub>H (HFE-338pcc13); and HCF<sub>2</sub>OCF<sub>2</sub>OCF<sub>2</sub>CF<sub>2</sub>OCF<sub>2</sub>H (H-Galden 1040x or H-Galden

ZT 130 (or 150 or 180)). A correction has also been made to 1,1,1,2,2,3,4,5,5,5-decafluoro-3-methoxy-4-trifluoromethyl-pentane (HFE-7300).

Issues: The general public health and welfare will benefit because the revision may encourage the use of the delisted substances in place of products containing more reactive and thereby more polluting substances. These substances are considered to be negligibly reactive in the formation of ground level ozone and are not expected to contribute to violations of the NAAQS. These substances are not hazardous air pollutants, and will not deplete upper atmosphere ozone. Therefore, these substances do not have a negative effect on human health or the environment.

Excluding these substances as VOCs will make it easier and less expensive for industry to use them. Companies that use these substances in place of more reactive substances may also benefit by reducing their VOC emissions and concomitant reductions in permitting and other regulatory requirements.

The revision will allow the department to focus VOC reduction strategies on substances that have a negative impact on human health and the environment.

There are no known disadvantages to the public, the department, or the Commonwealth.

Department of Planning and Budget's Economic Impact Analysis:

Summary of the Proposed Amendments to Regulation. The State Air Pollution Control Board (Board) proposes to revise the definition of volatile organic compound (VOC) to include HCF<sub>2</sub>OCF<sub>2</sub>H (HFE-134); HCF<sub>2</sub>OCF<sub>2</sub>OCF<sub>2</sub>H (HFE-236cal2); HCF<sub>2</sub>OCF<sub>2</sub>CF<sub>2</sub>OCF<sub>2</sub>H (HFE-338pcc13); and HCF<sub>2</sub>OCF<sub>2</sub>OCF<sub>2</sub>CF<sub>2</sub>OCF<sub>2</sub>H (H-Galden 1040x or H-Galden ZT 130 (or 150 or 180)) on the list of compounds not considered to be VOC.

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

Estimated Economic Impact. The general definitions of 9VAC5-10 impose no regulatory requirements in and of themselves, but provide support to other Board regulations. The U.S. Environmental Protection Agency has revised the definition of VOC to add four compounds that have been demonstrated to be less reactive to the list of compounds that are not considered to be VOCs: HCF<sub>2</sub>OCF<sub>2</sub>H (HFE-134); HCF<sub>2</sub>OCF<sub>2</sub>OCF<sub>2</sub>H (HFE-236cal2); HCF<sub>2</sub>OCF<sub>2</sub>CF<sub>2</sub>OCF<sub>2</sub>H (HFE-338pcc13); and HCF<sub>2</sub>OCF<sub>2</sub>OCF<sub>2</sub>CF<sub>2</sub>OCF<sub>2</sub>H (H-Galden 1040x or H-Galden ZT 130 (or 150 or 180)). Consequently, the Board proposed to update the list of compounds not considered to be VOC.

These substances may be used in some heat transfer applications (as refrigerants) and as fire suppressants. The Department of Environmental Quality is aware of only one manufacturer that produces these compounds. However, there are no known sources located in Virginia that currently use

these substances. There are sources that may someday eventually wish to use them; however, DEQ has not identified any specific sources that plan to do so.

The general public health and welfare may benefit because the revision may encourage the use of these compounds in place of products containing more reactive, and thereby more polluting, substances. Due to their low photochemical reactivity, these compounds are considered to be negligibly reactive in the formation of tropospheric (ground level) ozone and are not expected to contribute to violations of the federal national ambient air quality standards. These compounds are not hazardous air pollutants, and will not deplete stratospheric (upper atmosphere) ozone. Therefore, they do not have a negative effect on human health or the environment.

Excluding these compounds as a VOC will make them easier and less expensive for industry to use. Companies that use these compounds in place of more reactive substances may also benefit by reducing their VOC emissions and concomitant reductions in permitting and other regulatory requirements. Thus, the proposal to add these compounds to the list of substances not considered to be VOC will create a net benefit.

Businesses and Entities Affected. These four compounds may be used in some heat transfer applications (as refrigerants) and as fire suppressants. Consequently, the proposal to add them to the list of substances not considered to be VOC will potentially affect firms which may start manufacturing products that contain these compounds.

Localities Particularly Affected. The proposal to add four new compounds to the list of substances not considered to be VOC does not have a disproportionate effect on any particular localities.

Projected Impact on Employment. The proposed amendment will not likely have a large impact on employment.

Effects on the Use and Value of Private Property. The proposal to add four new compounds to the list of substances not considered to be VOC will have no immediate impact since currently there are no known firms located in Virginia that currently use these compounds. Adding these compounds to the list of substances not considered to be VOC will make them less costly to use, which may encourage firms to start using them in production. Thus, the proposed amendment may eventually affect some firms' production methods, lower their costs, and consequently moderately increase firm value.

Small Businesses: Costs and Other Effects. The proposal to add four new compounds to the list of substances not considered to be VOC will have no immediate impact since currently there are no known firms located in Virginia that currently use these compounds. Adding them to the list of substances not considered to be VOC will make them less costly to use. Thus, some small firms may eventually use these compounds to lower costs.

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# Regulations

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

**Real Estate Development Costs.** The proposed amendment will not likely have a large impact on 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, a determination of the public benefit, the projected number of businesses or other entities to whom the regulation would apply, the identity of any localities and types of businesses or other entities particularly affected, the projected number of persons and employment positions to be affected, the projected costs to affected businesses or entities to implement or comply with the regulation, and the impact on the use and value of private property. Further, if the proposed regulation has an adverse effect on small businesses, § 2.2-4007.04 requires that such economic impact analyses include (i) an identification and estimate of the number of small businesses subject to the regulation; (ii) the projected reporting, recordkeeping, and other administrative costs required for small businesses to comply with the regulation, including the type of professional skills necessary for preparing required reports and other documents; (iii) a statement of the probable effect of the regulation on affected small businesses; and (iv) a description of any less intrusive or less costly alternative methods of achieving the purpose of the regulation. The analysis presented above represents DPB's best estimate of these economic impacts.

**Agency's Response to Economic Impact Analysis:** The department has reviewed the economic impact analysis prepared by the Department of Planning and Budget and has no comment.

**Summary:**

*The amendment revises the definition of volatile organic compound (VOC) to include HCF<sub>2</sub>OCF<sub>2</sub>H (HFE-134); HCF<sub>2</sub>OCF<sub>2</sub>OCF<sub>2</sub>H (HFE-236cal2); HCF<sub>2</sub>OCF<sub>2</sub>CF<sub>2</sub>OCF<sub>2</sub>H (HFE-338pcc13); and HCF<sub>2</sub>OCF<sub>2</sub>OCF<sub>2</sub>CF<sub>2</sub>OCF<sub>2</sub>H (H-Galden 1040x or H-Galden ZT 130 (or 150 or 180)) on the list of compounds not considered to be a VOC.*

**9VAC5-10-20. Terms defined.**

"Actual emissions rate" means the actual rate of emissions of a pollutant from an emissions unit. In general actual emissions shall equal the average rate, in tons per year, at which the unit actually emitted the pollutant during the most recent two-year period or some other two-year period which is representative of normal source operation. If the board determines that no two-year period is representative of normal source operation, the board shall allow the use of an alternative period of time upon a determination by the board

that it is more representative of normal source operation. Actual emissions shall be calculated using the unit's actual operating hours, production rates, and types of materials processed, stored, or combusted during the selected time period.

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

"Affected facility" means, with reference to a stationary source, any part, equipment, facility, installation, apparatus, process or operation to which an emission standard is applicable or any other facility so designated. The term "affected facility" includes any affected source as defined in 40 CFR 63.2.

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

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

"Air quality control region" means any area designated as such in 9VAC5-20-200.

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

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

"Ambient air quality standard" means any primary or secondary standard designated as such in 9VAC5-30 (Ambient Air Quality Standards).

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

"Certified mail" means electronically certified or postal certified mail, except that this definition shall only apply to the mailing of plan approvals, permits, or certificates issued under the provisions of these regulations and only where the recipient has notified the department of the recipient's consent to receive plan approvals, permits, or certificates by electronic mail. Any provision of these regulations requiring the use of certified mail to transmit special orders or administrative orders pursuant to enforcement proceedings shall mean postal certified mail.

"Class I area" means any prevention of significant deterioration area (i) in which virtually any deterioration of existing air quality is considered significant and (ii) designated as such in 9VAC5-20-205.

"Class II area" means any prevention of significant deterioration area (i) in which any deterioration of existing air quality beyond that normally accompanying well-controlled

growth is considered significant and (ii) designated as such in 9VAC5-20-205.

"Class III area" means any prevention of significant deterioration area (i) in which deterioration of existing air quality to the levels of the ambient air quality standards is permitted and (ii) designated as such in 9VAC5-20-205.

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

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

1. The date by which contracts for emission control system or process modifications are to be awarded, or the date by which orders are to be issued for the purchase of component parts to accomplish emission control or process modification.
2. The date by which the on-site construction or installation of emission control equipment or process change is to be initiated.
3. The date by which the on-site construction or installation of emission control equipment or process modification is to be completed.
4. The date by which final compliance is to be achieved.

"Criteria pollutant" means any pollutant for which an ambient air quality standard is established under 9VAC5-30 (Ambient Air Quality Standards).

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

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

"Department" means any employee or other representative of the Virginia Department of Environmental Quality, as designated by the director.

"Director" or "executive director" means the director of the Virginia Department of Environmental Quality or a designated representative.

"Dispersion technique"

1. Means any technique which attempts to affect the concentration of a pollutant in the ambient air by:
  - a. Using that portion of a stack which exceeds good engineering practice stack height;

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

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

2. The preceding sentence does not include:

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

b. The merging of exhaust gas streams where:

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

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

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

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

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

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

"Emergency" means a situation that immediately and unreasonably affects, or has the potential to immediately and unreasonably affect, public health, safety or welfare; the health of animal or plant life; or property, whether used for

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# Regulations

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recreational, commercial, industrial, agricultural or other reasonable use.

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

"Emission standard" means any provision of 9VAC5-40 (Existing Stationary Sources), 9VAC5-50 (New and Modified Stationary Sources), or 9VAC5-60 (Hazardous Air Pollutant Sources) that prescribes an emissions limitation, or other requirements that control air pollution emissions.

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

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

"EPA" means the U.S. Environmental Protection Agency or an authorized representative.

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

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

1. For sources seeking credit for stack height exceeding that established under subdivision 2 of the GEP definition, a maximum ground-level concentration due to emissions from a stack due in whole or part to downwash, wakes, and eddy effects produced by nearby structures or nearby terrain features which individually is at least 40% in excess of the maximum concentration experienced in the absence of such downwash, wakes, or eddy effects and which contributes to a total concentration due to emissions from all sources that is greater than an ambient air quality standard. For sources subject to the provisions of Article 8 (9VAC5-80-1605 et seq.) of Part II of 9VAC5-80 (Permits for Stationary Sources), an excessive concentration alternatively means a maximum ground-level concentration due to emissions from a stack due in whole or part to downwash, wakes, or eddy effects produced by nearby structures or nearby terrain features which individually is at least 40% in excess of the maximum concentration experienced in the absence of the maximum concentration experienced in the absence of such downwash, wakes, or eddy effects and greater than a prevention of significant deterioration increment. The allowable emission rate to be used in making demonstrations under this provision shall be prescribed by

the new source performance standard that is applicable to the source category unless the owner demonstrates that this emission rate is infeasible. Where such demonstrations are approved by the board, an alternative emission rate shall be established in consultation with the owner;

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

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

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

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

"Federal Clean Air Act" means Chapter 85 (§ 7401 et seq.) of Title 42 of the United States Code.

"Federally enforceable" means all limitations and conditions which are enforceable by the administrator and citizens under the federal Clean Air Act or that are enforceable under other statutes administered by the administrator. Federally enforceable limitations and conditions include, but are not limited to, the following:

1. Emission standards, alternative emission standards, alternative emissions limitations, and equivalent emissions limitations established pursuant to § 112 of the federal Clean Air Act as amended in 1990.
2. New source performance standards established pursuant to § 111 of the federal Clean Air Act, and emission

standards established pursuant to § 112 of the federal Clean Air Act before it was amended in 1990.

3. All terms and conditions in a federal operating permit, including any provisions that limit a source's potential to emit, unless expressly designated as not federally enforceable.

4. Limitations and conditions that are part of an implementation plan.

5. Limitations and conditions that are part of a section 111(d) or section 111(d)/129 plan.

6. Limitations and conditions that are part of a federal construction permit issued under 40 CFR 52.21 or any construction permit issued under regulations approved by EPA in accordance with 40 CFR Part 51.

7. Limitations and conditions that are part of an operating permit issued pursuant to a program approved by EPA into an implementation plan as meeting EPA's minimum criteria for federal enforceability, including adequate notice and opportunity for EPA and public comment prior to issuance of the final permit and practicable enforceability.

8. Limitations and conditions in a Virginia regulation or program that has been approved by EPA under subpart E of 40 CFR Part 63 for the purposes of implementing and enforcing § 112 of the federal Clean Air Act.

9. Individual consent agreements issued pursuant to the legal authority of EPA.

"Good engineering practice" or "GEP," with reference to the height of the stack, means the greater of:

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

2. a. For stacks in existence on January 12, 1979, and for which the owner had obtained all applicable permits or approvals required under 9VAC5-80 (Permits for Stationary Sources),

$$Hg = 2.5H,$$

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

b. For all other stacks,

$$Hg = H + 1.5L,$$

where:

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

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

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

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

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

"Implementation plan" means the portion or portions of the state implementation plan, or the most recent revision thereof, which has been approved under § 110 of the federal Clean Air Act, or promulgated under § 110(c) of the federal Clean Air Act, or promulgated or approved pursuant to regulations promulgated under § 301(d) of the federal Clean Air Act and which implements the relevant requirements of the federal Clean Air Act.

"Initial emission test" means the test required by any regulation, permit issued pursuant to 9VAC5-80 (Permits for Stationary Sources), control program, compliance schedule or other enforceable mechanism for determining compliance with new or more stringent emission standards or permit limitations or other emissions limitations requiring the installation or modification of air pollution control equipment or implementation of a control method. Initial emission tests shall be conducted in accordance with 9VAC5-40-30.

"Initial performance test" means the test required by (i) 40 CFR Part 60 for determining compliance with standards of performance, or (ii) a permit issued pursuant to 9VAC5-80 (Permits for Stationary Sources) for determining initial compliance with permit limitations. Initial performance tests shall be conducted in accordance with 9VAC5-50-30 and 9VAC5-60-30.

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

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

"Mail" means electronic or postal delivery.

"Maintenance area" means any geographic region of the United States previously designated as a nonattainment area and subsequently redesignated to attainment subject to the requirement to develop a maintenance plan and designated as such in 9VAC5-20-203.

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

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# Regulations

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the owner or other person. Failures that are caused in part by poor maintenance or careless operation are not malfunctions.

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

"Nearby" as used in the definition of good engineering practice (GEP) is defined for a specific structure or terrain feature and:

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

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

"Nonattainment area" means any area which is shown by air quality monitoring data or, where such data are not available, which is calculated by air quality modeling (or other methods determined by the board to be reliable) to exceed the levels allowed by the ambient air quality standard for a given pollutant including, but not limited to, areas designated as such in 9VAC5-20-204.

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

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

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

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

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

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

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

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

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

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

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

"Potential to emit" means the maximum capacity of a stationary source to emit a pollutant under its physical and operational design. Any physical or operational limitation on the capacity of the source to emit a pollutant, including air pollution control equipment, and restrictions on hours of operation or on the type or amount of material combusted, stored, or processed, shall be treated as part of its design only if the limitation or its effect on emissions is state and federally enforceable.

"Prevention of significant deterioration area" means any area not designated as a nonattainment area in 9VAC5-20-204 for a particular pollutant and designated as such in 9VAC5-20-205.

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

"Public hearing" means, unless indicated otherwise, an informal proceeding, similar to that provided for in § 2.2-4007.02 of the Administrative Process Act, held to afford persons an opportunity to submit views and data relative to a matter on which a decision of the board is pending.

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

1. For ambient air quality standards in 9VAC5-30 (Ambient Air Quality Standards): The applicable appendix of 40 CFR Part 50 or any method that has been designated as a reference method in accordance with 40 CFR Part 53, except that it does not include a method for which a reference designation has been canceled in accordance with 40 CFR 53.11 or 40 CFR 53.16.
2. For emission standards in 9VAC5-40 (Existing Stationary Sources) and 9VAC5-50 (New and Modified

Stationary Sources): Appendix M of 40 CFR Part 51 or Appendix A of 40 CFR Part 60.

3. For emission standards in 9VAC5-60 (Hazardous Air Pollutant Sources): Appendix B of 40 CFR Part 61 or Appendix A of 40 CFR Part 63.

"Regional director" means the regional director of an administrative region of the Department of Environmental Quality or a designated representative.

"Regulation of the board" means any regulation adopted by the State Air Pollution Control Board under any provision of the Code of Virginia.

"Regulations for the Control and Abatement of Air Pollution" means 9VAC5-10 (General Definitions) through 9VAC5-80 (Permits for Stationary Sources).

"Reid vapor pressure" means the absolute vapor pressure of volatile crude oil and volatile nonviscous petroleum liquids except liquefied petroleum gases as determined by American Society for Testing and Materials publication, "Standard Test Method for Vapor Pressure of Petroleum Products (Reid Method)" (see 9VAC5-20-21).

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

"Section 111(d) plan" means the portion or portions of the plan, or the most recent revision thereof, which has been approved under 40 CFR 60.27(b) in accordance with § 111(d)(1) of the federal Clean Air Act, or promulgated under 40 CFR 60.27(d) in accordance with § 111(d)(2) of the federal Clean Air Act, and which implements the relevant requirements of the federal Clean Air Act.

"Section 111(d)/129 plan" means the portion or portions of the plan, or the most recent revision thereof, which has been approved under 40 CFR 60.27(b) in accordance with §§ 111(d)(1) and 129(b)(2) of the federal Clean Air Act, or promulgated under 40 CFR 60.27(d) in accordance with §§ 111(d)(2) and 129(b)(3) of the federal Clean Air Act, and which implements the relevant requirements of the federal Clean Air Act.

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

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

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

"Stack in existence" means that the owner had:

1. Begun, or caused to begin, a continuous program of physical on site construction of the stack; or
2. Entered into binding agreements or contractual obligations, which could not be canceled or modified without substantial loss to the owner, to undertake a program of construction of the stack to be completed in a reasonable time.

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

"Standard of performance" means any provision of 9VAC5-50 (New and Modified Stationary Sources) which prescribes an emissions limitation or other requirements that control air pollution emissions.

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

"State enforceable" means all limitations and conditions which are enforceable by the board or department, including, but not limited to, those requirements developed pursuant to 9VAC5-20-110; requirements within any applicable regulation, order, consent agreement or variance; and any permit requirements established pursuant to 9VAC5-80 (Permits for Stationary Sources).

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

"Stationary source" means any building, structure, facility or installation which emits or may emit any air pollutant. A stationary source shall include all of the pollutant-emitting activities which belong to the same industrial grouping, are located on one or more contiguous or adjacent properties, and are under the control of the same person (or persons under common control) except the activities of any vessel. Pollutant-emitting activities shall be considered as part of the same industrial grouping if they belong to the same "Major Group" (i.e., which have the same two-digit code) as described in the Standard Industrial Classification Manual (see 9VAC5-20-21).

"These regulations" means 9VAC5-10 (General Definitions) through 9VAC5-80 (Permits for Stationary Sources).

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

"True vapor pressure" means the equilibrium partial pressure exerted by a petroleum liquid as determined in accordance with methods described in American Petroleum Institute (API) publication, "Evaporative Loss from External Floating-Roof Tanks" (see 9VAC5-20-21). The API procedure may not be applicable to some high viscosity or high pour crudes. Available estimates of true vapor pressure may be used in special cases such as these.



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# Regulations

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"Urban area" means any area consisting of a core city with a population of 50,000 or more plus any surrounding localities with a population density of 80 persons per square mile and designated as such in 9VAC5-20-201.

"Vapor pressure," except where specific test methods are specified, means true vapor pressure, whether measured directly, or determined from Reid vapor pressure by use of the applicable nomograph in American Petroleum Institute publication, "Evaporative Loss from Floating-Roof Tanks" (see 9VAC5-20-21).

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

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

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

- a. Methane;
- b. Ethane;
- c. Methylene chloride (dichloromethane);
- d. 1,1,1-trichloroethane (methyl chloroform);
- e. 1,1,2-trichloro-1,2,2-trifluoroethane (CFC-113);
- f. Trichlorofluoromethane (CFC-11);
- g. Dichlorodifluoromethane (CFC-12);
- h. Chlorodifluoromethane (H CFC-22);
- i. Trifluoromethane (H FC-23);
- j. 1,2-dichloro 1,1,2,2,-tetrafluoroethane (CFC-114);
- k. Chloropentafluoroethane (CFC-115);
- l. 1,1,1-trifluoro 2,2-dichloroethane (HCFC-123);
- m. 1,1,1,2-tetrafluoroethane (HFC-134a);
- n. 1,1-dichloro 1-fluoroethane (HCFC-141b);
- o. 1-chloro 1,1-difluoroethane (HCFC-142b);
- p. 2-chloro-1,1,1,2-tetrafluoroethane (HCFC-124);
- q. Pentafluoroethane (HFC-125);
- r. 1,1,2,2-tetrafluoroethane (HFC-134);
- s. 1,1,1-trifluoroethane (HFC-143a);
- t. 1,1-difluoroethane (HFC-152a);
- u. Parachlorobenzotrifluoride (PCBTF);
- v. Cyclic, branched, or linear completely methylated siloxanes;
- w. Acetone;
- x. Perchloroethylene (tetrachloroethylene);
- y. 3,3-dichloro-1,1,1,2,2-pentafluoropropane (HCFC-225ca);

- z. 1,3-dichloro-1,1,2,2,3-pentafluoropropane (HCFC-225cb);
- aa. 1,1,1,2,3,4,4,5,5,5-decafluoropentane (HFC 43-10mee);
- bb. Difluoromethane (HFC-32);
- cc. Ethylfluoride (HFC-161);
- dd. 1,1,1,3,3,3-hexafluoropropane (HFC-236fa);
- ee. 1,1,2,2,3-pentafluoropropane (HFC-245ca);
- ff. 1,1,2,3,3-pentafluoropropane (HFC-245ea);
- gg. 1,1,1,2,3-pentafluoropropane (HFC-245eb);
- hh. 1,1,1,3,3-pentafluoropropane (HFC-245fa);
- ii. 1,1,1,2,3,3-hexafluoropropane (HFC-236ea);
- jj. 1,1,1,3,3-pentafluorobutane (HFC-365mfc);
- kk. Chlorofluoromethane (HCFC-31);
- ll. 1 chloro-1-fluoroethane (HCFC-151a);
- mm. 1,2-dichloro-1,1,2-trifluoroethane (HCFC-123a);
- nn. 1,1,1,2,2,3,3,4,4-nonafluoro-4-methoxy-butane (C<sub>4</sub>F<sub>9</sub>OCH<sub>3</sub> or HFE-7100);
- oo. 2-(difluoromethoxymethyl)-1,1,1,2,3,3,3-heptafluoropropane ((CF<sub>3</sub>)<sub>2</sub>CF<sub>2</sub>OCH<sub>3</sub>);
- pp. 1-ethoxy-1,1,2,2,3,3,4,4,4-nonafluorobutane (C<sub>4</sub>F<sub>9</sub>OC<sub>2</sub>H<sub>5</sub> or HFE-7200);
- qq. 2-(ethoxydifluoromethyl)-1,1,1,2,3,3,3-heptafluoropropane ((CF<sub>3</sub>)<sub>2</sub>CF<sub>2</sub>OC<sub>2</sub>H<sub>5</sub>);
- rr. Methyl acetate;
- ss. 1,1,1,2,2,3,3-heptafluoro-3-methoxy-propane (n-C<sub>3</sub>F<sub>7</sub>OCH<sub>3</sub>) (HFE-7000);
- tt. 3-ethoxy-1,1,1,2,3,4,4,5,5,6,6,6-dodecafluoro-2-(trifluoromethyl) hexane (HFE-7500);
- uu. 1,1,1,2,3,3,3-heptafluoropropane (HFC 227ea);
- vv. methyl formate (HCOOCH<sub>3</sub>);
- ww. (±) 1,1,1,2,2,3,4,5,5,5-decafluoro-3-methoxy-4-trifluoromethyl-pentane (HFE-7300);
- xx. propylene carbonate;
- yy. dimethyl carbonate;
- zz. trans-1,3,3,3-tetrafluoropropene; and
- aaa. HCF<sub>2</sub>OCF<sub>2</sub>H (HFE-134);
- bbb. HCF<sub>2</sub>OCF<sub>2</sub>OCF<sub>2</sub>H (HFE-236cal2);
- ccc. HCF<sub>2</sub>OCF<sub>2</sub>CF<sub>2</sub>OCF<sub>2</sub>H (HFE-338pcc13);
- ddd. HCF<sub>2</sub>OCF<sub>2</sub>OCF<sub>2</sub>CF<sub>2</sub>OCF<sub>2</sub>H (H-Galden 1040x or H-Galden ZT 130 (or 150 or 180)); and
- eee. Perfluorocarbon compounds which fall into these classes:
  - (1) Cyclic, branched, or linear, completely fluorinated alkanes;
  - (2) Cyclic, branched, or linear, completely fluorinated ethers with no unsaturations;

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

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

2. For purposes of determining compliance with emissions standards, volatile organic compounds shall be measured by the appropriate reference method in accordance with the provisions of 9VAC5-40-30 or 9VAC5-50-30, as applicable. Where such a method also measures compounds with negligible photochemical reactivity, these negligibly reactive compounds may be excluded as a volatile organic compound if the amount of such compounds is accurately quantified, and such exclusion is approved by the board.

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

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

5. The following compound is a VOC for purposes of all recordkeeping, emissions reporting, photochemical dispersion modeling and inventory requirements that apply to VOCs and shall be uniquely identified in emission reports, but is not a VOC for purposes of VOC emission standards, VOC emissions limitations, or VOC content requirements: t-butyl acetate.

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

VA.R. Doc. No. R14-3611; Filed January 10, 2014, 1:33 p.m.

### Fast-Track Regulation

**Title of Regulation:** 9VAC5-80. Permits for Stationary Sources (Rev. G13) (amending 9VAC5-80-1110).

**Statutory Authority:** § 10.1-1308 of the Code of Virginia; Clean Air Act (§§ 110, 112, 165, 173, 182, and Title V); 40 CFR Parts 51, 61, 63, 63, 70, and 72.

**Public Hearing Information:** No public hearings are scheduled.

**Public Comment Deadline:** March 12, 2014.

**Effective Date:** March 27, 2014.

**Agency Contact:** Gary E. Graham, Department of Environmental Quality, 629 East Main Street, P.O. Box 1105, Richmond, VA 23218, telephone (804) 698-4103, FAX (804) 698-4510, TTY (804) 698-4021, or email gary.graham@deq.virginia.gov.

**Basis:** Section 10.1-1308 of the Virginia Air Pollution Control Law (Chapter 13 (§ 10.1-1300 et seq.) of Title 10.1 of the Code of Virginia) authorizes the State Air Pollution Control Board to promulgate regulations abating, controlling, and prohibiting air pollution to protect public health and welfare. Written assurance from the Office of the Attorney General that the State Air Pollution Control Board possesses the statutory authority to promulgate the proposed regulation amendments is available upon request.

**Federal Requirements.** Section 110(a) of the Clean Air Act (CAA) mandates that each state adopt and submit to EPA a plan that provides for the implementation, maintenance, and enforcement of each primary and secondary air quality standard within each air quality control region in the state. The state implementation plan shall be adopted only after reasonable public notice is given and public hearings are held.

40 CFR Part 51 sets out the requirements for the preparation, adoption, and submittal of state implementation plans. These requirements mandate that any such plan shall include several provisions, which are found in Subpart F (Procedural Requirements), Subpart G (Control Strategy), Subpart I (Review of New Sources and Modifications), and Subpart L (Legal Authority).

**State Requirements.** § 10.1-1322.4 of the Code of Virginia provides an exemption (unless required by the federal government law or regulation) from permit requirements for the use of an alternative fuel or raw material, if the owner demonstrates to the board that, as a result of trial burns at the facility or other facilities or other sufficient data, the emissions resulting from the use of the alternative fuel or raw material supply are decreased. The Code of Virginia further provides (to the extent allowed by federal law or regulation) that no demonstration shall be required for the use of processed animal fat, processed fish oil, processed vegetable oil, distillate oil, or any mixture thereof in place of the same quantity of residual oil to fire industrial boilers.

**Purpose:** The purpose of the regulation is to protect public health, safety, and welfare by establishing the procedural and legal basis for the issuance of new source permits for a proposed new stationary source or a project at an existing one that will (i) enable the agency to conduct a preconstruction review in order to determine compliance with applicable control technology and other standards, (ii) assess the impact of the emissions from the source on air quality, and (iii) provide a state and federally enforceable mechanism to enforce permit program requirements. The purpose of the

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# Regulations

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proposed amendments is to make the definition of "nonroad engine" consistent with the federal definition in Subpart A (40 CFR 89.2) of 40 CFR 89 (Control of Emissions from New and In-use Nonroad Compression Ignition Engines).

Rationale for Using Fast-Track Process: Federal design standards for internal combustion engines and federal fuel standards are more restrictive than minor new source review (NSR) permit standards for portable and temporary engines used as nonroad engines. Adopting the federal definition of "nonroad engine," which groups portable engines and temporary engines together with other non-mobile engines in that definition, will make it unnecessary to issue minor NSR permits without meaningful additional emission control requirements for those engines. Because amending this definition does not increase emissions or otherwise affect air quality, this change is not expected to be controversial.

Substance: This amendment revises the definition of "nonroad engine" to be more consistent with a similar federal definition. The definition is expanded to include portable and temporary engines. Since nonroad engines are excluded from the definition of "stationary source," this amendment increases the number of engines that are not subject to minor NSR permitting requirements.

Issues: The primary advantage to the public of the revised definition of "nonroad engine" is that businesses with such engines on site will avoid permit application costs for those engines. Because federal regulations already place restrictive design requirements on these engines, there are no disadvantages to the public.

The primary advantage to the department of the revised definition of "nonroad engine" is that resources will be conserved and put to better use reviewing permit applications that have to potential for reducing emissions. There is no disadvantage to the department of this revised definition.

## Department of Planning and Budget's Economic Impact Analysis:

Summary of the Proposed Amendments to Regulation. The State Air Pollution Control Board (Board) proposes to revise the definition of "nonroad engine" to be more consistent with a similar federal definition. The definition is expanded to include portable and temporary engines. Since nonroad engines are excluded from the definition of "stationary source," this amendment increases the number of engines that are not subject to minor new source review (NSR) permitting requirements.

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

Estimated Economic Impact. Between 2002 and 2012 the definition of nonroad engine in these regulations was identical to the federal definition. In an action that became effective November 7, 2012, the definition of nonroad engine in these regulations was changed in such a way that some previous nonroad engines (portable and temporary engines)

would have become subject to minor NSR permitting requirements. The Department of Environmental Quality (Department) issued a guidance document that allows a phase-in period for owners and operators of those engines to adjust to the new requirements. Specifically, the guidance document states that these owners and operators: 1) must submit a permit application by January 1, 2014, and 2) will not be considered out of compliance for failing to receive a permit prior to January 1, 2014.

The Board's current proposed action restores the conformity of the state definition to the current federal definition. Thus, if this action becomes effective prior to January 1, 2014, owners and operators of portable and temporary engines will at no point be required to obtain a minor NSR permit. The Department expects that this action will become effective prior to January 1, 2014.

As a result of the proposed change to the definition of "nonroad engine," affected sources may avoid permit costs of \$800 - \$1200 per facility.<sup>1</sup> Due to existing federal requirements, beyond paperwork and fee paying the owners and operators of portable and temporary engines would not likely have had to alter their actions in order to become and remain permitted<sup>2</sup>; consequently there would not likely have been an impact on emissions and air quality. The proposed amendment to conform the definition of nonroad engine in these regulations to the current federal definition will enable the Department to reallocate some of its permitting resources to other permit actions that are more likely to reduce emissions and improve air quality. Thus the proposed amendment is likely to produce a net benefit.

Businesses and Entities Affected. Any business or other entity that owns or operates portable or temporary engines is potentially affected by the proposed amendment. There is no information available on the number of entities that may be affected by the proposed change to the definition of "nonroad engines" since portable and temporary engines have thus far not been required to apply for permits.

Localities Particularly Affected. No localities are disproportionately affected by the proposed amendment.

Projected Impact on Employment. The proposed amendment will not likely have a large impact on employment.

Effects on the Use and Value of Private Property. The proposed amendment will save private owners of portable or temporary engines approximately \$800 to \$1200 in permit costs per facility, plus the time involved in applying for and renewing permits.

Small Businesses: Costs and Other Effects. The proposed amendment will reduce costs for small owners and operators of portable or temporary engines.

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

Real Estate Development Costs. Real estate developers who use portable or temporary engines may save approximately \$800 to \$1200 in permit costs due to the proposed amendment.

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

<sup>1</sup> Source: Department of Environmental Quality

<sup>2</sup> Ibid

Agency's Response to Economic Impact Analysis: The department has reviewed the economic impact analysis prepared by the Department of Planning and Budget and has no comment.

Summary:

*The amendment revises the definition of "nonroad engine" to be more consistent with a similar federal definition by expanding it to include portable and temporary engines. Since nonroad engines are excluded from the definition of "stationary source," this amendment increases the number of engines that are not subject to minor new source review permitting requirements.*

**9VAC5-80-1110. Definitions.**

A. For the purpose of applying this article in the context of the Regulations for the Control and Abatement of Air Pollution and related uses, the words or terms shall have the meanings given them in subsection C of this section.

B. As used in this article, all terms not defined herein shall have the meanings given them in 9VAC5-10 (General Definitions), unless otherwise required by context.

C. Terms defined.

"Addition" means the construction of a new emissions unit at or the relocation of an existing emissions unit to a stationary source.

"Affected emissions units" means the following emissions units, as applicable:

1. For a new stationary source, all emissions units.
2. For a project, the added, modified, and replacement emissions units that are part of the project.

"Applicable federal requirement" means all of, but not limited to, the following as they apply to affected emissions units subject to this article (including requirements that have been promulgated or approved by the administrator through rulemaking at the time of permit issuance but have future-effective compliance dates):

1. Any standard or other requirement provided for in an implementation plan established pursuant to § 110, § 111(d), or § 129 of the federal Clean Air Act, including any source-specific provisions such as consent agreements or orders.
2. Any term or condition in any construction permit issued under the new source review program or in any operating permit issued pursuant to the state operating permit program. However, those terms or conditions designated as state-only enforceable pursuant to 9VAC5-80-1120 F or 9VAC5-80-820 G shall not be applicable federal requirements.
3. Any emission standard, alternative emission standard, alternative emissions limitation, equivalent emissions limitation or other requirement established pursuant to § 112 or § 129 of the federal Clean Air Act as amended in 1990.
4. Any new source performance standard or other requirement established pursuant to § 111 of the federal Clean Air Act, and any emission standard or other requirement established pursuant to § 112 of the federal Clean Air Act before it was amended in 1990.
5. Any limitations and conditions or other requirement in a Virginia regulation or program that has been approved by EPA under Subpart E of 40 CFR Part 63 for the purposes of implementing and enforcing § 112 of the federal Clean Air Act.
6. Any requirement concerning accident prevention under § 112(r)(7) of the federal Clean Air Act.
7. Any compliance monitoring requirements established pursuant to either § 504(b) or § 114(a)(3) of the federal Clean Air Act.

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# Regulations

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8. Any standard or other requirement for consumer and commercial products under § 183(e) of the federal Clean Air Act.

9. Any standard or other requirement for tank vessels under § 183(f) of the federal Clean Air Act.

10. Any standard or other requirement in 40 CFR Part 55 to control air pollution from outer continental shelf sources.

11. Any standard or other requirement of the regulations promulgated to protect stratospheric ozone under Title VI of the federal Clean Air Act, unless the administrator has determined that such requirements need not be contained in a federal operating permit.

12. With regard to temporary sources subject to 9VAC5-80-130, (i) any ambient air quality standard, except applicable state requirements, and (ii) requirements regarding increments or visibility as provided in Article 8 (9VAC5-80-1605 et seq.) of this part.

13. Any standard or other requirement under § 126 (a)(1) and (c) of the federal Clean Air Act.

"Begin actual construction" means initiation of permanent physical on-site construction of an emissions unit. This includes, but is not limited to, installation of building supports and foundations, laying of underground pipework, and construction of permanent storage structures. With respect to a change in method of operation, this term refers to those on-site activities other than preparatory activities which mark the initiation of the change. With respect to the initial location or relocation of a portable emissions unit, this term refers to the delivery of any portion of the portable emissions unit to the site.

"Clean wood" means uncontaminated natural or untreated wood. Clean wood includes but is not limited to byproducts of harvesting activities conducted for forest management or commercial logging, or mill residues consisting of bark, chips, edgings, sawdust, shavings, or slabs. It does not include wood that has been treated, adulterated, or chemically changed in some way; treated with glues, binders, or resins; or painted, stained, or coated.

"Commence," as applied to the construction of an emissions unit, means that the owner has all necessary preconstruction approvals or permits and has either:

1. Begun, or caused to begin, a continuous program of actual on-site construction of the unit, to be completed within a reasonable time; or
2. Entered into binding agreements or contractual obligations, which cannot be canceled or modified without substantial loss to the owner, to undertake a program of actual construction of the unit, to be completed within a reasonable time.

"Complete application" means that the application contains all the information necessary for processing the application and that the provisions of § 10.1-1321.1 of the Virginia Air

Pollution Control Law have been met. Designating an application complete for purposes of permit processing does not preclude the board from requesting or accepting additional information.

"Construction" means fabrication, erection, installation, demolition, relocation, addition, replacement, or modification of an emissions unit that would result in a change in the uncontrolled emission rate.

"Construction waste" means solid waste that is produced or generated during construction, remodeling, or repair of pavements, houses, commercial buildings, and other structures. Construction wastes include, but are not limited to, lumber, wire, sheetrock, broken brick, shingles, glass, pipe, concrete, paving materials, and metal and plastics if the metal or plastics are a part of the materials of construction or empty containers for such materials. Paints, coatings, solvents, asbestos, any liquid, compressed gases or semi-liquids, and garbage are not construction wastes.

"Debris waste" means wastes resulting from land clearing operations. Debris wastes include, but are not limited to, stumps, wood, brush, leaves, soil, and road spoils.

"Demolition waste" means that solid waste that is produced by the destruction of structures or their foundations, or both, and includes the same materials as construction wastes.

"Diesel engine" means, for the purposes of 9VAC5-80-1105 A 1 b, any internal combustion engine that burns diesel or #2 fuel oil to provide power to processing equipment for a vegetative waste recycling/mulching operation.

"Emergency" means a condition that arises from sudden and reasonably unforeseeable events where the primary energy or power source is disrupted or disconnected due to conditions beyond the control of an owner or operator of a facility including:

1. A failure of the electrical grid;
2. On-site disaster or equipment failure;
3. Public service emergencies such as flood, fire, natural disaster, or severe weather conditions; or
4. An ISO-declared emergency, where an ISO emergency is:
  - a. An abnormal system condition requiring manual or automatic action to maintain system frequency, to prevent loss of firm load, equipment damage, or tripping of system elements that could adversely affect the reliability of an electric system or the safety of persons or property;
  - b. Capacity deficiency or capacity excess conditions;
  - c. A fuel shortage requiring departure from normal operating procedures in order to minimize the use of such scarce fuel;
  - d. Abnormal natural events or man-made threats that would require conservative operations to posture the system in a more reliable state; or

e. An abnormal event external to the ISO service territory that may require ISO action.

"Emissions cap" means any limitation on the rate of emissions of any air pollutant from one or more emissions units established and identified as an emissions cap in any permit issued pursuant to the new source review program or operating permit program.

"Emissions limitation" means a requirement established by the board that limits the quantity, rate, or concentration of emissions of air pollutants on a continuous basis, including any requirement relating to the operation or maintenance of a source to assure continuous emissions reduction, and any design standard, equipment standard, work practice, operational standard, or pollution prevention technique.

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

"Enforceable as a practical matter" means that the permit contains emissions limitations that are enforceable by the board or the department and meet the following criteria:

1. Are permanent;
2. Contain a legal obligation for the owner to adhere to the terms and conditions;
3. Do not allow a relaxation of a requirement of the implementation plan;
4. Are technically accurate and quantifiable;
5. Include averaging times or other provisions that allow at least monthly (or a shorter period if necessary to be consistent with the implementation plan) checks on compliance. This may include, but not be limited to, the following: compliance with annual limits in a rolling basis, monthly or shorter limits, and other provisions consistent with this article and other regulations of the board; and
6. Require a level of recordkeeping, reporting and monitoring sufficient to demonstrate compliance.

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

"Federal hazardous air pollutant new source review program" means a program for the preconstruction review and approval of the construction, reconstruction, or modification of any stationary source in accordance with regulations specified below and promulgated to implement the requirements of § 112 (relating to hazardous air pollutants) of the federal Clean Air Act.

1. The provisions of 40 CFR 61.05, 40 CFR 61.06, 40 CFR 61.07, 40 CFR 61.08 and 40 CFR 61.15 for issuing approvals of the construction of any new source or modification of any existing source subject to the provisions of 40 CFR Part 61.
2. The provisions of 40 CFR 63.5 for issuing approvals to construct a new source or reconstruct a source subject to

the provisions of 40 CFR Part 63, except for Subparts B, D and E.

3. The provisions of 40 CFR 63.50 through 40 CFR 63.56 for issuing Notices of MACT Approval prior to the construction of a new emissions unit.

"Federally enforceable" means all limitations and conditions that are enforceable by the administrator and citizens under the federal Clean Air Act or that are enforceable under other statutes administered by the administrator. Federally enforceable limitations and conditions include, but are not limited to, the following:

1. Emission standards, alternative emission standards, alternative emissions limitations, and equivalent emissions limitations established pursuant to § 112 of the federal Clean Air Act, as amended in 1990.
2. New source performance standards established pursuant to § 111 of the federal Clean Air Act, and emission standards established pursuant to § 112 of the federal Clean Air Act before it was amended in 1990.
3. All terms and conditions (unless expressly designated as state-only enforceable) in a federal operating permit, including any provisions that limit a source's potential to emit.
4. Limitations and conditions that are part of an implementation plan established pursuant to § 110, § 111(d) or § 129 of the federal Clean Air Act.
5. Limitations and conditions (unless expressly designated as state-only enforceable) that are part of a federal construction permit issued under 40 CFR 52.21 or any construction permit issued under regulations approved by EPA into the implementation plan.
6. Limitations and conditions (unless expressly designated as state-only enforceable) that are part of a state operating permit where the permit and the permit program pursuant to which it was issued meet all of the following criteria:
  - a. The operating permit program has been approved by the EPA into the implementation plan under § 110 of the federal Clean Air Act.
  - b. The operating permit program imposes a legal obligation that operating permit holders adhere to the terms and limitations of such permits and provides that permits that do not conform to the operating permit program requirements and the requirements of EPA's underlying regulations may be deemed not federally enforceable by EPA.
  - c. The operating permit program requires that all emissions limitations, controls, and other requirements imposed by such permits will be at least as stringent as any other applicable limitations and requirements contained in the implementation plan or enforceable under the implementation plan, and that the program may not issue permits that waive, or make less stringent, any limitations or requirements contained in or issued

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# Regulations

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pursuant to the implementation plan, or that are otherwise federally enforceable.

d. The limitations, controls, and requirements in the permit in question are permanent, quantifiable, and otherwise enforceable as a practical matter.

e. The permit in question was issued only after adequate and timely notice and opportunity for comment by the EPA and the public.

7. Limitations and conditions in a regulation of the board or program that has been approved by EPA under Subpart E of 40 CFR Part 63 for the purposes of implementing and enforcing § 112 of the federal Clean Air Act.

8. Individual consent agreements that EPA has legal authority to create.

"Federal operating permit" means a permit issued under the federal operating permit program.

"Federal operating permit program" means an operating permit system (i) for issuing terms and conditions for major stationary sources, (ii) established to implement the requirements of Title V of the federal Clean Air Act and associated regulations, and (iii) codified in Article 1 (9VAC5-80-50 et seq.), Article 2 (9VAC5-80-310 et seq.), Article 3 (9VAC5-80-360 et seq.), and Article 4 (9VAC5-80-710 et seq.) of this part.

"Fixed capital cost" means the capital needed to provide all the depreciable components.

"Fugitive emissions" means those emissions that could not reasonably pass through a stack, chimney, vent, or other functionally equivalent opening.

"General permit" means a permit issued under this article that meets the requirements of 9VAC5-80-1250.

"Hazardous air pollutant" means (i) any air pollutant listed in § 112(b) of the federal Clean Air Act, as amended by Subpart C of 40 CFR Part 63, and (ii) incorporated by reference into the regulations of the board at 9VAC5-60-92 B.

"Independent system operator" or "ISO" means a person that may receive or has received by transfer pursuant to § 56-576 of the Code of Virginia any ownership or control of, or any responsibility to operate, all or part of the transmission systems in the Commonwealth.

"Major modification" means any project at a major stationary source that would result in a significant emissions increase in any regulated air pollutant. For projects, the emissions increase may take into consideration any state and federally enforceable permit conditions that will be placed in a permit resulting from a permit application deemed complete under the provisions of 9VAC5-80-1160 B.

"Major new source review (NSR) permit" means a permit issued under the major new source review program.

"Major new source review (major NSR) program" means a preconstruction review and permit program (i) for new major

stationary sources or major modifications (physical changes or changes in the method of operation); (ii) established to implement the requirements of §§ 112, 165 and 173 of the federal Clean Air Act and associated regulations; and (iii) codified in Article 7 (9VAC5-80-1400 et seq.), Article 8 (9VAC5-80-1605 et seq.) and Article 9 (9VAC5-80-2000 et seq.) of this part.

"Major stationary source" means any stationary source that emits, or has the potential to emit, 100 tons or more per year of any regulated air pollutant. For new stationary sources, the potential to emit may take into consideration any state and federally enforceable permit conditions that will be placed in a permit resulting from a permit application deemed complete under the provisions of 9VAC5-80-1160 B.

"Minor new source review (NSR) permit" means a permit issued pursuant to this article.

"Minor new source review (minor NSR) program" means a preconstruction review and permit program (i) for regulated air pollutants from new stationary sources or projects that are not subject to review under the major new source review program; (ii) established to implement the requirements of §§ 110(a)(2)(C) and 112 of the federal Clean Air Act and associated regulations; and (iii) codified in this article. The minor NSR program may also be used to implement the terms and conditions described in 9VAC5-80-1120 F 1; however, those terms and conditions shall be state-only enforceable and shall not be applicable federal requirements.

"Modification" means any physical change in, or change in the method of operation of an emissions unit that increases the uncontrolled emission rate of any regulated air pollutant emitted into the atmosphere by the unit or that results in the emission of any regulated air pollutant into the atmosphere not previously emitted. The following shall not be considered physical changes or changes in the method of operation under this definition:

1. Maintenance, repair and replacement of components that the board determines to be routine for a source type and which does not fall within the definition of "replacement";
2. An increase in the throughput or production rate of a unit (unless previously limited by any state enforceable and federally enforceable permit conditions established pursuant to this chapter), if that increase does not exceed the operating design capacity of that unit;
3. An increase in the hours of operation (unless previously limited by any state enforceable and federally enforceable permit conditions established pursuant to this chapter);
4. Use of an alternative fuel or raw material (unless previously limited by any state enforceable and federally enforceable permit conditions established pursuant to this chapter) if, prior to the date any provision of the regulations of the board becomes applicable to the source type, the emissions unit was designed to accommodate that alternative use. A unit shall be considered to be designed to

accommodate an alternative fuel or raw material if provisions for that use were included in the final construction specifications;

5. Use of an alternative fuel or raw material that the emissions unit is approved to use under any new source review permit;

6. The addition, replacement or use of any system or device whose primary function is the reduction of air pollutants, except when a system or device that is necessary to comply with applicable air pollution control laws, permit conditions or regulations is replaced by a system or device which the board considers to be less efficient in the control of air pollution emissions;

7. The removal of any system or device whose primary function is the reduction of air pollutants if the system or device is not (i) necessary for the source to comply with any applicable air pollution control laws, permit conditions, or regulations or (ii) used to avoid any applicable new source review program requirement; or

8. A change in ownership at a stationary source.

"Necessary preconstruction approvals or permits" means those permits or approvals required under the NSR program that is part of the implementation plan.

"New source review (NSR) permit" means a permit issued under the new source review program.

"New source review (NSR) program" means a preconstruction review and permit program (i) for regulated air pollutants from new stationary sources or projects (physical changes or changes in the method of operation); (ii) established to implement the requirements of §§ 110(a)(2)(C), 112 (relating to permits for hazardous air pollutants), 165 (relating to permits in prevention of significant deterioration areas), and 173 (relating to permits in nonattainment areas) of the federal Clean Air Act and associated regulations; and (iii) codified in this article, Article 7 (9VAC5-80-1400 et seq.), Article 8 (9VAC5-80-1605 et seq.) and Article 9 (9VAC5-80-2000 et seq.) of this part. The NSR program may also be used to implement the terms and conditions described in 9VAC5-80-1120 F 1; however, those terms and conditions shall be state-only enforceable and shall not be applicable federal requirements.

"New stationary source" means any stationary source to be constructed at or relocated to an undeveloped site.

"Nonroad engine" means any internal combustion engine:

1. In or on a piece of equipment that is self-propelled or serves a dual purpose by both propelling itself and performing another function (such as garden tractors, off-highway mobile cranes and bulldozers); ~~or~~

2. In or on a piece of equipment that is intended to be propelled while performing its function (such as lawnmowers and string trimmers); or

3. That, by itself or in or on a piece of equipment, is portable or transportable, meaning designed to be capable of being carried or moved from one location to another. Indications of transportability include, but are not limited to, wheels, skids, carrying handles, dollies, trailers, or platforms.

An internal combustion engine is not a nonroad engine if (i) the engine is used to propel a motor vehicle or a vehicle used solely for competition, or is subject to standards promulgated under § 202 of the federal Clean Air Act; or (ii) the engine otherwise included in subdivision 3 of this definition remains or will remain at a location for more than 12 consecutive months or a shorter period of time for an engine located at a seasonal source.

For purposes of this definition, a location is any single site at a building, structure, facility, or installation. Any engine or engines that replaces an engine at a location and that is intended to perform the same or similar function as the engine replaced will be included in calculating the consecutive time period. An engine located at a seasonal source is an engine that remains at a seasonal source during the full annual operating period of the seasonal source. A seasonal source is a stationary source that remains in a single location on a permanent basis (i.e., at least two years) and that operates at the single location approximately three months or more each year. This subdivision does not apply to an engine after the engine is removed from the location.

"Plantwide applicability limitation (PAL)" means an emissions limitation expressed in tons per year, for a pollutant at a major stationary source, that is enforceable as a practical matter and established sourcewide in accordance with 9VAC5-80-1865 or 9VAC5-80-2144.

"PAL permit" means the state operating permit issued by the board that establishes a PAL for a major stationary source.

"Portable," in reference to emissions units, means an emissions unit that is designed to have the capability of being moved from one location to another for the purpose of operating at multiple locations and storage when idle. Indications of portability include, but are not limited to, wheels, skids, carrying handles, dolly, trailer, or platform.

"Potential to emit" means the maximum capacity of a stationary source to emit a pollutant under its physical and operational design. Any physical or operational limitation on the capacity of the source to emit a pollutant, including air pollution control equipment, and restrictions on hours of operation or on the type or amount of material combusted, stored, or processed, shall be treated as part of its design only if the limitation or its effect on emissions is state and federally enforceable. Secondary emissions do not count in determining the potential to emit of a stationary source.

"Precursor pollutant" means the following:

(4) 1. Volatile organic compounds and nitrogen oxides are precursors to ozone.



# Regulations

(2) 2. Sulfur dioxide is a precursor to PM<sub>2.5</sub>.

(3) 3. Nitrogen oxides are presumed to be precursors to PM<sub>2.5</sub> in all PM<sub>2.5</sub>, unless the board determines that emissions of nitrogen oxides from sources in a specific area are not a significant contributor to that area's ambient PM<sub>2.5</sub> concentrations.

(4) 4. Volatile organic compounds and ammonia are presumed not to be precursors to PM<sub>2.5</sub>, unless the board determines that emissions of volatile organic compounds or ammonia from sources in a specific area are a significant contributor to that area's ambient PM<sub>2.5</sub> concentrations.

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

"Project" means any change at an existing stationary source consisting of the addition, replacement, or modification of one or more emissions units.

"Public comment period" means a time during which the public shall have the opportunity to comment on the permit application information (exclusive of confidential information) for a new stationary source or project, the preliminary review and analysis of the effect of the source upon the ambient air quality, and the preliminary decision of the board regarding the permit application.

"Reactivation" means beginning operation of an emissions unit that has been shut down.

"Reconstruction" means, for the sole purposes of 9VAC5-80-1210 A, B, and C, the replacement of an emissions unit or its components to such an extent that:

1. The fixed capital cost of the new components exceeds 50% of the fixed capital cost that would be required to construct a comparable entirely new unit;
2. The replacement significantly extends the life of the emissions unit; and
3. It is technologically and economically feasible to meet the applicable emission standards prescribed under regulations of the board.

Any determination by the board as to whether a proposed replacement constitutes reconstruction shall be based on:

1. The fixed capital cost of the replacements in comparison to the fixed capital cost of the construction of a comparable entirely new unit;
2. The estimated life of the unit after the replacements compared to the life of a comparable entirely new unit;
3. The extent to which the components being replaced cause or contribute to the emissions from the unit; and
4. Any economic or technical limitations on compliance with applicable standards of performance that are inherent in the proposed replacements.

"Regulated air pollutant" means any of the following:

1. Nitrogen oxides or any volatile organic compound.
2. Any pollutant (including any associated precursor pollutant) for which an ambient air quality standard has been promulgated.
3. Any pollutant subject to any standard promulgated under 40 CFR Part 60.
4. Any pollutant subject to a standard promulgated under or other requirements established under 40 CFR Part 61 and any pollutant regulated under 40 CFR Part 63.
5. Any pollutant subject to a regulation adopted by the board.

"Relocation" means a change in physical location of a stationary source or an emissions unit from one stationary source to another stationary source.

"Replacement" means the substitution of an emissions unit for an emissions unit located at a stationary source, which will thereafter perform the same function as the replaced emissions unit.

"Secondary emissions" means emissions which occur or would occur as a result of the construction or operation of a new stationary source or an emissions unit, but do not come from the stationary source itself. For the purpose of this article, secondary emissions must be specific, well-defined, and quantifiable; and must affect the same general areas as the stationary source that causes the secondary emissions. Secondary emissions include emissions from any off site support facility that would not be constructed or increase its emissions except as a result of the construction or operation of the stationary source or emissions unit. Secondary emissions do not include any emissions that come directly from a mobile source, such as emissions from the tailpipe of a motor vehicle, from a train, or from a vessel.

"Significant" means:

1. In reference to an emissions increase, an increase in potential to emit that would equal or exceed any of the following rates:
  - a. In ozone nonattainment areas classified as serious or severe in 9VAC5-20-204:

Pollutant	Emissions Rate
Carbon Monoxide	100 tons per year (tpy)
Nitrogen Oxides	25 tpy
Sulfur Dioxide	40 tpy
Particulate Matter (PM)	25 tpy
Particulate Matter (PM <sub>10</sub> )	15 tpy

Particulate Matter (PM <sub>2.5</sub> )	10 tpy
Volatile organic compounds	25 tpy
Lead	0.6 tpy

b. In all other areas:

Pollutant	Emissions Rate
Carbon Monoxide	100 tons per year (tpy)
Nitrogen Oxides	40 tpy
Sulfur Dioxide	40 tpy
Particulate Matter (PM)	25 tpy
Particulate Matter (PM <sub>10</sub> )	15 tpy
Particulate Matter (PM <sub>2.5</sub> )	10 tpy
Volatile organic compounds	40 tpy
Lead	0.6 tpy

2. In reference to an emissions increase for a regulated air pollutant not listed in subdivision 1 of this definition, there is no emissions rate that shall be considered significant.

3. If the particulate matter (PM<sub>10</sub> or PM<sub>2.5</sub>) emissions for a stationary source or emissions unit can be determined in a manner acceptable to the board and the emissions increase is determined to be significant using the emission rate for particulate matter (PM<sub>10</sub> or PM<sub>2.5</sub>), the stationary source or emissions unit shall be considered to be significant for particulate matter (PM). If the emissions of particulate matter (PM<sub>10</sub> or PM<sub>2.5</sub>) cannot be determined in a manner acceptable to the board, the emission rate for particulate matter (PM) shall be used to determine whether the emissions increase is significant.

"Significant emissions increase" means, for a regulated air pollutant, an increase in emissions that is significant for that pollutant.

"Site" means one or more contiguous or adjacent properties under the control of the same person (or persons under common control).

"Source category schedule for standards" means the schedule (i) issued pursuant to § 112(e) of the federal Clean Air Act for promulgating MACT standards issued pursuant to § 112(d) of the federal Clean Air Act and (ii) incorporated by reference into the regulations of the board in subdivision 2 of 9VAC5-60-92.

"Space heater" means any fixed or portable, liquid or gaseous fuel-fired, combustion unit used to heat air in a space, or used to heat air entering a space, for the purpose of maintaining an air temperature suitable for comfort, storage, or equipment operation. Space heaters do not include combustion units used primarily for the purpose of conditioning or processing raw materials or product, such as driers, kilns, or ovens.

"State enforceable" means all limitations and conditions that are enforceable as a practical matter, including any regulation of the board, those requirements developed pursuant to 9VAC5-170-160, requirements within any applicable order or variance, and any permit requirements established pursuant to this chapter.

"State operating permit" means a permit issued under the state operating permit program.

"State operating permit program" means an operating permit program (i) for issuing limitations and conditions for stationary sources; (ii) promulgated to meet the EPA's minimum criteria for federal enforceability, including adequate notice and opportunity for the EPA and public comment prior to issuance of the final permit, and practicable enforceability; and (iii) codified in Article 5 (9VAC5-80-800 et seq.) of this part.

"Stationary source" means any building, structure, facility or installation that emits or may emit any regulated air pollutant. A stationary source shall include all of the pollutant-emitting activities that belong to the same industrial grouping, are located on one or more contiguous or adjacent properties, and are under the control of the same person (or persons under common control) except the activities of any watercraft or any nonroad engine. Pollutant-emitting activities shall be considered as part of the same industrial grouping if they belong to the same "major group" (i.e., that have the same two-digit code) as described in the "Standard Industrial Classification Manual" (see 9VAC5-20-21).

"Synthetic minor source" means a stationary source that otherwise has the potential to emit regulated air pollutants in amounts that are at or above those for major stationary sources, as applicable, but is subject to restrictions such that its potential to emit is less than such amounts for major stationary sources. Such restrictions must be enforceable as a practical matter. The term "synthetic minor source" applies independently for each regulated air pollutant that the source has the potential to emit.

"Temporary facility" means a facility that (i) is operated to achieve a specific objective (such as serving as a pilot test facility, a process feasibility project, or a remediation project) and (ii) does not contribute toward the commercial production of any product or service (including byproduct and intermediate product) during the operational period. Portable emissions units covered by the exemption under 9VAC5-80-1105 A 1 c and facilities used to augment or enable routine

# Regulations

production are not considered temporary facilities for the purposes of this definition.

"Toxic pollutant" means any air pollutant (i) listed in § 112(b) of the federal Clean Air Act, as amended by Subpart C of 40 CFR Part 63 and (ii) incorporated by reference into the regulations of the board at subdivision 1 of 9VAC5-60-92, or any other air pollutant that the board determines, through adoption of regulation, to present a significant risk to public health. This term excludes asbestos, fine mineral fibers, radionuclides, and any glycol ether that does not have a TLV®.

"Uncontrolled emission rate" means the emission rate from an emissions unit when operating at maximum capacity without air pollution control equipment. Air pollution control equipment includes control equipment that is not vital to its operation, except that its use enables the owner to conform to applicable air pollution control laws and regulations. Annual uncontrolled emissions shall be based on the maximum annual rated capacity (based on 8,760 hours of operation per year) of the emissions unit, unless the emissions unit or stationary source is subject to state and federally enforceable permit conditions that limit the annual hours of operation. Enforceable permit conditions on the type or amount of material combusted, stored, or processed may be used in determining the uncontrolled emission rate of an emissions unit or stationary source. The uncontrolled emission rate of a stationary source is the sum of the uncontrolled emission rates of the individual emissions units. Secondary emissions do not count in determining the uncontrolled emission rate of a stationary source.

"Undeveloped site" means any site or facility at which no emissions units are located at the time the permit application is deemed complete, or at the time the owner begins actual construction, whichever occurs first. An undeveloped site also includes any site or facility at which all of the emissions units have been determined to be shut down pursuant to the provisions of 9VAC5-20-220.

"Vegetative waste" means decomposable materials generated by land clearing activities and includes shrub, bush and tree prunings, bark, brush, leaves, limbs, roots, and stumps. Vegetative waste does not include construction or demolition waste or any combination of them.

"Vegetative waste recycling/mulching operation" means any activity related to size reduction or separating, or both, of clean wood or vegetative waste, or both, by grinding, shredding, chipping, screening, or any combination of them.

VA.R. Doc. No. R14-3825; Filed January 9, 2014, 2:03 p.m.

## VIRGINIA WASTE MANAGEMENT BOARD

### Final Regulation

**REGISTRAR'S NOTICE:** The following regulatory action is exempt from Article 2 of the Administrative Process Act in accordance with § 2.2-4006 A 4 c of the Code of Virginia, which excludes regulations that are necessary to meet the requirements of federal law or regulations provided such regulations do not differ materially from those required by federal law or regulation. The Virginia Waste Management Board will receive, consider, and respond to petitions by any interested person at any time with respect to reconsideration or revision.

**Title of Regulation:** 9VAC20-60. Virginia Hazardous Waste Management Regulations (amending 9VAC20-60-18).

**Statutory Authority:** §§ 10.1-1402 and 10.1-1426 of the Code of Virginia; 42 USC § 6921; 40 CFR Parts 260 through 272.

**Effective Date:** March 12, 2014.

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

#### Summary:

*The amendments incorporate the July 1, 2013, update of Title 40 of the Code of Federal Regulations and adopt the conditional exclusions for solvent contaminated wipes published in 78 FR 46448 (July 31, 2013).*

#### **9VAC20-60-18. Applicability of incorporated references based on the dates on which they became effective.**

Except as noted, when a regulation of the United States Environmental Protection Agency set forth in Title 40 of the Code of Federal Regulations is referenced and incorporated herein, that regulation shall be as it exists and has been published in the July 1, ~~2012~~ 2013, update and shall also include the conditional exclusions for solvent contaminated wipes as promulgated by the United States Environmental Protection Agency in 78 FR 46448 (July 31, 2013).

VA.R. Doc. No. R14-3912; Filed January 9, 2014, 9:00 a.m.

### Final Regulation

**REGISTRAR'S NOTICE:** The following regulatory action is exempt from Article 2 of the Administrative Process Act in accordance with § 2.2-4006 A 4 c of the Code of Virginia, which excludes regulations that are necessary to meet the requirements of federal law or regulations provided such regulations do not differ materially from those required by federal law or regulation. The Virginia Waste Management Board will receive, consider, and respond to petitions by any interested person at any time with respect to reconsideration or revision.

**Title of Regulation: 9VAC20-110. Regulations Governing the Transportation of Hazardous Materials (amending 9VAC20-110-110).**

**Statutory Authority:** §§ 10.1-1450 and 44-146.30 of the Code of Virginia; 49 USC §§ 1809-1810; 49 CFR Parts 107, 170-180, 383, and 390-397.

**Effective Date:** March 12, 2014.

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

**Summary:**

*The amendment incorporates certain federal amendments to regulations governing the transportation of hazardous materials promulgated by the U.S. Secretary of Transportation as of October 1, 2013.*

Part III

Compliance With Federal Regulations

**9VAC20-110-110. Compliance.**

Every person who transports or offers for transportation hazardous materials within or through the Commonwealth of Virginia shall comply with the federal regulations governing the transportation of hazardous materials promulgated by the United States Secretary of Transportation with amendments promulgated as of October 1, ~~2012~~ 2013, pursuant to the Hazardous Materials Transportation Act, and located at Title 49 of the Code of Federal Regulations as set forth below and which are incorporated in these regulations by reference:

1. Special Permits. 49 CFR Part 107, Subpart B.
2. Registration of Persons Who Offer or Transport Hazardous Materials in 49 CFR Part 107, Subpart G.
3. Hazardous Materials Regulations in 49 CFR Parts 171 through 177.
4. Specifications for Packagings in 49 CFR Part 178.
5. Specifications for Tank Cars in 49 CFR Part 179.
6. Continuing Qualification and Maintenance of Packagings in 49 CFR Part 180.
7. Motor Carrier Safety Regulations in 49 CFR Parts 390 through 397.

VA.R. Doc. No. R14-3911; Filed January 9, 2014, 9:02 a.m.



**TITLE 12. HEALTH**

**DEPARTMENT OF MEDICAL ASSISTANCE SERVICES**

**Final 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.

**Effective Date:** March 13, 2014.

**Agency Contact:** Nichole Martin, R.N., Long Term Care Division, Department of Medical Assistance Services, 600 East Broad Street, Suite 1300, Richmond, VA 23219, telephone (804) 371-5003 ext. 16, FAX (804) 786-1680, or email [nichole.martin@dmas.virginia.gov](mailto:nichole.martin@dmas.virginia.gov).

**Summary:**

*The amendments repeal the existing technology assisted waiver regulations (12VAC30-120-70 through 12VAC30-120-120) and promulgate new regulations (12VAC30-120-1700 through 12VAC30-120-1770).*

*The new provisions (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; (iii) update provider participation standards and staff qualifications; (iv) clarify that DMAS has direct oversight for the waiver and for authorization of services; (v) update and clarify waiver services and provider service delivery standards; (vi) clarify that assistive technology that is available through the State Plan for Medical Assistance will not be covered through the waiver; (vii) include and expand waiver participant rights and responsibilities; and (viii) update the waiver individual's right to file grievances and to appeal.*

*Changes since publication of the proposed regulation include (i) raising the limit on congregate private duty respite care services to 360 hours per calendar year per household; (ii) allowing 21 days of absence from the Commonwealth per calendar year for coverage of tech waiver services with the stipulation that skilled private duty nursing hours cannot exceed the amount authorized; (iii) giving the primary caregiver the right to participate in the scheduling of providers and services; (iv) adding personal care for adults only to the list of covered services; (v) permitting authorized private duty nursing care hours to be made up or traded within the same week of the missed scheduled shift; (vi) covering repairs of environmental modifications that DMAS has already reimbursed; (vii) as directed by Item 307 QQQQ of Chapter 806 of the 2013 Acts of Assembly, modifying the unit of service for skilled private duty nursing to a one-*

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# Regulations

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*quarter hour increment; and (viii) making other technical and editorial changes to improve clarity and readability.*

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.

## Part II

### Home and Community-Based Services for Technology Assisted Individual (Repealed)

#### **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.

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# Regulations

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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 waived 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 waived 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 device 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.



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# Regulations

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## ~~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.

e. 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.

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# Regulations

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## ~~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 XVII~~ ]~~

#### ~~Home and Community-Based Services for Technology Assisted Individuals [ Waiver ]~~

## **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~~, each of whom ] 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 [ years of age ] and [ ~~over~~ older ] and incapacitated adults [ ~~over~~ ] 18 years of age [ and older ] 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)~~ ] intellectually disabled (ICF/ID) ], 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~~ ADLs/IADLs ] 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 [ either ] the [ employment or 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 that ] investigates reports of abuse, neglect, and exploitation of children [ ~~under~~ younger than ] 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~~ 360 ] 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~~ younger than ] 21 years of age according to federal

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# Regulations

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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 ADLs/IADLs ].

"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 ICF/IDs ].

"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 [ demonstration ] 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~~ ADLs/IADLs ], 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.

[ "Service authorization" or "serv auth" means the DMAS approval of a requested medical service for reimbursement prior to the provision of the service. Service authorizations shall be performed by DMAS or its service authorization contractor.

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

"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.

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# Regulations

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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" [ or the Department of Health ] means the [ ~~state Health Virginia~~ Department [ of Health ] ].

"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 Intellectually Disabled~~ ], group homes licensed by DBHDS, general acute care hospitals, or adult foster care homes.

C. An individual [ ~~must~~ shall ] 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. Payments for tech waiver services shall not be provided to any financial institution or entity located outside of the United States pursuant to the Social Security Act § 1902(a)(80). Payments for tech waiver services furnished in another state shall (i) be provided for an individual who meets the requirements of 42 CFR § 431.52 and (ii) be 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;~~ individuals; ] 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 younger] 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~~ service ] 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 [ once ] 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~~ all ] 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~~ ICF/ID ], 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



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# Regulations

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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~~ require ] 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~~ require ] 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~~ determined ] 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~~ shall ] 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~~ body ] 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 [ ~~waiver enrollment and~~ ] 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~~ health care ] 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 [ , and scheduling ] 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 service~~ ] authorization for skilled PDN services, [ ~~skilled private duty respite services,~~ ] PC for adults, and transition services. DMAS or the [ ~~prior service~~ ] authorization contractor shall perform [ ~~prior service~~ ] authorization for [ skilled private duty respite services, ] AT services and EM services.
- 6. When a particular service requires [ ~~prior service~~ ] authorization, reimbursement shall not be made until the

[ ~~prior service~~ ] authorization is secured from either DMAS or the DMAS-designated [ ~~prior service~~ ] authorization contractor.

B. Covered services. Covered services shall include: skilled PDN; skilled private duty respite care; [ personal care only for adults, ] 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~~ requires ] 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 [ , and where 16 scheduled PDN hours are not completed within a 24-hour period, the hours may be rescheduled and worked within the following 72 hours to support the primary caregiver ].

(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

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# Regulations

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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 [ that DMAS may allocate for ] 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 service~~ ] 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~~ required ] 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 [ based on the individual's total technology and nursing scores and provided that the aggregate cost-effectiveness standard is not exceeded for the individual's care ].

(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~~ authorized ] hours of care may be done within [ ~~72 hours~~ the same week (Sunday through Saturday) ] 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 [ based on the individual's total technology and nursing scores and ] provided that the [ aggregate ]

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.~~ e.g. ], 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 [ , or should the individual be out of the Commonwealth for 48 hours or more ].

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~~ no more than ] 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~~ 360 ] 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~~ a ] primary caregiver who requires temporary or intermittent relief from the burden of [ ~~care giving~~ caregiving ].

a. This service shall be provided by skilled nursing staff licensed to practice in the Commonwealth under the direct supervision of a [ licensed, certified, or accredited ] 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~~ ADLs/IADLs ], 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~~ 360 ] 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~~ shall ] 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~~ AT services ] 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~~ ADLs/IADLs ], 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~~ shall ] be obtained from qualified professionals who are knowledgeable of that item for each AT request prior to approval by DMAS or the designated [ ~~prior~~ service ] 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

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# Regulations

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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 \$5,000 per individual per calendar year ].

(2) The cost for AT shall not be carried over from one calendar year to the next. Each item must be [ prior service ] 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 shall ] be within the [ prior service ] 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 service ] authorization shall not be modified to accommodate delays in product deliveries. In such situations, new [ prior service ] 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 service ] 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 service ] authorization by DMAS or the designated [ prior service ] authorization contractor. The vendor [ must shall ] 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 shall ] 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, ADLs/IADLs; ] 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 service ] authorization of EM services is completed by DMAS or the DMAS-designated [ prior service ] 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 shall ] 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 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~~ service ] 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. [ Repairs of modifications that have been reimbursed by DMAS shall be covered. ]

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~~ service ] authorization approval dates, which may be prior to the completion date as long as the work commenced during the approval dates. The [ ~~prior~~ service ] 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~~ service ] authorization contractor for revision to the previously issued [ ~~prior~~ service ] authorization and [ ~~must~~ shall ] include justification and supporting documentation of medical needs.

k. EM exclusions.

(1) There shall be no duplication of [ previous ] EM services [ ~~with~~ within ] the same residence such as multiple wheelchair ramps or [ ~~multiple~~ previous ]

modifications to the same room. [ There shall be no duplication of EM within the same plan year. ]

(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 [ are ] 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.

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# Regulations

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a. PC services are either of a supportive or health-related nature and may include, but are not limited to, assistance with [ ~~ADLs~~ ADLs/IADLs ], 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~~ ADLs/IADLs ]. 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~~ service ] 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~~ period ] 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~~ service ] authorized by DMAS or the designated [ ~~prior~~ service ] 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~~ service ] authorized by DMAS or its designated [ ~~prior~~ service ] authorization contractor in order for reimbursement to occur. These services shall include those set out in the MFP [ ~~program~~ demonstration ].

b. For the purposes of transition funding [ for the technology assisted waiver ], an institution means an [ ~~ICF/MR~~ ICF/ID ], 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 [ or expires ] 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~~ service ] 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~~ private duty nursing authorization]. 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~~ the individual's] representative to include documentation in the individual's record. The DMAS staff or the DMAS designated [~~prior~~ service] authorization contractor shall notify in writing the individual or [~~individual~~ the individual's] 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~~ or] 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~~ is] not endangered), the provider shall provide the individual and [~~individual~~ the individual's] 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~~ long] as the waiver eligibility and medical necessity criteria continue to be met. For individuals 21 years of age and older, the individual [~~must~~ shall] follow the criteria for specialized care nursing facility admission. For individuals who are younger than 21 years of age, the individual [~~must~~ shall] 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:



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# Regulations

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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~~ be performed by ] the Virginia State Police for the Commonwealth. [ ~~Searches When the Medicaid individual is a minor child, 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@dmass.virginia.gov](mailto:providerexclusion@dmass.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 [ § 63.2-100, §§ 63.2-1508 through 63.2-1513, and ] § 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 [ the records of ] 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~~ a waiver ] applicant or [ recipient individual ] that could disclose the individual's identity is confidential and shall be safeguarded. Access to information concerning [ waiver ] applicants or [ recipients ~~must~~ individuals shall ] 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)~~ provider's written program participation agreement with DMAS ].

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~~ minors have ] reached [ ~~18~~ 21 ] 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~~ shall ] 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~~ ensure ] the health, safety, and welfare of the individual when the primary caregiver is ill, incapacitated, or using PDN respite. Documentation in the

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# Regulations

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medical record [ ~~must~~ shall ] 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 [ RN and LPN ] employees shall have a satisfactory work record, as evidenced by at least two references from prior job experiences. In lieu of this requirement [ for personal care aides only ], employees who have [ ~~only~~ ] worked for [ only ] one employer shall be permitted to provide two personal references. [ Providers who are not able to obtain previous job references about personal care aides shall retain written documentation showing their good faith efforts to obtain such references in the new employee's work record. ]

b. Staff and agencies shall meet any certifications, licensure, or registration, as applicable and as required by applicable state law. Staff qualifications [ ~~must~~ shall ] 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~~ shall ] 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~~ service ] 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~~ Service ] authorization decisions performed by the DMAS staff or the DMAS-designated [ ~~prior~~ service ] 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~~ ensuring ] 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~~ that ] 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~~ that ] 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. [ Upon such notice, DMAS shall immediately terminate the provider's Medicaid provider agreement pursuant to § 32.1-325 D of the Code of Virginia and as may be required for federal financial participation. ] Such provider agreement terminations shall be immediate and conform to [ ~~12VAC30-10-690 and 12VAC30-20-491~~ § 32.1-325 E of the Code of Virginia ].

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~~ non-home ] and community-based care services, such as companion or home health services. The following documentation [ ~~must~~ shall ] 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~~ shall ] 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 [ the ] individual's status and, as appropriate, progress toward the identified goals on the POC;
4. All related communication with the individual and the [ ~~individual~~ individual's ] representative, the DMAS designated agent for [ ~~prior~~ service ] 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~~ service ] authorization decisions rendered by the DMAS staff or the DMAS-designated [ ~~prior~~ service ] 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~~ individual's ] 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. [ For records requiring weekly signatures, such signatures, times, and dates shall be placed on these records no earlier than the last day of the week in which services were provided and no later than seven calendar days from the date of the last service. ] An employee providing services to the [ ~~Tech-Waiver~~ tech waiver ] individual cannot sign for the individual. If the individual is unable to sign the nurses' records, it [ ~~must~~ shall ] be documented in the record how [ the nurses' records will be signed ] 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

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# Regulations

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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, [ private duty ] respite, and PC services, providers [ ~~must~~ shall ] 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, [ and personal care services ] to assess the individual's and [ ~~individual~~ the individual's ] 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~~ shall ] 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. The RN supervisor may delegate personal care aide supervisory visits to an LPN. The provider's RN or LPN supervisor shall make supervisory visits at least every 90 days. During visits to the waiver individual's home, the RN/LPN supervisor shall observe, evaluate, and document the adequacy and appropriateness of personal care services with regard to the individual's current functioning status and medical and social needs. The personal care aide's record shall be reviewed and the waiver individual's or family/caregiver's, or both, satisfaction with the type and amount of services discussed. ]

[ ~~d~~. e. ] 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 [ private duty ] respite services are routine in nature and offered in conjunction with PC services [ for adults ], the RN supervisory visit conducted for PC may serve as the supervisory visit for respite services. However, the supervisor [ ~~must~~ shall ] document supervision of [ private duty ] respite services separately. For this purpose, the same individual record can be used with a separate section for [ private duty ] respite services documentation.

7. For this waiver, personal care services shall only be agency directed and provided by a DMAS-enrolled PC provider [ to adult waiver individuals ].

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~~ ensure ] 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~~ that ] have a DMAS provider agreement to provide AT or EM [ or both ].

2. AT and EM shall be covered in the least expensive, most cost-effective manner. The provider [ ~~must~~ shall ] document and justify why more cost-effective solutions cannot be used. DMAS and the DMAS-designated [ ~~prior~~

service ] 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~~ the individual's ] 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~~ shall ] 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. [ All skilled PDN services and skilled PDN respite care services shall be reimbursed in increments of 15 minutes as a unit and shall be reimbursed at a 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~~ for the same ] 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~~ individuals ] 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~~ ensuring ] high quality of service delivery consistent with the attending physicians' orders, approved POCs, and [ ~~prior~~ service ] authorized services for the waiver individuals. Providers identified as not rendering reimbursed services consistent with such orders, POCs, and [ ~~prior~~ service ] 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 [ ~~the aggregated~~ ] cost-effectiveness standards or medical necessity criteria, then the DMAS staff, as appropriate, shall

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# Regulations

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deny payment for such waiver individual. Such waiver individuals shall be discharged from the waiver.

C. Securing [ ~~prior~~ service ] 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~~ by ] 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).~~

[Technology Assisted Waiver Provider RN Initial Home Assessment, DMAS-116 \(11/10\) \]](#)

~~Medicaid Long Term Care Communication Form, DMAS-225 (3/09).~~

[Medicaid Long Term Care Communication Form, DMAS-225 \(rev. 10/11\)](#)

Technology Assisted Waiver/EPSTD 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 (12VAC30-120)

Intellectual Disability: Definition, Classification, and Systems of Supports, 11th edition, 2010, American Association on Intellectual and Developmental Disabilities, 501 3rd Street, NW, Suite 200, Washington, DC 20001-2760; <http://www.aaid.org/intellectualdisabilitybook/>

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

[MR/ID Waiver Slot Assignment Process, August 20, 2010, Department of Behavioral Health and Developmental Services](#)

Virginia Medicaid Provider Manual

[Chapter I: General Information \(rev. 12/1/2011\)](#)

[Chapter II: Provider Participation Requirements \(rev. 2/8/2012\)](#)

[Chapter III: Recipient Eligibility \(rev. 12/1/2011\)](#)

[Chapter IV: Covered Services and Limitations \(rev. 7/14/2010\)](#)

[Chapter V: Billing Instructions \(rev. 1/26/2011\)](#)

[Chapter VI: Quality Management Review \(rev. 7/14/2010\)](#)

[Chapter VII: Day Support Waiver \(rev. 7/14/2010\)](#)

[ [PDN Authorization](#)

[Medical Assistance Program Participation Agreement](#) ]

VA.R. Doc. No. R09-597; Filed January 13, 2014, 12:38 p.m.

### Fast-Track Regulation

**Titles of Regulations: 12VAC30-60. Standards Established and Methods Used to Assure High Quality Care (amending 12VAC30-60-147, 12VAC30-60-200).**

**12VAC30-120. Waivered Services (amending 12VAC30-120-360, 12VAC30-120-370; repealing 12VAC30-120-260 through 12VAC30-120-350).**

**12VAC30-141. Family Access to Medical Insurance Security Plan (amending 12VAC30-141-10, 12VAC30-141-20, 12VAC30-141-70, 12VAC30-141-200, 12VAC30-141-500, 12VAC30-141-570, 12VAC30-141-660, 12VAC30-141-670, 12VAC30-141-680, 12VAC30-141-730, 12VAC30-141-830, 12VAC30-141-850, 12VAC30-141-880).**

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

**Public Hearing Information:** No public hearings are scheduled.

**Public Comment Deadline:** March 12, 2014.

**Effective Date:** March 28, 2014.

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

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

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

Chapter 3 of the 2012 Acts of Assembly, Special Session I, Item 307 N, established the agency's authority to seek federal approval of changes to its MEDALLION waiver. As of June 21, 2012, the Centers for Medicare and Medicaid Services (CMS) has approved Virginia's request to expand its managed care program and repeal its primary care case management (PCCM) program.

**Purpose:** The MEDALLION PCCM regulations (12VAC30-120-260 through 12VAC30-120-350) are repealed because they are no longer needed with the advent of statewide managed care organization service delivery. Managed care organizations will be operational statewide by the time this action is effective, and all Medicaid beneficiaries who are eligible for managed care enrollment will be served via that system. Once managed care organizations provide health care services throughout the Commonwealth, there will be no need to offer this alternative service delivery system. The managed care organization expansion statewide, effective July 1, 2012, renders the MEDALLION program obsolete. Medicaid beneficiaries who are excluded from managed care will receive their required medical care via the ongoing fee-for-service delivery system.

This repeal action also affects the Family Access to Medical Insurance Security (FAMIS) and FAMIS-MOMS programs. This repeal action will not affect the health, safety, or welfare of either Medicaid individuals or citizens.

**Rationale for Using Fast-Track Process:** The fast-track rulemaking process for these proposed regulatory changes was selected for several reasons. Repealing the MEDALLION program is not expected to be controversial because managed care organizations will be operational statewide by the time this action is effective, and all Medicaid beneficiaries who are eligible for managed care enrollment will be served via that system. The managed care organization expansion statewide renders the MEDALLION program obsolete.

**Substance:** The primary regulations affected by this action are MEDALLION (Part V) (12VAC30-120-260 through 12VAC30-120-350). Other regulations merely containing references to primary care case management (PCCM) are as follows: 12VAC30-60-147; 12VAC30-60-200; 12VAC30-120-360; 12VAC30-120-370; 12VAC30-141-10; 12VAC30-



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## Regulations

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141-20; 12VAC30-141-70; 12VAC30-141-200; 12VAC30-141-500; 12VAC30-141-570; 12VAC30-141-660; 12VAC30-141-670; 12VAC30-141-680; 12VAC30-141-730; 12VAC30-141-830, 12VAC30-141-850, and 12VAC30-141-880.

In December 1991, CMS approved the Commonwealth's 1915(b) waiver application to implement the MEDALLION PCCM program. The goal of the MEDALLION program was to improve Medicaid individuals' quality of care and to assist in controlling the Commonwealth's escalating health care costs. The MEDALLION program began as an experiment in managed care to address the fact that (i) many physicians were refusing (in 1990) to provide care to Medicaid recipients; (ii) hospital emergency rooms were often used for primary care; and (iii) medical care costs were increasing. The MEDALLION PCCM program began in four pilot cities and counties in January 1992. At its inception, it was intended to be a stepping stone towards managed care for the entire Commonwealth.

The initial response on the part of providers and beneficiaries was positive, and the program achieved cost savings. In 1993, CMS approved the phase-in of the program statewide. The MEDALLION program was expanded statewide in 1995, and Virginia became one of the first states to expand its PCCM program eligibility to cover beneficiaries in the aged, blind, and disabled categories.

MEDALLION is based on the concept of building ongoing relationships between providers and Medicaid recipients. MEDALLION's purpose was to encourage a relationship between the primary care physician (PCP) and Medicaid individuals resulting in a trusting environment called the "medical home." The goals of the MEDALLION program included: (i) enhancing access to care; (ii) providing for the continuity of care; (iii) providing a "medical home"; (iv) promoting improved patient compliance and responsibility when accessing medical care; and (v) increasing physician participation in the program. This was accomplished by linking beneficiaries with sources for coordinated primary care, assuring appropriate use of inpatient and emergency room care, reducing unnecessary prescriptions and laboratory tests, and improving access to routine and urgent primary care. MEDALLION provided for all services contained in the State Plan for Medical Assistance.

As with other PCCM programs, the PCP acted as a gatekeeper, providing or coordinating the medical needs of beneficiaries. The primary care provider was the first contact for care, offering coverage seven days a week, 24 hours a day. The PCP assumed a long-term responsibility for beneficiaries' health while coordinating care within the health care system, especially visits to specialists. Under the MEDALLION program, providers who enrolled as PCPs included, but were not limited to, general practice, family practice, internal medicine, and pediatricians. In Medicaid,

the PCP/patient ratios of MEDALLION have compared favorably to other health care delivery systems.

The MEDALLION program provided DMAS with an introduction to managed care. It defined the managed care eligible population and changed the way individuals and providers viewed Medicaid enrollees. Because MEDALLION introduced the concept of a PCP to Virginia Medicaid, Medicaid individuals became accustomed to being viewed as "clients" who were introduced to the concept of seeking referrals. As a result, MEDALLION produced better medical outcomes and promoted the physician/patient relationship, preventive care, and patient education, while reducing the inappropriate use of medical services as exists in fee-for-service Medicaid. The MEDALLION program became the foundation of the (former) Options and (current) Medallion II (MCO) programs. With federal approval, DMAS expanded its network of managed care organizations to far southwest Virginia, and the MEDALLION program has become obsolete.

This change also affects the agency's Title XXI program, Family Access to Medical Insurance Security (FAMIS), and FAMIS MOMS. The changes in 12VAC30-141 (Family Access to Medical Insurance Security Plan) are technical in nature to maintain consistency between Title XIX and Title XXI. The changes in 12VAC30-60 (Standards Established and Methods Used to Assure High Quality of Care) are also technical in nature to maintain consistency across the Virginia Administrative Code.

Issues: There are no advantages or disadvantages to private citizens in this regulatory action. The disadvantage to Medicaid individuals in this action is that it removes a service delivery model that previously existed, but this is more than balanced by the fact that former PCCM enrollees will now have a broader range of case management services available through the MCO network. There are no disadvantages to either the Commonwealth or DMAS in this action. The advantage to the department in this action is the removal of unnecessary regulations from DMAS's part of the Virginia Administrative Code.

### Department of Planning and Budget's Economic Impact Analysis:

Summary of the Proposed Amendments to Regulation. The proposed changes repeal the Medallion primary care case management regulations which have been obsolete since July 2012 due to expansion of managed care services statewide.

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

Estimated Economic Impact. The Medallion program used to pay a small monthly fee to the primary care providers for their case management services provided to enrollees located outside the managed care coverage areas. The cost of case management services is included in the monthly capitation fee paid to the managed care organizations. As of July 2012, Virginia Medicaid has reached statewide coverage for

managed care services. Thus, there is no longer a need for these regulations to continue to exist as they are currently obsolete. No significant economic impact is expected from the repeal of these regulations other than reducing the obsolete regulatory language in the Virginia Administrative Code.

**Businesses and Entities Affected.** As these regulations have been obsolete since July 2012, no businesses and entities will be directly affected.

**Localities Particularly Affected.** The proposed repeal of these regulations apply throughout the Commonwealth.

**Projected Impact on Employment.** No significant effect on employment is expected.

**Effects on the Use and Value of Private Property.** No significant effect on the use and value of private property is expected.

**Small Businesses: Costs and Other Effects.** The proposed changes do not create any costs or other effects for small businesses.

**Small Businesses: Alternative Method that Minimizes Adverse Impact.** The proposed changes do not have an adverse impact on small businesses.

**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, a determination of the public benefit, the projected number of businesses or other entities to whom the regulation would apply, the identity of any localities and types of businesses or other entities particularly affected, the projected number of persons and employment positions to be affected, the projected costs to affected businesses or entities to implement or comply with the regulation, and the impact on the use and value of private property. Further, if the proposed regulation has an adverse effect on small businesses, § 2.2-4007.04 requires that such economic impact analyses include (i) an identification and estimate of the number of small businesses subject to the regulation; (ii) the projected reporting, recordkeeping, and other administrative costs required for small businesses to comply with the regulation, including the type of professional skills necessary for preparing required reports and other documents; (iii) a statement of the probable effect of the regulation on affected small businesses; and (iv) a description of any less intrusive or less costly alternative methods of achieving the purpose of the regulation. The analysis presented above represents DPB's best estimate of these economic impacts.

**Agency's Response to Economic Impact Analysis:** The agency has reviewed the economic impact analysis prepared

by the Department of Planning and Budget. The agency concurs with this analysis.

**Summary:**

*This action (i) repeals the MEDALLION primary care case management program and (ii) amends provisions of 12VAC30-60 (Standards Established and Methods Used to Assure High Quality Care), 12VAC30-120 (Waivered Services), and 12VAC30-141 (Family Access to Medical Insurance Security Plan) to reflect this repeal.*

**12VAC30-60-147. Substance abuse treatment services utilization review criteria.**

A. Substance abuse residential treatment services for pregnant and postpartum women. This subsection provides for required services ~~which~~ that must be provided to participants, linkages to other programs tailored to specific ~~recipient~~ individual needs, and program staff qualifications. The following services must be rendered to program participants and documented in their case files in order for this residential service to be reimbursed by Medicaid.

1. Services must be authorized following face-to-face evaluation/diagnostic assessment conducted by one of the appropriately licensed or certified professionals as specified in 12VAC30-50-510.

a. To assess whether the woman will benefit from the treatment provided by this service, the professional shall utilize the Adult Patient Placement Criteria for Level III.3 (Clinically-Managed Medium-Intensity Residential Treatment) or Level III.5 (Clinically-Managed Medium/High Intensity Residential Treatment) as described in Patient Placement Criteria for the Treatment of Substance-Related Disorders, Second Edition, Revised 2001, published by the American Society of Addiction Medicine. Services must be reauthorized every 90 days by one of the appropriately authorized professionals, based on documented assessment using Adult Continued Service Criteria for Level III.3 (Clinically-Managed Medium-Intensity Residential Treatment) or Level III.5 (Clinically-Managed Medium-High Intensity Residential Treatment) as described in Patient Placement Criteria for the Treatment of Substance-Related Disorders, Second Edition, Revised 2001, published by the American Society of Addiction Medicine. In addition, services must be reauthorized by one of the authorized professionals if the patient is absent for more than 72 hours from the program without staff permission. All of the professionals must demonstrate competencies in the use of these criteria. The authorizing professional must not be the same individual providing nonmedical clinical supervision in the program.

b. Utilization reviews shall verify, but not be limited to, the presence of these 90-day reauthorizations as well as the appropriate ~~re-authorizations~~ reauthorizations after absences.

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# Regulations

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c. Documented assessment regarding the woman's need for the intense level of services must have occurred within 30 days prior to admission.

d. The Individual Service Plan (ISP) shall be developed within one week of admission and the obstetric assessment completed and documented within a two-week period following admission. Development of the ISP shall involve the woman, appropriate significant others, and representatives of appropriate service agencies.

e. The ISP shall be reviewed and updated every two weeks.

f. Psychological and psychiatric assessments, when appropriate, shall be completed within 30 days of admission.

g. Face-to-face therapeutic contact with the woman which is directly related to her Individual Service Plan shall be documented at least twice per week.

h. While the woman is participating in this substance abuse residential program, reimbursement shall not be made for any other community ~~mental health/mental retardation/substance abuse rehabilitative~~ mental health, intellectual disability, or substance abuse rehabilitation services concurrently rendered to her.

i. Documented discharge planning shall begin at least 60 days prior to the estimated date of delivery. If the service is initiated later than 60 days prior to the estimated date of delivery, discharge planning must begin within two weeks of admission. Discharge planning shall involve the woman, appropriate significant others, and representatives of appropriate service agencies. The priority services of discharge planning shall seek to assure a stable, sober, and drug-free environment and treatment supports for the woman.

2. Linkages to other services. Access to the following services shall be provided and documented in either the woman's record or the program documentation:

a. The program must have a contractual relationship with an obstetrician/gynecologist who must be licensed by the Board of Medicine of the Virginia Department of Health Professions.

b. The program must also have a documented agreement with a high-risk pregnancy unit of a tertiary care hospital to provide 24-hour access to services for the woman and ongoing training and consultation to the staff of the program.

c. In addition, the provider must provide access to the following services either through staff at the residential program or through contract:

(1) Psychiatric assessments as needed, which must be performed by a physician licensed to practice by the Virginia Board of Medicine.

(2) Psychological assessments as needed, which must be performed by a clinical psychologist licensed to practice by the Board of Psychology of the Virginia Department of Health Professions.

(3) Medication management as needed or at least quarterly for women in the program, which must be performed by a physician licensed to practice by the Board of Medicine in consultation with the high-risk pregnancy unit, if appropriate.

(4) Psychological treatment, as appropriate, for women present in the program, with clinical supervision provided by a clinical psychologist licensed to practice by the Board of Psychology.

(5) Primary health care, including routine gynecological and obstetrical care, if not already available to the women in the program through other means (e.g., ~~Medallion or~~ other Medicaid-sponsored primary health care ~~program~~ programs).

3. Program and staff qualifications. In order to be eligible for Medicaid reimbursement, the following minimum program and staff qualifications must be met:

a. The provider of treatment services shall be licensed by ~~DMHMRSAS~~ DBHDS to provide residential substance abuse services.

b. Nonmedical clinical supervision must be provided to staff at least weekly by one of the following professionals:

(1) A counselor who has completed master's level training in either psychology, social work, counseling or rehabilitation who is also either certified as a substance abuse counselor by the Board of ~~Licensed Professional Counselors, Marriage and Family Therapists, and Substance Abuse Treatment Professionals~~ Counseling of the Virginia Department of Health Professions or as a certified addictions counselor by the Substance Abuse Certification Alliance of Virginia, or who holds any certification from the National Association of Alcoholism and Drug Abuse Counselors.

(2) A professional licensed by the appropriate board of the Virginia Department of Health Professions as either a professional counselor, clinical social worker, registered nurse, clinical psychologist, or physician who demonstrates competencies in all of the following areas of addiction counseling: clinical evaluation; treatment planning; referral; service coordination; counseling; client, family, and community education; documentation; professional and ethical responsibilities; or as a licensed substance abuse professional.

(3) A professional certified as either a clinical supervisor by the Substance Abuse Certification Alliance of Virginia or as a master addiction counselor by the National Association of Alcoholism and Drug Abuse Counselors.

c. Residential facility capacity shall be limited to 16 adults. Dependent children who accompany the woman into the residential treatment facility and neonates born while the woman is in treatment shall not be included in the 16-bed capacity count. These children shall not receive any treatment for substance abuse or psychiatric disorders from the facility.

d. The minimum ratio of clinical staff to women should ensure that sufficient numbers of staff are available to adequately address the needs of the women in the program.

B. Substance abuse day treatment services for pregnant and postpartum women. This subsection provides for required services ~~which~~ that must be provided to women, linkages to other programs tailored to specific needs, and program and staff qualifications.

1. The following services must be rendered and documented in case files in order for this day treatment service to be reimbursed by Medicaid:

a. Services must be authorized following a face-to-face evaluation/diagnostic assessment conducted by one of the appropriately licensed professionals as specified in 12VAC30-50-510.

b. To assess whether the woman will benefit from the treatment provided by this service, the licensed health professional shall utilize the Adult Patient Placement Criteria for Level II.1 (Intensive Outpatient Treatment) or Level II.5 (Partial Hospitalization) as described in Patient Placement Criteria for the Treatment of Substance-Related Disorders, Second Edition, Revised 2001, published by the American Society of Addiction Medicine. Services shall be reauthorized every 90 days by one of these appropriately authorized professionals, based on documented assessment using Level II.1 (Adult Continued Service Criteria for Intensive Outpatient Treatment) or Level II.5 (Adult Continued Service Criteria for Partial Hospitalization Treatment) as described in Patient Placement Criteria for the Treatment of Substance-Related Disorders, Second Edition, Revised 2001, published by the American Society of Addiction Medicine. In addition, services shall be reauthorized by one of the appropriately authorized professionals if the patient is absent for five consecutively scheduled days of services without staff permission. All of the authorized professionals shall demonstrate competency in the use of these criteria. This individual shall not be the same individual providing nonmedical clinical supervision in the program.

c. Utilization reviews shall verify, but not be limited to, the presence of these 90-day reauthorizations, as well as the appropriate reauthorizations after absences.

d. Documented assessment regarding the woman's need for the intense level of services; the assessment must have occurred within 30 days prior to admission.

e. The Individual Service Plan (ISP) shall be developed within 14 days of admission and an obstetric assessment completed and documented within a 30-day period following admission. Development of the ISP shall involve the woman, appropriate significant others, and representatives of appropriate service agencies.

f. The ISP shall be reviewed and updated every four weeks.

g. Psychological and psychiatric assessments, when appropriate, shall be completed within 30 days of admission.

h. Face-to-face therapeutic contact with the woman, which is directly related to her ISP, shall be documented at least once per week.

i. Documented discharge planning shall begin at least 60 days prior to the estimated date of delivery. If the service is initiated later than 60 days prior to the estimated date of delivery, discharge planning shall seek to begin within two weeks of admission. Discharge planning shall involve the woman, appropriate significant others, and representatives of appropriate service agencies. The priority services of discharge planning shall seek to assure a stable, sober, and drug-free environment and treatment supports for the woman.

j. While participating in this substance abuse day treatment program, the only other mental health, ~~mental retardation~~ intellectual disability, or substance abuse rehabilitation services which can be concurrently reimbursed shall be mental health emergency services or mental health crisis stabilization services.

2. Linkages to other services or programs. Access to the following services shall be provided and documented in the woman's record or program documentation.

a. The program must have a contractual relationship with an obstetrician/gynecologist. The obstetrician/gynecologist must be licensed by the Virginia Board of Medicine as a medical doctor.

b. The program must have a documented agreement with a high-risk pregnancy unit of a tertiary care hospital to provide 24-hour access to services for the women and ongoing training and consultation to the staff of the program.

c. In addition, the program must provide access to the following services (either by staff in the day treatment program or through contract):

(1) Psychiatric assessments, which must be performed by a physician licensed to practice by the Board of Medicine of the Virginia Department of Health Professions.

(2) Psychological assessments, as needed, which must be performed by clinical psychologist licensed to practice by the Virginia Board of Psychology.

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# Regulations

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(3) Medication management as needed or at least quarterly for women in the program, which must be performed by a physician licensed to practice by the Virginia Board of Medicine in consultation with the high-risk pregnancy unit, if appropriate.

(4) Psychological treatment, as appropriate, for women present in the program, with clinical supervision provided by a clinical psychologist licensed to practice by the Board of Psychology of the Virginia Department of Health Professions.

(5) Primary health care, including routine gynecological and obstetrical care, if not already available to the women in the program through other means (e.g., ~~Medallion or~~ other Medicaid-sponsored primary health care ~~program~~ programs).

3. Program and staff qualifications. In order to be eligible for Medicaid reimbursement, the following minimum program and staff qualifications must be met:

a. The provider of treatment services shall be licensed by ~~DMHMRSAS~~ DBHDS to provide either substance abuse outpatient services or substance abuse day treatment services.

b. Nonmedical clinical supervision must be provided to staff at least weekly by one of the following appropriately licensed professionals:

(1) A counselor who has completed master's level training in either psychology, social work, counseling or rehabilitation who is also either certified as a substance abuse counselor by the Virginia Board of ~~Licensed Professional Counselors, Marriage and Family Therapists and Substance Abuse Treatment Professionals~~ Counseling or as a certified addictions counselor by the Substance Abuse Certification Alliance of Virginia, or who holds any certification from the National Association of Alcoholism and Drug Abuse Counselors.

(2) A professional licensed by the appropriate board of the Virginia Department of Health Professions as either a professional counselor, clinical social worker, clinical psychologist, or physician who demonstrates competencies in all of the following areas of addiction counseling: clinical evaluation; treatment planning; referral; service coordination; counseling; client, family, and community education; documentation; professional and ethical responsibilities; or as a licensed substance abuse professional.

(3) A professional certified as either a clinical supervisor by the Substance Abuse Certification Alliance of Virginia or as a master addiction counselor by the National Association of Alcoholism and Drug Abuse Counselors.

c. The minimum ratio of clinical staff to women should ensure that adequate staff are available to address the needs of the women in the program.

## **12VAC30-60-200. Ticket to Work and Work Incentives Improvement Act (TWWIA) basic coverage group: alternative benefits for Medicaid Buy-In program.**

A. The state elects to provide alternative benefits under § 1937 of the Social Security Act. The alternative benefit package will be available statewide.

B. The population who will be offered opt-in alternative coverage and who will be informed of the available benefit options prior to having the option to voluntarily enroll in an alternative benefit package consists of working individuals with disabilities enrolled pursuant to the Social Security Act, § 1902(a)(10)(A)(ii)(XV) (Ticket to Work and Work Incentives Improvement Act) covered group or who meet the income, resource and eligibility requirements for the § 1902(a)(10)(A)(ii)(XV) covered group.

C. Medicaid Buy-In: program outreach.

1. Future Medicaid Works solicitations will be geared towards individuals who are currently covered in the SSI and blind and disabled 80% federal poverty level groups; the letter will be an invitation to consider going to work, or to increase how much they work, and inform them that they will still be able to keep their Medicaid health care coverage.

2. They will be advised that this is voluntary and will enable them to earn higher income and retain more assets from their earnings. It will also explain that this option includes an alternative benefits package comprised of their regular Medicaid benefits plus personal assistance services for those who need personal assistance and related services in order to live and work in the community. It will be clearly stated that this program is optional. Their local eligibility worker will be able to review the advantages and disadvantages of this option in order to assist individuals in making an informed choice.

3. Current Medicaid Works enrollees will each receive personal communication by mail advising them of the new alternative benefits package and the steps needed in order to access personal assistance services. Should an enrolled individual be dissatisfied with this option or be unable to continue to be employed, their eligibility worker will reevaluate eligibility for other covered groups pursuant to changing the individual back to regular Medicaid coverage and, if necessary, to accessing personal assistance and related services through the existing home-based and community-based services waivers.

4. Brochures describing this work incentive opportunity and alternative benefits option shall be prominently displayed and readily available at local departments of social services.

D. Description of Medicaid Buy-In alternative benefit package.

1. The state will offer an alternative benefit package that the secretary determines provides appropriate coverage for the population served.

2. This alternative benefits package includes all federally mandated and optional Medicaid State Plan services, as described and limited in 12VAC30-50, plus personal assistance services (PAS) for enrollees who otherwise meet the standards to receive PAS, defined as follows:

a. "Personal assistance services" or "PAS" means support services provided in home and community settings necessary to maintain or improve an individual's current health status. Personal care services are defined as help with activities of daily living, monitoring of self-administered medications, and the monitoring of health status and physical condition.

b. These services may be provided in home and community settings to enable an individual to maintain the health status and functional skills necessary to live in the community or participate in community activities. An additional component of PAS is work-related and postsecondary education personal services. This service will extend the ability of the personal assistance attendant to provide assistance in the workplace.

c. These services include filing, retrieving work materials that are out of reach; providing travel assistance for an individual with a mobility impairment; helping an individual with organizational skills; reading handwritten mail to an individual with a visual impairment; or ensuring that a sign language interpreter is present during staff meetings to accommodate an employee with a hearing impairment.

d. This service is only available to individuals who also require personal assistance services to meet their ADLs. Workplace or school supports are not provided if they are services provided by the Department of Rehabilitative Services, under IDEA, or if they are an employer's responsibility under the Americans with Disabilities Act or § 504 of the Rehabilitation Act.

e. Following an individual's assessment of the need for PAS and development of a plan of care, the individual will decide whether to have PAS through a personal care agency or whether to self direct his care. For individuals who choose consumer-directed care, DMAS will provide for the services of a fiscal agent to perform certain tasks as an agent for the ~~recipient/employer~~ individual/employer who is receiving consumer-directed services. The fiscal agent will handle certain responsibilities for the individual, including but not limited to, employment taxes.

f. All governmental and private PAS providers are reimbursed according to the same published fee schedule, located on the agency's website at the following address: [http://www.dmas.virginia.gov/pr-fee\\_files.htm](http://www.dmas.virginia.gov/pr-fee_files.htm). The agency's rates, based upon one-hour increments, were set

as of July 1, 2006, and are effective for services on or after said dates. The agency's rates are updated periodically.

E. Wrap-around/additional services.

1. The state assures that wrap-around or additional benefits will be provided for individuals under 21 years of age who are covered under the state plan pursuant to § 1902(a)(10)(A) of the Social Security Act to ensure early and periodic screening, diagnostic and treatment (EPSDT) services are provided when medically necessary.

2. Wrap-around benefits must be sufficient so that, in combination with the Medicaid Buy-In package, these individuals receive the full EPSDT benefit, as medically necessary. The wrap-around services provided are described in 12VAC30-50-130.

F. Delivery system.

1. The alternative benefit package will be furnished through a combination of the following methods:

a. On a fee-for-service basis consistent with the requirements of § 1902(a) and implementing regulations relating to payment and beneficiary free choice of provider;

~~b. On a fee for service basis consistent with the requirements cited in subdivision 1 a of this subsection, except that it will be operated with a primary care case management system consistent with § 1915(b)(1);~~

~~e. b.~~ Through a managed care entity consistent with applicable managed care requirements; or

~~d. c.~~ Through premium assistance for benchmark-equivalent in employer-sponsored coverage.

2. Personal assistance services will always be fee-for-service, whereas all other Medicaid-covered services shall be through one of ~~three~~ two models: fee-for-service ~~primary care case management~~ or through managed care organizations.

G. Additional assurances.

1. The state assures that individuals will have access, through the Medicaid Buy-In alternative benefit package, to rural health clinic (RHC) services and federally qualified health center (FQHC) services as defined in subparagraphs (B) and (C) of § 1905(a)(2).

2. The state assures that payment for RHC and FQHC services is made in accordance with the requirements of § 1902(bb) of the Social Security Act.

H. Cost effectiveness of plans: the Medicaid Buy-In alternative benefit package and any additional benefits must be provided in accordance with economy and efficiency principles.

I. Compliance with the law: The state will continue to comply with all other provisions of the Social Security Act in the administration of the state plan under this title.

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# Regulations

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## Part V Medallion (Repealed)

### 12VAC30-120-260. Definitions. (Repealed.)

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

"ABD" means aged, blind and disabled recipients of public assistance programs as defined by the Virginia Department of Social Services.

"Action" means a termination, suspension, or reduction of Medicaid eligibility or covered services, including the type or level of service; the reduction, suspension, or termination of a previously authorized service; or the denial, in whole or in part, of payment for a service.

"AFDC" means the Aid to Families with Dependent Children program; this program was replaced by the Temporary Assistance to Needy Families (TANF) program. Medicaid utilizes AFDC rules in determining Medicaid eligibility for families and children.

"AFDC related" means those recipients eligible for assistance as an extension of the AFDC program, such as pregnant women and indigent children under specific ages. It shall not include foster care or spend down medically needy clients.

"Ancillary services" means those services accorded to a client that are intended to support the diagnosis and treatment of that client. These services include, but are not necessarily limited to, laboratory, pharmacy, radiology, physical therapy, and occupational therapy.

"Appeal" means a request for review of an action; all enrollee appeals are subject to the regulations set forth in 12VAC30-110.

"Area of residence" means the recipient's address in the Medicaid eligibility file.

"Client" or "clients" means an individual or individuals having current Medicaid eligibility who is enrolled in or who shall be authorized to participate as a member or members of MEDALLION.

"Comparison group" means the group of Medicaid recipients whose utilization and costs will be compared against similar groups of MEDALLION clients.

"Covered services" means Medicaid services as defined in the State Plan for Medical Assistance.

"Covering provider" means a provider designated by the primary care provider to render health care services in the temporary absence of the primary provider.

"DMAS" means the Department of Medical Assistance Services.

"Eligible person" means any person eligible for Virginia Medicaid in accordance with the State Plan for Medical Assistance under Title XIX of the Social Security Act.

"Emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following:

1. Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
2. Serious impairment to bodily functions; or
3. Serious dysfunction of any bodily organ or part.

"Emergency services" means covered inpatient and outpatient services that are (i) furnished by a provider that is qualified to furnish these services under this title and (ii) needed to evaluate or stabilize an emergency medical condition.

"Enrollee" is a Medicaid recipient who is currently enrolled with a PCP in a given managed care program.

"Enrollment broker" means an independent contractor that enrolls recipients in MEDALLION and is responsible for the operation and documentation of a toll free recipient service helpline. The responsibilities of the enrollment broker shall include, but not be limited to, recipient education, recipient enrollment, and tracking and resolving recipient complaints, and may include recipient marketing and outreach.

"EPSDT" means the Early and Periodic Screening, Diagnosis, and Treatment program.

"Exclusion from MEDALLION" means the denial of a Medicaid recipient from initially enrolling in MEDALLION or the removal of an enrollee from the MEDALLION program on a temporary or permanent basis.

"External Quality Review Organization (EQRO)" is an organization that meets the competence and independence requirements set forth in 42 CFR 438.354 and performs external quality reviews, other EQR related activities as set forth in 42 CFR 438.358, or both.

"Foster care" is a program in which a child receives either foster care assistance under Title IV E of the Social Security Act or state and local foster care assistance.

"General practitioner" means a licensed physician who provides routine medical treatment, diagnosis, and advice to maintain a client's health and welfare.

"Grievance" is an expression of dissatisfaction about any matter other than an action, as "action" is defined in this section. The term is also used to refer to the overall system that includes grievances and appeals and access to the state fair hearing process. Examples of subjects for grievances include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships, such as rudeness of a provider or employee, or the failure to respect the enrollee's rights.

"Health care professional" means a provider who has appropriate clinical training in treating an enrollee's condition or disease, and as further defined in 42 CFR 438.2.

~~"Post stabilization care services" means covered services related to an emergency medical condition that are provided after an enrollee is stabilized in order to maintain the stabilized condition or to improve or resolve the enrollee's condition.~~

~~"Potential enrollee" means a Medicaid recipient who is subject to mandatory enrollment or may voluntarily elect to enroll in a given managed care program, but is not yet assigned to a specific primary care provider.~~

~~"Primary care case management" or "PCCM" means a system under which a primary care case manager contracts with the Commonwealth to furnish case management services (which include the location, coordination, and monitoring of primary health care services) to those Medicaid recipients assigned to him.~~

~~"Primary care provider" or "PCP" means that MEDALLION provider responsible for the coordination of all medical care provided to a MEDALLION client and shall be recognized by DMAS as a Medicaid provider.~~

~~"School health services" means those physical therapy, occupational therapy, speech therapy, nursing, psychiatric and psychological services rendered to children who qualify for these services under the federal Individuals with Disabilities Education Act (20 USC § 1471 et seq.) by (i) employees of the school divisions or (ii) providers that subcontract with school divisions, as described in 12VAC30-50-229.1.~~

~~"Site" means, for purposes of this part, the geographical areas that best represent the health care delivery systems in the Commonwealth. In certain areas (sites), there may be two or more identifiable health care delivery systems.~~

~~"Specialty" or "specialist services" means those services, treatments, or diagnostic tests intended to provide the patient with a higher level of medical care or a more definitive level of diagnosis than that routinely provided by the primary care provider.~~

~~"Spend down" means the process of reducing countable income by deducting incurred medical expenses for medically needy individuals, as determined in the State Plan for Medical Assistance.~~

~~"State" means the Commonwealth of Virginia.~~

~~"TANF" means Temporary Assistance to Needy Families and is a public assistance program administered by the Department of Social Services providing financial assistance to needy citizens.~~

**12VAC30-120-270. Program purpose. (Repealed.)**

~~The purpose of MEDALLION shall be to provide management in the delivery of health care services by linking the primary care provider (PCP) with targeted clients. The PCP shall provide medical services as appropriate for clients'~~

~~health care needs and shall coordinate clients' receipt of other health services. This shall include, but not be limited to, referral to specialty providers as medically appropriate.~~

**12VAC30-120-280. MEDALLION clients. (Repealed.)**

~~A. DMAS shall determine enrollment in MEDALLION. Enrollment in MEDALLION is not a guarantee of continuing eligibility for services and benefits under the Virginia Medical Assistance Services Program. Clients of MEDALLION shall be individuals receiving Medicaid as ABD, AFDC or AFDC related categorically needy and medically needy (except those becoming eligible through spend down) and except for foster care children, whether or not receiving cash assistance grants.~~

~~B. Exclusions.~~

~~1. The following individuals shall be excluded from participation in MEDALLION, or excluded from continued enrollment if any of the following apply:~~

~~a. Individuals who are inpatients in state mental hospitals and skilled nursing facilities, or reside in an Intermediate Care Facility for the Mentally Retarded (ICF/MR) or a long stay hospital;~~

~~b. Individuals who are enrolled in § 1915 c home and community based waivers, the family planning waiver, or the Family Access to Medical Insurance Security Plan (FAMIS);~~

~~e. Individuals who are participating in foster care or subsidized adoption programs, who are members of spend down cases, or who are refugees or who receive client medical management services;~~

~~d. Individuals receiving Medicare;~~

~~e. Individuals who are enrolled in DMAS authorized residential treatment or treatment foster care programs;~~

~~f. Individuals whose coverage is retroactive only; and~~

~~g. Birth Injury Fund (BIF).~~

~~2. A client may be excluded from participating in MEDALLION if any of the following apply:~~

~~a. The client is not accepted to the caseload of any participating PCP.~~

~~b. The client's enrollment in the caseload of assigned PCP has been terminated, and other PCPs have declined to enroll the client.~~

~~e. The individual receives hospice services in accordance with DMAS criteria.~~

~~C. Client enrollment process.~~

~~1. All ABD, AFDC or AFDC related recipients excepting those meeting one of the exclusions of subsection B of this section shall be enrolled in MEDALLION.~~

~~2. Newly eligible individuals shall not participate in MEDALLION until completion of the Medicaid enrollment process. This shall include initial enrollment in the Medicaid program at the time of eligibility~~



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# Regulations

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determination by Department of Social Services staff, or any subsequent reenrollment in the Medicaid program that may occur.

~~3. During the preassignment period and registration as MEDALLION clients, recipients shall be provided Medicaid covered services via the fee for service delivery mechanism administered by DMAS.~~

~~4. Once clients are fully registered as MEDALLION clients, they will receive MEDALLION identification material in addition to the Medicaid card.~~

**D. PCP selection.** Clients shall be given the opportunity to select the PCP of their choice.

~~1. Clients shall notify DMAS of their PCP selection within 30 days of receiving their MEDALLION enrollment notification letter. If notification is not received by DMAS within that timeframe, DMAS shall select a PCP for the client.~~

~~2. The selected PCP shall be a MEDALLION enrolled provider.~~

~~3. The PCP will provide 24 hour, seven day/week access, which shall include as a minimum a 24 hour, seven day/week telephone number to be provided to each MEDALLION client.~~

~~4. DMAS shall review client requests in choosing a specific PCP for appropriateness and to ensure client accessibility to all required medical services.~~

~~5. Individuals who lose then regain eligibility for MEDALLION within 60 days will be reassigned to their previous PCP without going through the preassignment and selection process.~~

**E. Mandatory assignment of PCP.**

~~1. The MEDALLION program enrolls clients with a primary care provider (PCP) who acts as a care coordinator, provides primary and preventive care, and refers most specialty services. The client is required to select a PCP from a list of available PCPs in his service area. If the client does not select a PCP, the client defaults to the department's pre assignment option. Clients can access any program provider for specialty services if they obtain the necessary referral from their PCP.~~

~~2. Clients shall initially be assigned to a PCP according to the region in which they reside. Should insufficient PCPs exist within the client's specific region, clients shall be assigned a PCP in an adjacent region.~~

~~3. Each PCP shall be assigned a client, or family group if appropriate, until the maximum number of clients the PCP has elected to serve or the PCP/client limit has been reached or until there are no more clients suitable for assignment to that PCP, or all clients have been assigned.~~

**F. Changing PCPs.** MEDALLION clients in areas without managed care organizations (MCO) will have the initial 90 calendar days following the effective date of enrollment with

a MEDALLION PCP to change PCPs without cause. After the initial 90 day assignment period, unless cause to change PCPs is shown pursuant to subdivision 1 or 2 of this subsection, the recipient will remain with the PCP for up to 12 months, or until the next open enrollment period. During open enrollment, the recipient will have the option to select another PCP. Recipients will be given at least 60 days notice prior to the end of the current enrollment period (and all future enrollment periods) during which time recipients can select another PCP. Open enrollment periods will occur annually.

~~1. Requests for change of PCP "for cause" are not subject to the 12 month limitation, but shall be reviewed and approved by DMAS staff on an individual basis. Examples of changing providers "for cause" may include but shall not be necessarily limited to:~~

~~a. Client has a special medical need which cannot be met in his service area or by his PCP.~~

~~b. Client has a pre existing relationship with a Medicaid provider rendering care for a special medical need.~~

~~c. Mutual decision by both client and provider to sever the relationship.~~

~~d. Provider or client moves to a new residence, causing transportation difficulties for the client.~~

~~e. Provider cannot establish a rapport with the client.~~

~~f. Performance or nonperformance of service to the client by a provider that is deemed by the department's external quality review organizations to be below the generally accepted community practice of health care. This may include poor quality care.~~

~~g. Other reasons as determined by DMAS through written policy directives.~~

~~2. The existing PCP shall continue to retain the client in the caseload, and provide services to the client until a new PCP is assigned or selected.~~

~~3. PCPs may elect to release MEDALLION clients from their caseloads for cause with review and approval by DMAS on a case by case basis. In such circumstances, subdivision F 2 of this section shall apply.~~

**G. PCP referral process.**

~~1. Clients shall contact their assigned PCP or designated covering provider to obtain a referral prior to seeking nonemergency care.~~

~~2. Emergency services and family planning services shall be provided without delay or referral. However, the emergency nature of the treatment shall be documented by the provider providing treatment and should be reported to the PCP after treatment is provided. Clients should inform the PCP of any emergency treatment received.~~

**H. Enrollee rights.**

~~1. Each primary care provider must comply with any and all applicable federal and state laws and regulations~~

regarding enrollee rights including, but not limited to, the applicable sections of 42 CFR 438.100 et seq., Title VI of the Civil Rights Act of 1964, and other applicable laws regarding privacy and confidentiality, and ensure that their staff and affiliated providers take those rights into account when furnishing services to enrollees.

2. Each enrollee shall be free to exercise his rights, and the exercise of those rights shall not adversely affect the way the primary care provider or DMAS treats the enrollee.

**12VAC30-120-290. Providers of services. (Repealed.)**

Providers who may enroll to provide MEDALLION services include, but are not limited to, physicians of the following primary care specialties: general practice, family practice, internal medicine, and pediatrics. Federally qualified health centers and rural health clinics as defined in 42 CFR 405.2401), and certain clinics (as defined by 12VAC5-90-10) administered by local health departments may also serve as primary care providers. Exceptions may be as follows:

1. Providers specializing in obstetric/gynecologic care may enroll as MEDALLION providers if selected by clients as PCPs but only if the providers agree to provide or refer clients for primary care.
2. Physicians with subspecialties may enroll as MEDALLION providers if selected by clients as PCPs but only if the providers agree to provide or refer clients for primary care.
3. Other specialty physicians may enroll as PCPs under extraordinary, client specific circumstances when DMAS determines with the provider's and recipient's concurrence that the assignment would be in the client's best interests. Such circumstances may include, but are not limited to, the usual and customary practice of general medicine by a board certified specialist, maintenance of a pre-existing patient-physician relationship, or support of the special medical needs of the client.
4. DMAS or its designee shall review applications from physicians and other health care professionals to determine appropriateness of their participating as a MEDALLION PCP.
5. The PCP must have admitting privileges at a local hospital or must make arrangements acceptable to DMAS for admissions by a physician who does have admitting privileges.

**12VAC30-120-300. MEDALLION provider requirements. (Repealed.)**

- A. PCPs must require their clients to present their currently effective MEDALLION identification material upon presentation for services.
- B. PCPs shall function as "gatekeeper" for assigned clients. Specific requirements shall include but are not necessarily limited to:

1. Providing patient management for the following services: physician, pharmacy, hospital inpatient and outpatient, laboratory, ambulatory surgical center, radiology, and durable medical equipment and supplies.
2. Providing or arranging for physician coverage 24 hours per day, seven days per week.
3. Determining the need for and authorizing when appropriate, all nonemergency care.
4. Being an EPSDT provider, or having a referral relationship with one, and providing or arranging for preventive health services for children under the age of 21 in accordance with the periodicity schedule recommended in the Guidelines for Health Supervision of the American Academy of Pediatrics, 1991.
5. Making referrals when appropriate, conforming to standard medical practices, to medical specialists or services as required. The referral duration shall be at the discretion of the PCP, and must be fully documented in the patient's medical record.
6. Coordinating inpatient admissions either by personally ordering the admission, or by referring to a specialist who may order the admission.
7. Maintaining a legibly written, comprehensive, and unified patient medical record for each client consistent with documentation requirements set forth in DMAS' Physician Manual.
8. Documenting in each client's record all authorizations for referred services.
9. Providing education and guidance to assigned clients for the purpose of teaching correct methods of accessing the medical treatment system and promoting good health practices.
10. Tracking and documenting any emergency care provided to clients.
11. Shall not refuse an assignment to, or otherwise discriminate against, any enrollee or potential enrollee on the basis of health status or need for health care services, or on the basis of race, color, or national origin, and shall not use any policy or practice that has the effect of discrimination on the basis of race, color, or national origin.

C. A PCP may not knowingly be affiliated with any of the following:

1. Any individual who is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation (48 CFR 9.400 et seq.) or from participating in nonprocurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549.

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# Regulations

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2. An individual who is an affiliate of a person described in subdivision C 1 of this subsection whose relationship is as follows:

- a. A director, officer, or partner of the PCP;
- b. A person with beneficial ownership of 5.0% or more of the PCP's equity;
- c. A person with an employment, consulting, or other arrangement with the PCP for the provision of items and services that are significant and material to the PCP's obligations under its contract with the state.

## **12VAC30-120-310. Services ~~exempted~~ from MEDALLION referral requirements. (Repealed.)**

A. The following services shall be exempt from the referral requirements of MEDALLION:

1. Obstetrical and gynecological services (pregnancy and pregnancy related);
2. Psychiatric and psychological services, to include but not be limited to mental health, mental retardation services;
3. Family planning services;
4. Routine newborn services;
5. Annual or routine vision examinations (under age 21);
6. Emergency services;
7. EPSDT well child exams;
8. Immunizations (health departments only);
9. All school health services provided pursuant to the Individuals with Disabilities Education Act (IDEA);
10. Services for the treatment of sexually transmitted diseases;
11. Targeted case management services;
12. Transportation services;
13. Pharmacy services;
14. Substance abuse treatment services; and
15. MR waiver services and MH community rehabilitation services.

B. While reimbursement for these services may not require a referral, an authorization, or a referral and an authorization by the PCP, the PCP must continue to track and document them to ensure continuity of care.

## **12VAC30-120-320. PCP payments. (Repealed.)**

A. DMAS shall pay for services rendered to MEDALLION clients through the existing fee for service methodology and a case management fee.

B. MEDALLION providers shall receive a monthly case management fee of \$3.00 per client.

C. Individual PCPs and PCPs in Department of Health clinics may serve a maximum of 2,000 MEDALLION clients. Exceptions to this will be considered on a case by case basis predicated upon client needs.

D. Federally qualified health centers, rural health clinics, and Department of Health clinics enrolled as Medicaid providers are limited to no more than 10,000 enrolled recipients per clinic. Exceptions to this will be considered on a case by case basis predicated upon client needs.

## **12VAC30-120-330. Utilization review. (Repealed.)**

DMAS shall review claims for services provided by or resulting from referrals by authorized PCPs. Claims review shall include, but not be limited to, review for the following:

1. Excessive or inappropriate services;
2. Unauthorized or excluded services; and
3. Analysis of possible trends in increases or reductions of services.

## **12VAC30-120-340. Client and provider appeals. (Repealed.)**

A. Client appeals. Clients shall have the right of appeal of any adverse action taken by DMAS consistent with the provisions of Part I (12VAC30-110-10 et seq.) of 12VAC30-110.

B. Provider appeals. Providers shall have the right to appeal any adverse action taken by DMAS under this part pursuant to the provisions of the Administrative Process Act (§ 9-6.14:1 et seq. of the Code of Virginia).

## **12VAC30-120-350. Sanctions. (Repealed.)**

A. The sanctions, as described in § 1932(e)(1) of the Social Security Act (the Act) and listed in subsection B of this section, may be imposed by DMAS if the PCP:

1. Fails substantially to provide medically necessary services that the PCP is required to provide, under law or under its contract with DMAS, to an enrollee covered under the contract;
2. Imposes on enrollees premiums or charges that are in excess of the premiums or charges permitted under the Medicaid program;
3. Acts to discriminate among enrollees on the basis of their health status or need for health care services;
4. Misrepresents or falsifies information furnished to the Commonwealth;
5. Misrepresents or falsifies information furnished to an enrollee, potential enrollee, or health care provider;
6. Has distributed directly or indirectly, through any agent or independent contractor, marketing materials that have not been approved by DMAS or that contain false or materially misleading information; or
7. Has violated any of the other applicable requirements of § 1932 or § 1905 (t)(3) of the Act and any implementing regulations.

B. Section 1932(e)(2) of the Act provides for the Commonwealth to impose the following civil money penalties and other sanctions:

1. A maximum of \$25,000 for each determination of failure to provide services, misrepresentations or false statements to enrollees, potential enrollees, or health care providers, or marketing violations;
2. A maximum of \$100,000 for each determination of discrimination or misrepresentation or false statements to the Commonwealth;
3. A maximum of \$15,000 for each recipient the Commonwealth determines was not enrolled because of a discriminatory practice (subject to a \$100,000 overall limit); and
4. Up to \$25,000 or double the amount of the excess charges (whichever is greater) for charging premiums or charges in excess of the amounts permitted under the Medicaid program. DMAS shall deduct the excess amount charged from the penalty and return it to the affected enrollees.
5. Termination. Either the PCP or DMAS may terminate the PCP's enrollment in the MEDALLION program at any time if either party determines that the other party has failed to perform any of its functions or duties under the addendum to the provider agreement (hereafter referred to as the addendum) between DMAS and the PCP. In such event, the party exercising this option shall notify the other party in writing of the intent to terminate the addendum and shall give the other party 30 days to correct the identified violation, breach or nonperformance of the addendum. If such violation, breach or nonperformance of the addendum is not satisfactorily addressed within this time period, the exercising party must notify the other party in writing of its intent to terminate the addendum at least 60 days prior to the proposed termination date. The termination date shall always be the last day of the month in which the 60th day falls. The addendum may be terminated by DMAS sooner than the time periods for notice specified in this subsection if DMAS determines that a recipient's health or welfare is jeopardized by continued enrollment under the care of the PCP. After DMAS notifies a PCP that it intends to terminate the contract, DMAS will give the entity's enrollees written notice of the state's intent to terminate the contract and will allow enrollees to disenroll immediately without cause.
6. Suspension of new enrollment, including default enrollment.
  - a. Whenever DMAS determines that the PCP is out of compliance with the addendum, it may suspend the PCP's right to enroll new recipients. DMAS, when exercising this option, shall notify the PCP in writing of its intent to suspend new enrollment at least 30 days prior to the beginning of the suspension period. The suspension period may be for any length of time specified by DMAS, or may be indefinite. The suspension period may extend up to any expiration date of the addendum.

b. DMAS may also suspend new enrollment or disenroll recipients in anticipation of the PCP not being able to comply with federal or state laws at its current enrollment level. Such suspension shall not be subject to the 30 day notification requirement. DMAS may notify recipients of their PCP's noncompliance and provide an opportunity to enroll with another PCP.

7. Withholding of management or other payments and recovery of damage costs. DMAS may withhold portions of management or other fees or otherwise recover damages from the PCP as follows:

a. Whenever DMAS determines that the PCP has failed to perform an administrative function required under this contract, DMAS may withhold a portion of management or other fees to compensate for the damages which this failure has entailed. For the purposes of this section, "administrative function" is defined as any contract obligation other than the actual provision of contract services.

b. In any case under this contract where DMAS has the authority to withhold management or other fees, DMAS also shall have the authority to use all other legal processes for the recovery of damages.

8. Department initiated disenrollment. DMAS may reduce the maximum enrollment level or number of current enrollees whenever it determines that the PCP has:

a. Failed to provide or arrange for the provision of one or more of the services required under the addendum to the provider agreement, or

b. Failed to maintain or make available any records or reports required under the addendum which DMAS requires to determine whether the PCP is providing services as required. The PCP shall be given at least 30 days notice prior to DMAS taking any action set forth in this subsection.

9. Inappropriate service delivery. PCPs demonstrating a pattern of inappropriate provision of services may be subject to suspension of new enrollments, withholding, in full or in part, of management fees, addendum termination, or refusal to be offered the opportunity to participate as a PCP in a future time period.

Part VI  
Medallion II

**12VAC30-120-360. Definitions.**

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

"Action" means the denial or limited authorization of a requested service, including the type or level of service; the reduction, suspension, or termination of a previously authorized service; the denial, in whole or in part, of payment for a service; the failure to provide services in a timely

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# Regulations

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manner, as defined by the state; or the failure of an MCO to act within the timeframes provided in 42 CFR 438.408(b).

"Appeal" means a request for review of an action, as "action" is defined in this section.

"Area of residence" means the ~~recipient's~~ individual's address in the Medicaid eligibility file.

"Capitation payment" means a payment the department makes periodically to a contractor on behalf of each ~~recipient~~ individual enrolled under a contract for the provision of medical services under the State Plan, regardless of whether the particular ~~recipient~~ individual receives services during the period covered by the payment.

~~"Client," "clients," "recipient," "enrollee," or "participant" means an individual or individuals having current Medicaid eligibility who shall be authorized by DMAS to be a member or members of Medallion II.~~

"Covered services" means Medicaid services as defined in the State Plan for Medical Assistance.

"Disenrollment" means the process of changing enrollment from one Medallion II Managed Care Organization (MCO) plan to another MCO ~~or to the Primary Care Case Management (PCCM) program~~, if applicable.

"DMAS" means the Department of Medical Assistance Services.

~~"Enrollee" or "enrollees" means people having current Medicaid eligibility who shall be in the process of being authorized by DMAS to be enrolled in Medallion II.~~

"Early Intervention" means EPSDT Early Intervention services provided pursuant to Part C of the Individuals with Disabilities Education Act (IDEA) of 2004 as set forth in 12VAC30-50-131.

"Eligible person" means any person eligible for Virginia Medicaid in accordance with the State Plan for Medical Assistance under Title XIX of the Social Security Act.

"Emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following:

1. Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,
2. Serious impairment to bodily functions, or
3. Serious dysfunction of any bodily organ or part.

"Emergency services" means covered inpatient and outpatient services that are furnished by a provider that is qualified to furnish these services and that are needed to evaluate or stabilize an emergency medical condition.

"Enrollment broker" means an independent contractor that enrolls ~~recipients~~ individuals in the contractor's plan and is

responsible for the operation and documentation of a toll-free ~~recipient~~ individual service helpline. The responsibilities of the enrollment broker include, but shall not be limited to, ~~recipient~~ individual education and MCO enrollment, assistance with and tracking of ~~recipients'~~ individuals' complaints resolutions, and may include ~~recipient~~ individual marketing and outreach.

"Exclusion from Medallion II" means the removal of an enrollee from the Medallion II program on a temporary or permanent basis.

"External quality review organization" or "EQRO" means an organization that meets the competence and independence requirements set forth in 42 CFR 438.354 and performs external quality reviews, other external quality review related activities as set forth in 42 CFR 438.358, or both.

"Grievance" means an expression of dissatisfaction about any matter other than an action, as "action" is defined in this section.

"Health care plan" means any arrangement in which any managed care organization undertakes to provide, arrange for, pay for, or reimburse any part of the cost of any health care services.

"Health care professional" means a provider as defined in 42 CFR 438.2.

"Individual" or "individuals" means people who are eligible for Medicaid but who are not yet undergoing enrollment nor enrolled in a managed care organization.

"Managed care organization" or "MCO" means an entity that meets the participation and solvency criteria defined in 42 CFR Part 438 and has an executed contractual agreement with DMAS to provide services covered under the Medallion II program. Covered services for Medallion II individuals must be as accessible (in terms of timeliness, amount, duration, and scope) as compared to other Medicaid ~~recipients~~ individuals served within the area.

"Member" or "members" means people who have current Medicaid eligibility who are also enrolled in Medallion II managed care.

"Network" means doctors, hospitals or other health care providers who participate or contract with an MCO and, as a result, agree to accept a mutually-agreed upon sum or fee schedule as payment in full for covered services that are rendered to eligible participants.

"Newborn enrollment period" means the period from the child's date of birth plus the next two calendar months.

"Nonparticipating provider" means a health care entity or health care professional not in the contractor's participating provider network.

"Participant" or "participants" means an individual or individuals having current Medicaid eligibility who shall be authorized by DMAS to be a member or members of Medallion II.

"PCP of record" means a primary care physician of record with whom the recipient has an established history and such history is documented in the individual's records.

"Post-stabilization care services" means covered services related to an emergency medical condition that are provided after an enrollee is stabilized in order to maintain the stabilized condition or to improve or resolve the enrollee's condition.

"Potential enrollee" means a Medicaid recipient individual who is subject to mandatory enrollment or may voluntarily elect to enroll in a given managed care program, but is not yet an enrollee of a specific MCO or PCCM.

~~"Primary care case management" or "PCCM" means a system under which a primary care case manager contracts with the Commonwealth to furnish case management services (which include the location, coordination, and monitoring of primary health care services) to Medicaid recipients.~~

"Retractions" means the departure of an enrolled managed care organization from any one or more localities as provided for in 12VAC30-120-370.

"Rural exception" means a rural area designated in the § 1915(b) managed care waiver, pursuant to § 1932(a)(3)(B) of the Social Security Act and 42 CFR § 438.52(b) and recognized by the Centers for Medicare and Medicaid Services, wherein qualifying Medallion II members are mandated to enroll in the one available contracted MCO.

"School health services" means those physical therapy, occupational therapy, speech therapy, nursing, psychiatric and psychological services rendered to children who qualify for these services under the federal Individuals with Disabilities Education Act (20 USC § 1471 et seq.) by (i) employees of the school divisions or (ii) providers that subcontract with school divisions, as described in 12VAC30-50-130.

"Spend-down" means the process of reducing countable income by deducting incurred medical expenses for medically needy individuals, as determined in the State Plan for Medical Assistance.

**12VAC30-120-370. Medallion II enrollees.**

A. DMAS shall determine enrollment in Medallion II. Medicaid eligible persons not meeting the exclusion criteria set out in this section must participate in the Medallion II program. Enrollment in Medallion II is not a guarantee of continuing eligibility for services and benefits under the Virginia Medical Assistance Services Program. DMAS reserves the right to exclude from participation in the Medallion II managed care program any individual member who has been consistently noncompliant with the policies and procedures of managed care or who is threatening to providers, MCOs, or DMAS. There must be sufficient documentation from various providers, the MCO, and DMAS of these noncompliance issues and any attempts at resolution. Individuals Members excluded from Medallion II through this provision may appeal the decision to DMAS.

B. The following individuals shall be excluded (as defined in 12VAC30-120-360) from participating in Medallion II as defined in the § 1915(b) managed care waiver. Individuals excluded from Medallion II include the following:

1. Individuals who are inpatients in state mental hospitals;
2. Individuals who are approved by DMAS as inpatients in long-stay hospitals, nursing facilities, or intermediate care facilities for ~~the intellectually disabled~~ individuals with intellectual disabilities;
3. Individuals who are placed on spend-down;
4. Individuals who are participating in the family planning waiver, or in federal waiver programs for home-based and community-based Medicaid coverage prior to managed care enrollment;
5. Individuals under age 21 who are approved for DMAS residential facility Level C programs as defined in 12VAC30-130-860;
6. Newly eligible individuals who are in the third trimester of pregnancy and who request exclusion within a department-specified timeframe of the effective date of their MCO enrollment. Exclusion may be granted only if the member's obstetrical provider (e.g., physician, hospital, midwife) does not participate with the enrollee's assigned MCO. Exclusion requests made during the third trimester may be made by the recipient member, MCO, or provider. DMAS shall determine if the request meets the criteria for exclusion. Following the end of the pregnancy, these individuals shall be required to enroll to the extent they remain eligible for Medicaid;
7. Individuals, other than students, who permanently live outside their area of residence for greater than 60 consecutive days except those individuals placed there for medically necessary services funded by the MCO;
8. Individuals who receive hospice services in accordance with DMAS criteria;
9. Individuals with other comprehensive group or individual health insurance coverage, including Medicare, insurance provided to military dependents, and any other insurance purchased through the Health Insurance Premium Payment Program (HIPP);
10. Individuals requesting exclusion who are inpatients in hospitals, other than those listed in subdivisions 1 and 2 of this subsection, at the scheduled time of MCO enrollment or who are scheduled for inpatient hospital stay or surgery within 30 calendar days of the MCO enrollment effective date. The exclusion shall remain effective until the first day of the month following discharge. This exclusion reason shall not apply to recipients members admitted to the hospital while already enrolled in a department-contracted MCO;
11. Individuals who request exclusion during preassignment to an MCO or within a time set by DMAS from the effective date of their MCO enrollment, who have

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# Regulations

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been diagnosed with a terminal condition and who have a life expectancy of six months or less. The client's physician must certify the life expectancy;

12. Certain individuals between birth and age three certified by the Department of Behavioral Health and Developmental Services as eligible for services pursuant to Part C of the Individuals with Disabilities Education Act (20 USC § 1471 et seq.) who are granted an exception by DMAS to the mandatory Medallion II enrollment;

13. Individuals who have an eligibility period that is less than three months;

14. Individuals who are enrolled in the Commonwealth's Title XXI SCHIP program;

15. Individuals who have an eligibility period that is only retroactive; and

16. Children enrolled in the Virginia Birth-Related Neurological Injury Compensation Program established pursuant to Chapter 50 (§ 38.2-5000 et seq.) of Title 38.2 of the Code of Virginia.

C. ~~Individuals~~ Members enrolled with a MCO who subsequently meet one or more of the criteria of subsections A and B of this section during MCO enrollment shall be excluded from MCO participation as determined by DMAS, with the exception of those who subsequently become ~~recipients participants~~ in the federal long-term care waiver programs, as otherwise defined elsewhere in this chapter, for home-based and community-based Medicaid coverage (AIDS, IFDDS, MR/ID, EDCD, Day Support, or Alzheimer's, or as may be amended from time to time). These individuals shall receive acute and primary medical services via the MCO and shall receive waiver services and related transportation to waiver services via the fee-for-service program.

Individuals excluded from mandatory managed care enrollment shall receive Medicaid services under the current fee-for-service system. When ~~enrollees~~ individuals no longer meet the criteria for exclusion, they shall be required to enroll in the appropriate managed care program.

D. Individuals who are enrolled in localities that qualify for the rural exception may meet exclusion criteria if their PCP of record, as defined in 12VAC30-120-360, cannot or will not participate with the one MCO in the locality. Individual requests to be excluded from MCO participation in localities meeting the qualification for the rural exception must be made to DMAS for consideration on a case-by-case basis. Recipients enrolled in MCO rural exception areas shall not have open enrollment periods and shall not be afforded the 90-day window after initial enrollment during which they may make a health plan or program change.

Individuals excluded from mandatory managed care enrollment shall receive Medicaid services under the current fee-for-service system. When ~~enrollees~~ individuals no longer meet the criteria for exclusion, they shall be required to enroll in the appropriate managed care program.

E. Medallion II managed care plans shall be offered to ~~recipients~~ individuals, and ~~recipients~~ individuals shall be enrolled in those plans, exclusively through an independent enrollment broker under contract to DMAS.

F. Clients shall be enrolled as follows:

1. All eligible ~~persons~~ individuals, except those meeting one of the exclusions of subsection B of this section, shall be enrolled in Medallion II.

2. ~~Clients~~ Individuals shall receive a Medicaid card from DMAS, and shall be provided authorized medical care in accordance with DMAS' procedures after Medicaid eligibility has been determined to exist.

3. Once individuals are enrolled in Medicaid, they will receive a letter indicating that they may select one of the contracted MCOs. These letters shall indicate a preassigned MCO, determined as provided in subsection F of this section, in which the ~~client~~ individual will be enrolled if he does not make a selection within a period specified by DMAS of not less than 30 days. ~~Recipients~~ Members who are enrolled in one mandatory MCO program who immediately become eligible for another mandatory MCO program are able to maintain consistent enrollment with their currently assigned MCO, if available. These ~~recipients~~ members will receive a notification letter including information regarding their ability to change health plans under the new program.

4. Any newborn whose mother is enrolled with an MCO at the time of birth shall be considered ~~an enrollee~~ a member of that same MCO for the newborn enrollment period. This requirement does not preclude the ~~enrollee~~ member, once he is assigned a Medicaid identification number, from disenrolling from one MCO to another in accordance with subdivision H 1 of this section.

The newborn's continued enrollment with the MCO is not contingent upon the mother's enrollment. Additionally, if the MCO's contract is terminated in whole or in part, the MCO shall continue newborn coverage if the child is born while the contract is active, until the newborn receives a Medicaid number or for the newborn enrollment period, whichever timeframe is earlier. ~~Infants~~ Children who do not receive a Medicaid identification number prior to the end of the newborn enrollment period will be disenrolled. Newborns who remain eligible for participation in Medallion II will be reenrolled in an MCO through the preassignment process upon receiving a Medicaid identification number.

5. Individuals who lose then regain eligibility for Medallion II within 60 days will be reenrolled into their previous MCO without going through preassignment and selection.

G. ~~Clients~~ Individuals who do not select an MCO as described in subdivision F 3 of this section shall be assigned to an MCO as follows:

1. ~~Clients~~ Individuals are assigned through a system algorithm based upon the client's history with a contracted MCO.

2. ~~Clients~~ Individuals not assigned pursuant to subdivision 1 of this subsection shall be assigned to the MCO of another family member, if applicable.

3. ~~Clients~~ Individuals who live in rural exception areas as defined in 12VAC30-120-360 must enroll with the one available MCO. These persons shall receive a preassignment notification for enrollment into the MCO. Individuals in rural exception areas who are assigned to the one MCO may request exclusion from MCO participation if their PCP of record, as defined in 12VAC30-120-360, cannot or will not participate with the one MCO in the locality. Individual requests to be excluded from MCO participation in rural exception localities must be made to DMAS for consideration on a case-by-case basis.

4. All other ~~clients~~ individuals shall be assigned to an MCO on a basis of approximately equal number by MCO in each locality.

5. ~~Recipients in areas where there is only one contracted MCO and the PCCM program~~ All eligible members are automatically assigned to ~~the a~~ a contracted MCO, ~~but in their localities. Members~~ are allowed 90 days after the effective date of new or initial enrollment to change from either the contracted MCO to the PCCM program, or vice versa to another MCO that participates in the geographic area where the member lives. Recipients residing in localities qualifying for rural exception shall not be afforded the 90-day window after initial enrollment during which they may make a health plan or program change.

6. DMAS shall have the discretion to utilize an alternate strategy for enrollment or transition of enrollment from the method described in this section for expansions, retractions, or changes to client populations, geographical areas, procurements, or any or all of these; such alternate strategy shall comply with federal waiver requirements.

H. Following their initial enrollment into an MCO ~~or PCCM program~~, ~~recipients~~ members shall be restricted to the MCO ~~or PCCM program~~ until the next open enrollment period, unless appropriately disenrolled or excluded by the department (as defined in 12VAC30-120-360).

1. During the first 90 calendar days of enrollment in a new or initial MCO, a ~~client~~ member may disenroll from that MCO to enroll into another MCO ~~or into PCCM, if applicable~~, for any reason. Such disenrollment shall be effective no later than the first day of the second month after the month in which the ~~client~~ member requests disenrollment.

2. During the remainder of the enrollment period, the ~~client~~ member may only disenroll from one MCO into another MCO ~~or PCCM, if applicable~~, upon determination by

DMAS that good cause exists as determined under subsection I of this section.

I. The department shall conduct an annual open enrollment for all Medallion II ~~participants~~ members with the exception of those clients who live in a designated rural exception area. The open enrollment period shall be the 60 calendar days before the end of the enrollment period. Prior to the open enrollment period, DMAS will inform the ~~recipient~~ member of the opportunity to remain with the current MCO or change to another MCO, without cause, for the following year. ~~In areas with only one contracted MCO and where the PCCM program is available, recipients will be given the opportunity to select either the MCO or the PCCM program.~~ Enrollment selections will be effective on the first day of the next month following the open enrollment period. ~~Recipients~~ Members who do not make a choice during the open enrollment period will remain with their current MCO selection.

J. Disenrollment for cause may be requested at any time.

1. After the first 90 days of enrollment in an MCO, ~~clients~~ members must request disenrollment from DMAS based on cause. The request may be made orally or in writing to DMAS and must cite the reasons why the ~~client~~ member wishes to disenroll. Cause for disenrollment shall include the following:

a. A ~~recipient's~~ member's desire to seek services from a federally qualified health center that is not under contract with the ~~recipient's~~ member's current MCO, and the ~~recipient (i)~~ member requests a change to another MCO that subcontracts with the desired federally qualified health center ~~or (ii) requests a change to the PCCM, if the federally qualified health center is contracting directly with DMAS as a PCCM;~~

b. Performance or nonperformance of service to the ~~recipient~~ member by an MCO or one or more of its providers that is deemed by the department's external quality review organizations to be below the generally accepted community practice of health care. This may include poor quality care;

c. Lack of access to a PCP or necessary specialty services covered under the State Plan or lack of access to providers experienced in dealing with the ~~enrollee's~~ member's health care needs;

d. A ~~client~~ member has a combination of complex medical factors that, in the sole discretion of DMAS, would be better served under another contracted MCO ~~or PCCM program, if applicable~~, or provider;

e. The ~~enrollee~~ member moves out of the MCO's service area;

f. The MCO does not, because of moral or religious objections, cover the service the ~~enrollee~~ member seeks;

g. The ~~enrollee~~ member needs related services to be performed at the same time; not all related services are available within the network, and the ~~enrollee's~~ member's



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# Regulations

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primary care provider or another provider determines that receiving the services separately would subject the enrollee member to unnecessary risk; or

h. Other reasons as determined by DMAS through written policy directives.

2. DMAS shall determine whether cause exists for disenrollment. Written responses shall be provided within a timeframe set by department policy; however, the effective date of an approved disenrollment shall be no later than the first day of the second month following the month in which the enrollee member files the request, in compliance with 42 CFR 438.56.

3. Cause for disenrollment shall be deemed to exist and the disenrollment shall be granted if DMAS fails to take final action on a valid request prior to the first day of the second month after the request.

4. The DMAS determination concerning cause for disenrollment may be appealed by the client member in accordance with the department's client appeals process at 12VAC30-110-10 through 12VAC30-110-380.

5. The current MCO shall provide, within two working days of a request from DMAS, information necessary to determine cause.

6. Individuals Members enrolled with a MCO who subsequently meet one or more of the exclusions in subsection B of this section during MCO enrollment shall be excluded as appropriate by DMAS, with the exception of those who subsequently become recipients into the AIDS, individuals participating in the IFDDS, MRAD ID, EDCD, Day Support, or Alzheimer's federal waiver programs for home-based and community-based Medicaid coverage. These individuals members shall receive acute and primary medical services via the MCO and shall receive waiver services and related transportation to waiver services via the fee-for-service program.

## Part I General Provisions

### 12VAC30-141-10. Definitions.

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

"Act" means the Social Security Act.

"Adult caretaker relative" or "caretaker relative" means an individual who is age 18 or older, who is not the parent of, but who is related to, the child by blood or marriage, and who lives with and assumes responsibility for day-to-day care of the child in a place of residence maintained as his or their own home.

"Adverse action" means the denial of eligibility; failure to make a timely determination of eligibility; suspension or termination of enrollment; or delay, denial, reduction, suspension, or termination of health services, in whole or in

part; provided, however, that determination of eligibility to participate in and termination of participation in the FAMIS Select program shall not constitute an adverse action.

"Agency" means a local department of social services, the central processing unit, or other entity designated by DMAS to make eligibility determinations for FAMIS.

"Agency error" means a person or persons received benefits to which they were not entitled as a result of an error on the part of an eligibility worker at a local department of social services or the central processing unit.

"Agent" means an individual designated in writing to act on behalf of a FAMIS Plan applicant or enrollee during the administrative review process.

"Applicant" means a child who has filed an application (or who has an application filed on his behalf) for child health insurance and is awaiting a determination of eligibility. A child is an applicant until his eligibility has been determined.

"Application for health insurance" means the form or forms developed and approved by the Department of Medical Assistance Services that are used for determining eligibility for Family Access to Medical Insurance Security Plan (FAMIS), FAMIS Plus (Children's Medicaid), for Medicaid for pregnant women, and for FAMIS MOMS.

"Authorized representative" means a person who is authorized to conduct the personal or financial affairs for an individual who is 18 years of age or older.

"Board" or "BMAS" means that policy board created by § 32.1-324 of the Code of Virginia to administer the plans established by the Social Security Act.

"CMSIP" means that original child health insurance program that preceded FAMIS.

"Central processing unit" or "CPU" means the private contractor that will determine eligibility for and administer part of the Family Access to Medical Insurance Security Plan or FAMIS.

"Child" means an individual under the age of 19 years.

"Competent individual" means a person who has not been judged by a court to be legally incapacitated.

"Comprehensive health insurance coverage" means health benefits coverage, which includes the following categories of services at a minimum: inpatient and outpatient hospital services; physician's surgical and medical services; and laboratory and radiological services.

"Conservator" means a person appointed by a court of competent jurisdiction to manage the estate and financial affairs of an incapacitated individual.

"Continuation of enrollment" means ensuring an enrollee's benefits are continued until completion of the review process, with the condition that should the enrollee not prevail in the review process, the enrollee shall be liable for the repayment of all benefits received during the review process.

"Director" means the individual, or his designee, specified in § 32.1-324 of the Code of Virginia with all of the attendant duties and responsibilities to administer the State Plan for Medical Assistance and the State Plan for FAMIS.

"DMAS" or "department" means the Department of Medical Assistance Services.

"Enrollee" means a child who has been determined eligible to participate in FAMIS and is enrolled in the FAMIS program.

"~~External Quality Review Organization~~ quality review organization" means the independent contractor assigned by DMAS to handle quality reviews and to conduct final review of MCHIP adverse actions for FAMIS.

"Family" means parents, including adoptive and stepparents, and their children under the age of 19, who are living in the same household. Family shall not mean grandparents, other relatives, or legal guardians.

"Family," when used in the context of the FAMIS Select component, means a unit or group that has access to an employer's group health plan. Thus, it includes the employee and any dependents who can be covered under the employer's plan.

"Family income" means the total income of all family members in a household. Income includes, but is not necessarily limited to, before-tax earnings from a job, including cash, wages, salary, commissions, tips, self-employment net profits, Social Security, Retirement Survivor Disability Insurance (RSDI), veterans benefits, Railroad Retirement, disability workers' compensation, unemployment benefits, child support, alimony, spousal support, pensions, retirement benefits, settlement benefits, rental income, and lottery/bingo winnings. Income excludes public assistance program benefits such as SSI and TANF payments, foster care payments, general relief, loans, grants, or scholarships for educational expenses or earned income of a child who is a student.

"FAMIS" means the Family Access to Medical Insurance Security Plan.

"FAMIS Select" means an optional program available to children determined eligible for FAMIS, whereby DMAS provides premium assistance to the family to cover the child through a private or employer-sponsored health plan instead of directly through the FAMIS program.

"Federal poverty level" or "FPL" means that income standard as published annually by the U.S. Department of Health and Human Services in the Federal Register.

"Fee-for-service" means the traditional Medicaid health care delivery and payment system in which physicians and other providers receive a payment for each unit of service they provide.

"Fixed premium assistance amount" means a predetermined amount of premium assistance that DMAS will pay per child to a family who chooses to enroll its FAMIS eligible child in

a private or employer-sponsored health plan. The fixed premium assistance amount will be determined annually by DMAS to ensure that the FAMIS Select program is cost-effective as compared to the cost of covering a child directly through the FAMIS program.

"Fraud" means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable federal or state laws.

"Group health plan" or "health insurance coverage" means that health care coverage as defined in § 2791 of the Public Health Services Act (42 USC § 300gg-91(a) and (b)(1)).

"Guardian" means a person appointed by a court of competent jurisdiction to be responsible for the affairs of an incapacitated individual, including responsibility for making decisions regarding the person's support, care, health, safety, habilitation, education, and therapeutic treatment, and if not inconsistent with an order of commitment, residence.

"Incapacitated individual" means a person who, pursuant to an order of a court of competent jurisdiction, has been found to be incapable of receiving and evaluating information effectively or responding to people, events, or environments to such an extent that the individual lacks the capacity to (i) meet the essential requirements of his health, care, safety, or therapeutic needs without the assistance or protection of a guardian, or (ii) manage property or financial affairs or provide for his support or for the support of his legal dependents without the assistance or protection of a conservator.

"Legally emancipated" means that the parents and child have gone through the court and a judge has declared that the parents have surrendered the right to care, custody, and earnings of the child and have renounced parental duties. A married minor is not emancipated unless a court has declared the married minor emancipated from his parents.

"LDSS" or "local department" means the local department of social services.

"Managed care health insurance plan" or "MCHIP" as defined in § 32.1-137.1 of the Code of Virginia means an arrangement for the delivery of health care in which a health carrier means under contract with DMAS for Title XXI delivery systems, undertakes to provide, arrange and pay for, or reimburse any of the costs of health care services for a covered person on a prepaid or insured basis, which contains one or more incentive arrangements, including any credential requirements intended to influence the cost of the health care services between the health carrier and one or more providers and requires or creates benefit payment differential incentives for covered persons to use providers that are directly or indirectly managed, owned, under contract with or employed by the health carrier.

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# Regulations

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"Maternal and child health insurance application" means the form or forms developed and approved by the Department of Medical Assistance Services that are used by local departments of social services and the FAMIS CPU for determining eligibility for Medicaid for poverty-level children and for the Family Access to Medical Insurance Security Plan (FAMIS).

"Member of a family," for purposes of determining whether the child is eligible for coverage under a state employee health insurance plan, means a parent or parents, including stepparents with whom the child is living if the stepparent claims the child as a dependent on the employee's federal tax return.

"Premium assistance" means the portion of the family's cost of participating in a private employer's health plan that DMAS will pay to cover the FAMIS-eligible children under the private or employer-sponsored plan if DMAS determines it is cost effective to do so.

~~"Primary care case management (PCCM)" means a system under which a physician acting as a primary care case manager furnishes case management services to FAMIS enrollees pursuant to a contract with DMAS.~~

~~"Primary care provider" or "PCP" means a physician enrolled in the PCCM program as a primary case manager.~~

"Private" or "employer-sponsored health insurance coverage"<sup>4</sup> means a health insurance policy that is either purchased by an individual directly or through an employer. This component of FAMIS refers to the ability of DMAS to provide coverage to FAMIS-eligible children by providing premium assistance to families who enroll the FAMIS-eligible children in a private or employer-sponsored health plan.

"Provider" means the individual, facility or other entity registered, licensed, or certified, as appropriate, and enrolled by an MCHIP,~~a PCCM~~, or in fee-for-service to render services to FAMIS enrollees eligible for services.

"Supplemental coverage" means coverage provided to FAMIS-eligible children covered under the FAMIS Select component so that they can receive all childhood immunizations included in the FAMIS benefits.

"Title XXI" means the federal State Children's Health Insurance Program as established by Subtitle J of the Balanced Budget Act of 1997.

"Virginia State Employee Health Insurance Plan" means a health insurance plan offered by the Commonwealth of Virginia to its employees.

~~4So in original.~~

## **12VAC30-141-20. Administration and general background.**

A. The state shall use funds provided under Title XXI for obtaining coverage that meets the requirements for a State Child Health Insurance Plan (also known as Title XXI).

B. The DMAS director will have the authority to contract with entities for the purpose of establishing a centralized processing site, determining eligibility, enrolling eligible children into health plans, performing outreach, data collection, reporting, and other services necessary for the administration of the Family Access to Medical Insurance Security Plan and for employing state staff to perform Medicaid eligibility determinations on children referred by FAMIS staff.

C. Health care services under FAMIS shall be provided through MCHIPs,~~PCCMs~~, and through fee-for-service or through any other ~~health health~~ care delivery system deemed appropriate by the Department of Medical Assistance Services.

## **12VAC30-141-70. Review procedures.**

A. At a minimum, the MCHIP review shall be conducted pursuant to written procedures as defined in § 32.1-137.6 of the Code of Virginia and as may be further defined by DMAS. Such procedures shall be subject to review and approval by DMAS.

B. The DMAS review shall be conducted pursuant to written procedures developed by DMAS.

C. The procedures in effect on the date a particular request for review is received by the MCHIP or DMAS shall apply throughout the review.

D. Copies of the procedures shall be promptly mailed by the MCHIP or DMAS to applicants and enrollees upon receipt of timely requests for review. Such written procedures shall include but not be limited to the following:

1. The right to representation by an attorney or other agent of the applicant's or enrollee's choice, but at no time shall the MCHIP, local department of social services, DSS, or DMAS be required to obtain or compensate attorneys or other agents acting on behalf of applicants or enrollees;
2. The right to timely review of their files and other applicable information relevant to the review of the decision;
3. The right to fully participate in the review process, whether the review is conducted in person or in writing, including the presentation of supplemental information during the review process;
4. The right to have personal and medical information and records maintained as confidential; and
5. The right to a written final decision within 90 calendar days of receipt of the request for review, unless the applicant or enrollee requests or causes a delay.
6. For eligibility and enrollment matters, if the applicant's or enrollee's physician or health plan determines that the 90-calendar-day timeframe could seriously jeopardize the applicant's or enrollee's life or health or ability to attain, maintain, or regain maximum function, an applicant or enrollee will have the opportunity to expedited review.

Under these conditions, a request for review shall result in a written final decision within three business days after DMAS receives, from the physician or health plan, the case record and information indicating that taking the time for a standard resolution of the review request could seriously jeopardize the applicant's or enrollee's life or health or ability to attain, maintain or regain maximum function, unless the applicant or enrollee or his authorized representative causes a delay.

7. For health services matters for FAMIS enrollees receiving services through MCHIPs, if the enrollee's physician or health plan determines that the 90-calendar-day timeframe could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function, an enrollee will have the opportunity to expedited review. Under these conditions, a request for review shall result in a written decision by the external quality review organization within 72 hours from the time an enrollee requests expedited review, unless the applicant, enrollee, or authorized representative requests or causes a delay. If a delay is requested or caused by the applicant, enrollee, or authorized representative, then expedited review may be extended up to 14 calendar days.

8. For health services matters for FAMIS enrollees receiving services through fee-for-service ~~and PCCM~~, if the enrollee's physician or health plan determines that the 90-calendar-day timeframe could seriously jeopardize the enrollee's life, health or ability to attain, maintain, or regain maximum function, an enrollee will have the opportunity to expedited review. Under these conditions, a request for review shall result in a written decision within 72 hours from the time an enrollee requests expedited review, unless the applicant, enrollee, or authorized representative requests or causes a delay. If a delay is requested or caused by the applicant, enrollee, or authorized representative, then expedited review may be extended up to 14 calendar days.

#### Part V Benefits and Reimbursement

##### **12VAC30-141-200. Benefit packages.**

The Commonwealth's Title XXI State Plan utilizes two benefit packages within FAMIS as set forth in the FAMIS State Plan, as may be amended from time to time. One package is a modified Medicaid look-alike component offered through a fee-for-service program ~~and a primary care case management (PCCM) program~~; the other package is modeled after the state employee health plan and delivered by contracted MCHIPs.

##### **12VAC30-141-500. Benefits reimbursement.**

A. Reimbursement for the services covered under FAMIS fee-for-service ~~and PCCM~~ and MCHIPs shall be as specified in this section.

B. Reimbursement for physician services, surgical services, clinic services, prescription drugs, laboratory and radiological services, outpatient mental health services, early intervention services, emergency services, home health services, immunizations, mammograms, medical transportation, organ transplants, skilled nursing services, well baby and well child care, vision services, durable medical equipment, disposable medical supplies, dental services, case management services, physical therapy/occupational therapy/speech-language therapy services, hospice services, school-based health services, and certain community-based mental health services shall be based on the Title XIX rates.

C. Reimbursement to MCHIPs shall be determined on the basis of the estimated cost of providing the MCHIP benefit package and services to an actuarially equivalent population. MCHIP rates will be determined annually and published 30 days prior to the effective date.

##### D. Exceptions.

1. Prior authorization is required after five visits in a fiscal year for physical therapy, occupational therapy and speech therapy provided by home health providers and outpatient rehabilitation facilities and for home health skilled nursing visits. Prior authorization is required after 26 visits for outpatient mental health visits in the first year of service and prior authorization is required for the following nonemergency outpatient procedures: Magnetic Resonance Imaging, including Magnetic Resonance Angiography (MRA), Computerized Axial Tomography (CAT) scans, including Computed Tomography Angiography (CTA), or Positron Emission Tomography (PET) scans performed for the purpose of diagnosing a disease process or physical injury. Prior authorization for dental services will be based on the Title XIX prior authorization requirements for dental services.

2. Reimbursement for inpatient hospital services will be based on the Title XIX rates in effect for each hospital. Reimbursement shall not include payments for disproportionate share or graduate medical education payments made to hospitals. Payments made shall be final and there shall be no retrospective cost settlements.

3. Reimbursement for outpatient hospital services shall be based on the Title XIX rates in effect for each hospital. Payments made will be final and there will be no retrospective cost settlements.

4. Reimbursement for inpatient mental health services other than by free standing psychiatric hospitals will be based on the Title XIX rates in effect for each hospital. Reimbursement will not include payments for disproportionate share or graduate medical education payments made to hospitals. Payments made will be final and there will be no retrospective cost settlements.

5. Reimbursement for outpatient rehabilitation services will be based on the Title XIX rates in effect for each

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# Regulations

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rehabilitation agency. Payments made will be final and there will be no retrospective cost settlements.

6. Reimbursement for outpatient substance abuse treatment services will be based on rates determined by DMAS for children ages ~~6~~ six through ~~18~~ years. Payments made will be final and there will be no retrospective cost settlements.

7. Reimbursement for prescription drugs will be based on the Title XIX rates in effect. Reimbursements for Title XXI do not receive drug rebates as under Title XIX.

8. Reimbursement for covered prescription drugs for noninstitutionalized FAMIS recipients receiving the fee-for-service ~~or PCCM~~ benefits will be subject to review and prior authorization when their current number of prescriptions exceeds nine unique prescriptions within 180 days, and as may be further defined by the agency's guidance documents for pharmacy utilization review and the prior authorization program. The prior authorization process shall be applied consistent with the process set forth in 12VAC30-50-210 A 7.

## 12VAC30-141-570. Utilization control.

A. Each MCHIP shall implement a utilization review system as determined by contract with DMAS, or administered by DMAS.

B. For ~~both~~ the fee-for-service ~~and PCCM programs~~ program, DMAS shall use the utilization controls already established and operational in the State Plan for Medical Assistance.

C. DMAS may collect and review comprehensive data to monitor utilization after receipt of services.

## 12VAC30-141-660. Assignment to managed care.

A. Except for children enrolled in the Virginia Birth-Related Neurological Injury Compensation Program established pursuant to Chapter 50 (§ 38.2-5000 et seq.) of Title 38.2 of the Code of Virginia, all eligible enrollees shall be assigned in managed care through the department or the central processing unit (CPU) under contract to DMAS. FAMIS ~~recipients~~ individuals, during the preassignment period to a ~~PCP or an~~ MCHIP, shall receive Title XXI benefits via fee-for-service utilizing a FAMIS card issued by DMAS. After assignment to a ~~PCP or an~~ MCHIP, benefits and the delivery of benefits shall be administered specific to the ~~type of~~ managed care program in which the ~~recipient~~ individual is enrolled. DMAS shall contract with MCHIPS to deliver health care services for infants born to mothers enrolled in FAMIS for the month of birth plus two additional months regardless of the status of the newborn's application for FAMIS. If federal funds are not available for those months of coverage, DMAS shall use state funding only.

1. MCHIPS shall be offered to enrollees in ~~certain~~ all areas.
2. ~~In areas with one contracted MCHIP, all~~ All enrollees shall be assigned to ~~that the~~ the contracted ~~MCHIP~~ MCHIPS.

3. ~~In areas with multiple contracted MCHIPS or in PCCM areas without contracted MCHIPS, enrollees~~ Enrollees shall be assigned through a random system algorithm; provided however, all children within the same family shall be assigned to the same MCHIP ~~or primary care provider (PCP), as is applicable.~~

4. ~~In areas without contracted MCHIPS, enrollees shall be assigned to the primary care case management program (PCCM) or into the fee for service component.~~ All children enrolled in the Virginia Birth-Related Neurological Injury Compensation Program shall be assigned to the fee-for-service component.

5. Enrolled individuals ~~residing in PCCM areas without contracted MCHIPS or in areas with multiple MCHIPS,~~ will receive a letter indicating that they may select one of the contracted MCHIPS ~~or primary care provider (PCP) in the PCCM program, in each case, which~~ that serve such area. Enrollees who do not select an ~~MCHIP/PCP~~ MCHIP as described above, shall be assigned to an ~~MCHIP/PCP~~ MCHIP as described in subdivision 3 of this ~~section~~ subsection.

6. Individuals assigned to an MCHIP ~~or a PCCM~~ who lose and then regain eligibility for FAMIS within 60 days will be ~~re-assigned~~ reassigned to their previous MCHIP ~~or PCP~~.

B. Following their initial assignment to a ~~MCHIP/PCP~~ an MCHIP, those enrollees shall be restricted to that ~~MCHIP/PCP~~ MCHIP until their next annual eligibility redetermination, unless appropriately disenrolled by the department.

1. During the first 90 calendar days of managed care assignment, an enrollee may request reassignment for any reason. Such reassignment shall be effective no later than the first day of the second month after the month in which the enrollee requests reassignment.

2. ~~If multiple MCHIPS exist, enrollees~~ Enrollees may only request reassignment to another MCHIP serving that geographic area. ~~In PCCM areas, an enrollee may only request reassignment to another PCP serving that geographic area. In areas with only one MCHIP, enrollees may request reassignment to fee for service.~~

3. After the first 90 calendar days of the assignment period, the enrollee may only be reassigned from one ~~MCHIP/PCP~~ MCHIP to another ~~MCHIP/PCP or to fee for service in areas with only one~~ MCHIP upon determination by DMAS that good cause exists pursuant to subsection C of this section.

C. Disenrollment for good cause may be requested at any time.

1. After the first 90 days of assignment in managed care, enrollees may request disenrollment from DMAS based on good cause. The request must be made in writing to DMAS and cite the reasons why the enrollee wishes to be

reassigned. The department shall establish procedures for good cause reassignment through written policy directives.

2. DMAS shall determine whether good cause exists for reassignment.

Part VII  
FAMIS MOMS

**12VAC30-141-670. Definitions.**

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

"Act" means the Social Security Act.

"Adult caretaker relative" or "caretaker relative" means an individual who is ~~age~~ 18 years of age or older, who is not the parent of but who is related to the child applicant by blood or marriage, and who lives with and assumes responsibility for day-to-day care of the child applicant in a place of residence maintained as his or their own home.

"Adverse action" means the denial of eligibility; failure to make a timely determination of eligibility; suspension or termination of enrollment; or delay, denial, reduction, suspension, or termination of health services, in whole or in part.

"Agency" means a local department of social services, the central processing unit, or other entity designated by DMAS to make eligibility determinations for FAMIS MOMS.

"Agency error" means a person or persons received benefits to which they were not entitled as a result of an error on the part of an eligibility worker at a local department of social services or the central processing unit.

"Agent" means an individual designated in writing to act on behalf of a FAMIS MOMS Plan applicant or enrollee during the administrative review process.

"Applicant" means a pregnant woman who has filed an application (or who has an application filed on her behalf) for health insurance and is awaiting a determination of eligibility. A pregnant woman is an applicant until her eligibility has been determined.

"Application for health insurance" means the form or forms developed and approved by the Department of Medical Assistance Services that are used for determining eligibility for Medicaid for poverty level children, for the Family Access to Medical Insurance Security Plan (FAMIS) for children, for Medicaid for pregnant women, and for FAMIS MOMS coverage for pregnant women.

"Authorized representative" means a person who is authorized to conduct the personal or financial affairs for an individual who is 18 years of age or older.

"Board" or "BMAS" means that policy board created by § 32.1-324 of the Code of Virginia to administer the plans established by the Social Security Act.

"Central processing unit" or "CPU" means the private contractor that will determine eligibility for and administer part of the FAMIS MOMS Plan.

"Child" means an individual under the age of 19 years.

"Competent individual" means a person who has not been judged by a court to be legally incapacitated.

"Comprehensive health insurance coverage" means health benefits coverage, which includes the following categories of services at a minimum: inpatient and outpatient hospital services, physician's surgical and medical services, and laboratory and radiological services.

"Conservator" means a person appointed by a court of competent jurisdiction to manage the estate and financial affairs of an incapacitated individual.

"Continuation of enrollment" means ensuring an enrollee's benefits are continued until completion of the review process, with the condition that should the enrollee not prevail in the review process, the enrollee shall be liable for the repayment of all benefits received during the review process.

"Director" means the individual, or his designee, specified in § 32.1-324 of the Code of Virginia with all of the attendant duties and responsibilities to administer the State Plan for Medical Assistance and the State Plan for Title XXI.

"DMAS" or "department" means the Department of Medical Assistance Services.

"Enrollee" means a pregnant woman who has been determined eligible to participate in FAMIS MOMS and is enrolled in the FAMIS MOMS program.

"External quality review organization" means the independent contractor assigned by DMAS to handle quality reviews and to conduct final review of MCHIP adverse actions for FAMIS MOMS.

"Family" for a pregnant woman under the age of 21, means parents, including adoptive parents, if they are all residing together and the spouse of the pregnant woman if the woman is married and living with her spouse, as well as any children under the age of 21 the woman may have.

For a pregnant woman over the age of 21, "family" means her spouse, if married and living together, as well as any children under the age of 21 the pregnant woman may have.

"Family income" means the total income of all family members in a household. Income includes, but is not necessarily limited to, before-tax earnings from a job, including cash, wages, salary, commissions, tips, self-employment net profits, Social Security, Retirement Survivor Disability Insurance (RSDI), veterans benefits, Railroad Retirement, disability workers' compensation, unemployment benefits, child support, alimony, spousal support, pensions, retirement benefits, settlement benefits, rental income, and lottery/bingo winnings. Income excludes public assistance program benefits such as SSI and TANF payments, foster care payments, general relief, loans, grants, or scholarships

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# Regulations

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for educational expenses or earned income of a child who is a student.

"FAMIS" means the Family Access to Medical Insurance Security Plan.

"FAMIS MOMS" means the Title XXI program available to eligible pregnant women.

"Federal poverty level" or "FPL" means that income standard as published annually by the U.S. Department of Health and Human Services in the Federal Register.

"Fee-for-service" means the traditional Medicaid health care delivery and payment system in which physicians and other providers receive a payment for each unit of service they provide.

"Fraud" means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to herself or some other person. It includes any act that constitutes fraud under applicable federal or state laws.

"Group health plan" or "health insurance coverage" means that health care coverage as defined in § 2791 of the Public Health Services Act (42 USC § 300gg-91(a) and (b)(1)).

"Guardian" means a person appointed by a court of competent jurisdiction to be responsible for the affairs of an incapacitated individual, including responsibility for making decisions regarding the person's support, care, health, safety, habilitation, education, and therapeutic treatment, and, if not inconsistent with an order of commitment, residence.

"Incapacitated individual" means a person who, pursuant to an order of a court of competent jurisdiction, has been found to be incapable of receiving and evaluating information effectively or responding to people, events, or environments to such an extent that the individual lacks the capacity to (i) meet the essential requirements of her health, care, safety, or therapeutic needs without the assistance or protection of a guardian, or (ii) manage property or financial affairs or provide for her support or for the support of her legal dependents without the assistance or protection of a conservator.

"Legally emancipated" means that the parents and child have gone through the court and a judge has declared that the parents have surrendered the right to care, custody, and earnings of the child and have renounced parental duties. A married minor is not emancipated unless a court has declared the married minor emancipated from her parents.

"LDSS" or "local department" means the local department of social services.

"Managed care health insurance plan" or "MCHIP" as defined in § 32.1-137.1 of the Code of Virginia means an arrangement for the delivery of health care in which a health carrier under contract with DMAS for Title XXI delivery systems undertakes to provide, arrange and pay for, or reimburse any of the costs of health care services for a covered person on a prepaid or insured basis, which contains

one or more incentive arrangements, including any credential requirements intended to influence the cost of the health care services between the health carrier and one or more providers and requires or creates benefit payment differential incentives for covered persons to use providers that are directly or indirectly managed, owned, under contract with or employed by the health carrier.

"Member of a family," for purposes of determining whether the applicant is eligible for coverage under a state employee health insurance plan, means a spouse, parent or parents, including stepparents with whom the child is living if the stepparent claims the child as a dependent on the employee's federal tax return.

"Pregnant woman" means a woman of any age who is medically determined to be pregnant. The pregnant woman definition is met from the first day of the earliest month that the medical practitioner certifies as being a month in which the woman was pregnant, through the last day of the month in which the 60th day occurs, following the last day of the month in which her pregnancy ended, regardless of the reason the pregnancy ended.

~~"Primary care case management (PCCM)" means a system under which a physician acting as a primary care case manager furnishes case management services to FAMIS MOMS enrollees pursuant to a contract with DMAS.~~

~~"Primary care provider" or "PCP" means a physician enrolled in the PCCM program as a primary case manager.~~

"Provider" means the individual, facility, or other entity registered, licensed, or certified, as appropriate, and enrolled by an MCHIP, ~~a PCCM~~, or in fee-for-service to render services to FAMIS MOMS enrollees eligible for services.

"Title XXI" means the federal State Children's Health Insurance Program as established by Subtitle J of the Balanced Budget Act of 1997.

"Virginia State Employee Health Insurance Plan" means a health insurance plan offered by the Commonwealth of Virginia to its employees.

## **12VAC30-141-680. Administration and general background.**

A. The state shall use funds provided under Title XXI for obtaining coverage that meets the requirements of Title XXI of the Social Security Act and any waiver of federal regulations approved by the Centers for Medicare and Medicaid Services.

B. The DMAS director will have the authority to contract with entities for the purpose of establishing a centralized processing site, determining eligibility, enrolling eligible pregnant women into health plans, performing outreach, data collection, reporting, and other services necessary for the administration of the FAMIS MOMS program; and for employing state staff to perform Medicaid eligibility determinations on pregnant women referred by the contractor's staff.

C. Health care services under FAMIS MOMS shall be provided through MCHIPs, ~~PCCMs~~, and fee-for-service or through any other ~~health~~ health care delivery system deemed appropriate by the Department of Medical Assistance Services.

**12VAC30-141-730. Review procedures.**

A. At a minimum, the MCHIP review shall be conducted pursuant to written procedures as defined in § 32.1-137.6 of the Code of Virginia and as may be further defined by DMAS. Such procedures shall be subject to review and approval by DMAS.

B. The DMAS review shall be conducted pursuant to written procedures developed by DMAS.

C. The procedures in effect on the date a particular request for review is received by the MCHIP or DMAS shall apply throughout the review.

D. Copies of the procedures shall be promptly mailed by the MCHIP or DMAS to applicants and enrollees upon receipt of timely requests for review. Such written procedures shall include but not be limited to the following:

1. The right to representation by an attorney or other agent of the applicant's or enrollee's choice, but at no time shall the MCHIP, local department of social services, DSS, or DMAS be required to obtain or compensate attorneys or other agents acting on behalf of applicants or enrollees;
2. The right to timely review of their files and other applicable information relevant to the review of the decision;
3. The right to fully participate in the review process, whether the review is conducted in person or in writing, including the presentation of supplemental information during the review process;
4. The right to have personal and medical information and records maintained as confidential; and
5. The right to a written final decision within 90 calendar days of receipt of the request for review, unless the applicant or enrollee requests or causes a delay.

E. For eligibility and enrollment matters, if the applicant's or enrollee's physician or health plan determines that the 90-calendar-day timeframe could seriously jeopardize the applicant's or enrollee's life or health or ability to attain, maintain, or regain maximum function, an applicant or enrollee will have the opportunity to expedited review. Under these conditions, a request for review shall result in a written final decision within three business days after DMAS receives, from the physician or health plan, the case record and information indicating that taking the time for a standard resolution of the review request could seriously jeopardize the applicant's or enrollee's life or health or ability to attain, maintain or regain maximum function, unless the applicant or enrollee or her authorized representative causes a delay.

F. For health services matters for FAMIS MOMS enrollees receiving services through MCHIPs, if the enrollee's physician or health plan determines that the 90-calendar-day timeframe could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function, an enrollee will have the opportunity to expedited review. Under these conditions, a request for review shall result in a written decision by the external quality review organization within 72 hours from the time an enrollee requests expedited review, unless the applicant, enrollee, or authorized representative requests or causes a delay. If a delay is requested or caused by the applicant, enrollee, or authorized representative, then expedited review may be extended up to 14 calendar days.

G. For health services matters for FAMIS MOMS enrollees receiving services through fee-for-service ~~or PCCM~~, if the enrollee's physician or health plan determines that the 90-calendar-day timeframe could seriously jeopardize the enrollee's life, health or ability to attain, maintain, or regain maximum function, an enrollee will have the opportunity to expedited review. Under these conditions, a request for review shall result in a written decision within 72 hours from the time an enrollee requests expedited review, unless the applicant, enrollee, or authorized representative requests or causes a delay. If a delay is requested or caused by the applicant, enrollee, or authorized representative, then expedited review may be extended up to 14 calendar days.

**12VAC30-141-830. Benefits reimbursement.**

A. Reimbursement for the services covered under FAMIS MOMS fee-for-service ~~and PCCM~~ and MCHIPs shall be as specified in this section.

B. Reimbursement for physician services, surgical services, clinic services, prescription drugs, laboratory and radiological services, outpatient mental health services, early intervention services, emergency services, home health services, immunizations, mammograms, medical transportation, organ transplants, skilled nursing services, well baby and well child care, vision services, durable medical equipment, disposable medical supplies, dental services, case management services, physical therapy/occupational therapy/speech-language therapy services, hospice services, school-based health services, and certain community-based mental health services shall be based on the Title XIX rates.

C. Reimbursement to MCHIPs shall be determined on the basis of the estimated cost of providing the MCHIP benefit package and services to an actuarially equivalent population. MCHIP rates will be determined annually and published 30 days prior to the effective date.

D. Exceptions.

1. Prior authorization is required after five visits in a fiscal year for physical therapy, occupational therapy and speech therapy provided by home health providers and outpatient rehabilitation facilities and for home health skilled nursing visits. Prior authorization is required after five visits for



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# Regulations

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outpatient mental health visits in the first year of service and prior authorization is required for the following nonemergency outpatient procedures: Magnetic Resonance Imaging, Computer Axial Tomography scans, or Positron Emission Tomography scans.

2. Reimbursement for inpatient hospital services will be based on the Title XIX rates in effect for each hospital. Reimbursement shall not include payments for disproportionate share or graduate medical education payments made to hospitals. Payments made shall be final and there shall be no retrospective cost settlements.

3. Reimbursement for outpatient hospital services shall be based on the Title XIX rates in effect for each hospital. Payments made will be final and there will be no retrospective cost settlements.

4. Reimbursement for inpatient mental health services other than by free standing psychiatric hospitals will be based on the Title XIX rates in effect for each hospital. Reimbursement will not include payments for disproportionate share or graduate medical education payments made to hospitals. Payments made will be final and there will be no retrospective cost settlements.

5. Reimbursement for outpatient rehabilitation services will be based on the Title XIX rates in effect for each rehabilitation agency. Payments made will be final and there will be no retrospective cost settlements.

6. Reimbursement for outpatient substance abuse treatment services will be based on rates determined by DMAS for children ages ~~6~~ six through 18 years. Payments made will be final and there will be no retrospective cost settlements.

7. Reimbursement for prescription drugs will be based on the Title XIX rates in effect. Reimbursements for Title XXI do not receive drug rebates as under Title XIX.

8. Reimbursement for covered prescription drugs for non-institutionalized FAMIS MOMS ~~recipients~~ individuals receiving the fee-for-service ~~or PCCM~~ benefits will be subject to review and prior authorization when their current number of prescriptions exceeds nine unique prescriptions within 180 days, and as may be further defined by the agency's guidance documents for pharmacy utilization review and the prior authorization program. The prior authorization process shall be applied consistent with the process set forth in 12VAC30-50-210 A 7.

## 12VAC30-141-850. Utilization control.

A. Each MCHIP shall implement a utilization review system as determined by contract with DMAS, or administered by DMAS.

B. For ~~both~~ the fee-for-service ~~and PCCM~~ program, DMAS shall use the utilization controls already established and operational in the State Plan for Medical Assistance.

C. DMAS may collect and review comprehensive data to monitor utilization after receipt of services.

## 12VAC30-141-880. Assignment to managed care.

A. All eligible enrollees shall be assigned in managed care through the department or the central processing unit (CPU) under contract to DMAS. FAMIS MOMS ~~recipients~~ individuals, during the preassignment period to a ~~PCP or an~~ MCHIP, shall receive Medicaid-like benefits via fee-for-service utilizing a FAMIS MOMS card issued by DMAS. After assignment to a ~~PCP or an~~ MCHIP, benefits and the delivery of benefits shall be administered specific to the ~~type~~ of managed care program in which the ~~recipient~~ individual is enrolled.

1. MCHIPs shall be offered to enrollees in ~~certain~~ all areas.

2. ~~In areas with one contracted MCHIP, all~~ All enrollees shall be assigned to that contracted MCHIP.

3. ~~In areas with multiple contracted MCHIPs or in PCCM areas without contracted MCHIPs, enrollees~~ Enrollees shall be assigned through a random system algorithm.

4. ~~In areas without contracted MCHIPs, enrollees shall be assigned to the primary care case management program (PCCM) or into the fee for service component.~~

~~5. 4.~~ Enrolled individuals ~~residing in PCCM areas without contracted MCHIPs or in areas with multiple MCHIPs~~ will receive a letter indicating that they may select one of the contracted MCHIPs ~~or primary care provider (PCP) in the PCCM program, in each case, which that~~ serve such area. Enrollees who do not select an ~~MCHIP/PCP~~ MCHIP as described above, shall be assigned to an ~~MCHIP/PCP~~ MCHIP as described in subdivision 3 of this subsection.

6. Individuals assigned to an MCHIP ~~or a PCCM~~ who lose and then regain eligibility for FAMIS MOMS within 60 days will be reassigned to their previous MCHIP ~~or PCP~~.

B. Following their initial assignment to a ~~MCHIP/PCP~~ an MCHIP, those enrollees shall be restricted to that ~~MCHIP/PCP~~ MCHIP until their next annual eligibility redetermination, unless appropriately disenrolled by the department.

1. During the first 90 calendar days of managed care assignment, an enrollee may request reassignment for any reason from that ~~MCHIP/PCP~~ MCHIP to another ~~MCHIP/PCP~~ MCHIP serving that geographic area. Such reassignment shall be effective no later than the first day of the second month after the month in which the enrollee requests reassignment.

~~2. Reassignment is available only in areas with the PCCM program or where multiple MCHIPs exist. If multiple MCHIPs exist, enrollees may only request reassignment to another MCHIP serving that geographic area. In PCCM areas, an enrollee may only request reassignment to another PCP serving that geographic area.~~

~~3. 2.~~ After the first 90 calendar days of the assignment period, the enrollee may only be reassigned from one ~~MCHIP/PCP~~ MCHIP to another ~~MCHIP/PCP~~ MCHIP

upon determination by DMAS that good cause exists pursuant to subsection C of this section.

C. Disenrollment for good cause may be requested at any time.

1. After the first 90 days of assignment in managed care, enrollees may request disenrollment from DMAS based on good cause. The request must be made in writing to DMAS and cite the reasons why the enrollee wishes to be reassigned. The department shall establish procedures for good cause reassignment through written policy directives.

2. DMAS shall determine whether good cause exists for reassignment.

D. Exclusion for assignment to a MCHIP. The following individuals shall be excluded from assignment to a MCHIP. Newly eligible individuals who are in the third trimester of pregnancy and who request exclusion within a department-specified time frame of the effective date of their MCHIP enrollment. Exclusion may be granted only if the member's obstetrical provider (physician or hospital) does not participate with the enrollee's assigned MCHIP. Exclusion requests made during the third trimester may be made by the enrollee, MCHIP, or provider. DMAS shall determine if the request meets the criteria for exclusion.

VA.R. Doc. No. R13-3371; Filed January 13, 2014, 4:21 p.m.



## TITLE 22. SOCIAL SERVICES

### STATE BOARD OF SOCIAL SERVICES

#### Fast-Track Regulation

**Title of Regulation:** 22VAC15-51. Background Checks for Licensed Child Day Centers (repealing 22VAC15-51-10 through 22VAC15-51-80).

**Statutory Authority:** §§ 63.2-1734 and 63.2-1735 of the Code of Virginia.

**Public Hearing Information:** No public hearings are scheduled.

**Public Comment Deadline:** March 12, 2014.

**Effective Date:** April 1, 2014.

**Agency Contact:** Karen Cullen, Program Consultant, Division of Licensing Programs, Department of Social Services, 801 East Main Street, Richmond, VA 23219, telephone (804) 726-7152, FAX (804) 726-7132, TTY (800) 828-1120, or email karen.cullen@dss.virginia.gov.

**Basis:** Section 63.2-217 of the Code of Virginia provides the State Board of Social Services the general authority to develop regulations to carry out the purposes of Title 63.2. Sections 63.2-1719 through 63.2-1721 of the Code of Virginia contain the requirements for background checks for child welfare agencies including child day centers.

**Purpose:** After the abolishment of the Child Day-Care Council per Chapter 835 of the 2012 Acts of Assembly, effective July 2012, amendments to Background Checks for Child Welfare Agencies (22VAC40-191) were approved by the board. The amendments added the requirements for background checks for licensed child day centers to 22VAC40-191 with substantially similar language to that of Background Checks for Licensed Child Day Centers (22VAC15-51). The amendments to 22VAC40-191 incorporating background checks for child day centers became effective December 1, 2013. Therefore, 22VAC15-51 is no longer necessary because the provisions of 22VAC40-191 protect the health, safety, and welfare of the public.

**Rationale for Using Fast-Track Process:** The requirements of Background Checks for Licensed Child Day Centers (22VAC15-51) have not changed but are now contained in Background Checks for Child Welfare Agencies (22VAC40-191) in substantially similar language. Repealing the unnecessary regulations should be noncontroversial.

**Substance:** This action is to repeal the regulation because the requirements of the regulation have been incorporated into another regulation with no substantive changes made.

**Issues:** With the repeal of this regulation, the primary advantages to the public and the agency are that background check requirements for all child welfare agencies will be in one regulation. There are no disadvantages to the public or the Commonwealth.

**Department of Planning and Budget's Economic Impact Analysis:**

**Summary of the Proposed Amendments to Regulation.** The State Board of Social Services (Board) proposes to repeal this regulation.

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

**Estimated Economic Impact.** The Child Day-Care Council (Council) adopted this regulation governing background checks for licensed child day centers in June 2004. Chapter 835 of the 2012 Acts of Assembly eliminated the Child Day-Care Council and assigned responsibility for regulating child day programs to the Board. Subsequently, background checks for licensed child day centers were incorporated into the Board's comprehensive background checks regulation, 22VAC40-191. Consequently, this regulation has become obsolete. Repealing this regulation would be beneficial in that it would help eliminate potential confusion by readers.

**Businesses and Entities Affected.** There are 2570 licensed child day centers in the Commonwealth, most of which are small businesses.<sup>1</sup> The proposed repeal of this regulation will not directly affect child day centers or any other any business or entity beyond eliminating potential confusion.

**Localities Particularly Affected.** The proposed repeal does not disproportionately affect particular localities.

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# Regulations

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**Projected Impact on Employment.** The proposed repeal will not affect employment.

**Effects on the Use and Value of Private Property.** The proposed repeal will not significantly affect the use and value of private property.

**Small Businesses: Costs and Other Effects.** The proposed repeal will not significantly affect costs for small businesses.

**Small Businesses: Alternative Method that Minimizes Adverse Impact.** The proposed repeal does not adversely affect small businesses.

**Real Estate Development Costs.** The proposed repeal does not affect 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, a determination of the public benefit, the projected number of businesses or other entities to whom the regulation would apply, the identity of any localities and types of businesses or other entities particularly affected, the projected number of persons and employment positions to be affected, the projected costs to affected businesses or entities to implement or comply with the regulation, and the impact on the use and value of private property. Further, if the proposed regulation has an adverse effect on small businesses, § 2.2-4007.04 requires that such economic impact analyses include (i) an identification and estimate of the number of small businesses subject to the regulation; (ii) the projected reporting, recordkeeping, and other administrative costs required for small businesses to comply with the regulation, including the type of professional skills necessary for preparing required reports and other documents; (iii) a statement of the probable effect of the regulation on affected small businesses; and (iv) a description of any less intrusive or less costly alternative methods of achieving the purpose of the regulation. The analysis presented above represents DPB's best estimate of these economic impacts.

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<sup>1</sup> Source: Department of Social Services

**Agency's Response to Economic Impact Analysis:** The Department of Social Services concurs with the economic impact analysis prepared by the Department of Planning and Budget.

**Summary:**

*This regulatory action repeals the regulation governing background checks for licensed child day centers that was adopted by the Child Day-Care Council in June 2004. Chapter 835 of the 2012 Acts of Assembly abolished the council effective July 1, 2012, and regulations for background checks for licensed child day*

*centers were incorporated into the State Board of Social Services' comprehensive background checks regulation, 22VAC40-191.*

VA.R. Doc. No. R14-3883; Filed January 14, 2014, 3:20 p.m.

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# GOVERNOR

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## EXECUTIVE ORDER NUMBER 5 (2014)

### **Declaration of a State of Emergency for the Commonwealth of Virginia in Support of West Virginia**

#### Importance of the Issue

On January 10, 2014, my predecessor, Governor Robert F. McDonnell, verbally declared a State of Emergency to exist for the Commonwealth of Virginia to support relief efforts to the state of West Virginia. Due to a chemical spill, water supplied to customers of West Virginia American Water Company cannot be used or consumed, and a State of Emergency has been declared in West Virginia. Relief efforts are necessary to facilitate trucks transporting water to these West Virginia Residents. I therefore direct that appropriate assistance be rendered by agencies of state government to respond to the needs of the state of West Virginia and the potential public safety issues in the Commonwealth presented by oversize water transport vehicles on the Commonwealth's highways.

The health and general welfare of the citizens of Virginia and West Virginia require that state action be taken to help alleviate the conditions caused by this situation. 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 subject always to my continuing and ultimate authority and responsibility to act in such matters, I hereby confirm, ratify, and memorialize in writing that verbal order issued on January 10, 2014, whereby a State of Emergency was found to exist and appropriate assistance was directed to be rendered by agencies of state government to alleviate any impediments to the transport of relief supplies.

In order to marshal public resources to meet this threat, and in accordance with my authority contained in § 44-146.17 of the Code of Virginia, I hereby order the following measures:

1. 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 (water) or providing restoration of water utilities 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.

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 until February 10, 2014, 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.

1. Authorization of the State Coordinator of Emergency Management to grant limited exemption of hours of service worked by any carrier when transporting critical supplies (water) 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, pursuant to § 52-8.4 of the Code of Virginia and Title 49 Code of Federal Regulations, Section 390.23 and Section 395.3. In no event shall the relief from hours of service last more than 30 days, unless a new declaration is issued. Motor carriers that have a Federal Out of Service Order in effect cannot take advantage of the relief from regulations that this declaration provides under 49 CFR 390.23.

2. The discontinuance of provisions authorized in paragraphs A and B 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.

#### Effective Date of this Executive Order

This Executive Order shall be effective retroactively to January 11, 2014, and shall remain in full force and effect until February 10, 2014, or whenever the emergency no longer exists, which ever time is shorter, unless sooner amended or rescinded by further executive order.

Given under my hand and under the Seal of the Commonwealth of Virginia, this 17th day of January, 2014.

/s/ Terence R. McAuliffe  
Governor

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# GENERAL NOTICES/ERRATA

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## AIR POLLUTION CONTROL BOARD

### Proposed State Implementation Plan Revision - Stage II Vapor Recovery Systems in Northern Virginia

Notice of action: The Department of Environmental Quality (DEQ) is announcing an opportunity for public comment on a proposed plan to attain and maintain the national ambient air quality standard (NAAQS) for ozone in the Northern Virginia portion of the Metropolitan Washington, D.C. Ozone Nonattainment Area. 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 (CAA). The SIP is the plan developed by the Commonwealth in order to fulfill its responsibilities under the CAA to attain and maintain the ambient air quality standards promulgated by the U.S. Environmental Protection Agency (EPA).

Purpose of notice: DEQ is seeking comments on the overall plan and on the issue of whether the plan will enable the Northern Virginia area to continue to meet obligations under the CAA.

Public comment period: February 10, 2014, to March 14, 2014.

Public hearing: A public hearing will be conducted on March 10, 2014, in Conference Room 1, Department of Environmental Quality, 13901 Crown Court, Woodbridge, Virginia at 11 a.m. Directions may be found at <http://www.deq.virginia.gov/Locations/NorthernRegionalOffice.aspx>.

Description of proposal: The purpose of this SIP revision is to amend the ozone attainment and maintenance plans for the portions of Virginia that are part of the Ozone Transport Region (OTR) such that Stage II vapor recovery systems (VRS) are no longer required after December 31, 2013. Since the original development of these plans, EPA has determined that onboard refueling vapor recovery (ORVR) is in widespread use and therefore no longer needed for ozone control in OTR localities that can further demonstrate that the removal of Stage II will not interfere with maintenance of the ozone NAAQS. The Commonwealth has determined that Stage II is no longer needed in the area's plans and that removing this control requirement does not interfere with maintenance of any ozone NAAQS.

Localities affected: Counties of Stafford, Arlington, Fairfax, Loudoun, and Prince William and Cities of Alexandria, Fairfax, Falls Church, Manassas, and Manassas Park.

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 CAA in accordance with 40 CFR 51.104. DEQ plans to

submit all provisions of the proposal as a revision to the Commonwealth of Virginia SIP.

How to comment: DEQ accepts written comments by email, fax, and postal mail. In order to be considered, comments must include the full name, address, and telephone number of the person commenting and be received by DEQ by the last day of the comment period. All materials received are part of the public record.

To review proposal: The proposal and 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) Northern Regional Office, 13901 Crown Court, Woodbridge, VA, telephone (703) 583-3800.

Contact Information: Doris A. McLeod, Air Quality Planner, Department of Environmental Quality, 629 East Main Street, P.O. Box 1105, Richmond, VA 23218, telephone (804) 698-4197, FAX (804) 698-4510, or email [doris.mcleod@deq.virginia.gov](mailto:doris.mcleod@deq.virginia.gov).

## STATE CORPORATION COMMISSION

### Bureau of Insurance

AT RICHMOND, JANUARY 13, 2014

COMMONWEALTH OF VIRGINIA, ex rel.

STATE CORPORATION COMMISSION

CASE NO. INS-2013-00238

Ex Parte: In the matter of revising the  
Rules Governing Long-term Care Insurance

### AMENDING ORDER

On November 25, 2013, the State Corporation Commission ("Commission") initiated a proceeding to consider whether Chapter 200 of Title 14 of the Virginia Administrative Code, entitled Rules Governing Long-term Care Insurance, 14 VAC 5-200-10 et seq. ("Rules"),<sup>1</sup> should be revised. This proceeding follows a report filed by the Bureau of Insurance ("Bureau"), at the direction of the Commission, which studied the premium rate increases implemented by insurers writing long-term care insurance in Virginia on or after January 1, 2009 ("Report").<sup>2</sup>

The Report, which was filed on October 4, 2013, found that: (1) recent long-term care premium rate increases were largely

the result of insurers' inability to adequately anticipate future claim costs given the lack of credible experience data that was available when they originally designed and priced the products; (2) many increases have been substantial and have resulted in a significant financial hardship to Virginia policyholders; and (3) those policyholders who are unable to afford the additional increases are faced with difficult choices such as reducing their benefits, if such option is available, or allowing their coverage to lapse.<sup>3</sup>

Thereafter, the Commission found that it was appropriate to undertake a review of the Report and the Rules and consider proposing revisions to the Rules. The Commission therefore sought comments on the Report or proposed amendments to the Rules from all interested persons, including insurers writing long-term care insurance in Virginia, on or before February 1, 2014.

NOW THE COMMISSION, upon further consideration of this matter, is of the opinion that additional notice should be provided to the general public, as well as to specific individuals who have filed written complaints or inquiries with the Bureau regarding long-term care premium rate increases within the last two years, of the opportunity to comment on the Report and propose amendments to the Rules. The Commission also finds that interested persons should be provided additional time for filing comments or proposed amendments to the Rules and that the Bureau should be provided an opportunity to respond to any comments or proposals.

While comments on any areas of the Report and Rules are welcome, we request comment on 14 VAC 5-200-150, to which rates associated with policies issued prior to October 1, 2003, are subject, and 14 VAC 5-200-77 and 14 VAC 5-200-153, to which rates associated with policies issued on or after October 1, 2003, are subject. Specifically, we seek comment on the appropriateness of applying the tests described in 14 VAC 5-200-153 to future rate increases on all policies, including those issued prior to October 1, 2003.

Accordingly, IT IS ORDERED THAT:

(1) The Commission's Division of Information Resources shall make a downloadable version of this Order available for public access on the Commission's website at <http://www.scc.virginia.gov/case>. The Clerk of the Commission shall also make a copy of this Order available, free of charge, in response to any written request for one.

(2) The Clerk of the Commission shall send a copy of this Order to the Bureau in care of Deputy Commissioner Althelia P. Battle, who forthwith shall mail a copy of this Order to: (i) all persons who have filed written complaints or inquiries with the Bureau regarding long-term care premium rate increases within the last two years; and (ii) all insurance companies who reported Long-Term Care

Insurance Earned Premium in the 2012 Long-Term Care Reporting Form as well as all other interested persons.

(3) The Bureau shall file with the Clerk of the Commission an affidavit of compliance with the notice requirements set forth in Paragraph (2) above.

(4) The Division of Information Resources shall have the following public notice published as display advertising (not classified) on one (1) occasion by January 31, 2014, in a newspaper of general circulation published in each of the following cities: Richmond, Norfolk, Newport News, Roanoke, Winchester, Lynchburg, Danville, Bristol, Fredericksburg, and Alexandria:

NOTICE TO THE PUBLIC OF THE OPPORTUNITY TO COMMENT ON THE BUREAU OF INSURANCE'S REPORT REGARDING LONG-TERM CARE INSURANCE PREMIUM RATE INCREASES AND TO PROPOSE AMENDMENTS TO THE RULES GOVERNING LONG-TERM CARE INSURANCE

CASE NO. INS-2013-00238

Notice is hereby given to the public that the State Corporation Commission ("Commission") is seeking comments on the Bureau of Insurance's ("Bureau") report studying the premium rate increases implemented by insurers writing long-term care insurance on or after January 1, 2009 ("Report"), as well as suggested revisions to Chapter 200 of Title 14 of the Virginia Administrative Code, Rules Governing Long-term Care Insurance, 14 VAC 5-200-10 et seq. ("Rules").

A copy of the Bureau's Report may be found on the Commission's website: <http://www.scc.virginia.gov/case>, by selecting the "Docket Search" feature and searching for Case No. INS-2013-00238. The Rules are included with the Report (Appendix B).

All persons who desire to comment on the Report or Rules shall file such comments on or before March 14, 2014, with Joel H. Peck, Clerk, State Corporation Commission, c/o Document Control Center, P.O. Box 2118, Richmond, Virginia 23218. Persons desiring to submit comments electronically may do so by following the instructions available on the Commission's website: <http://www.scc.virginia.gov/case>. All comments shall refer to Case No. INS-2013-00238.

STATE CORPORATION COMMISSION

(5) All persons who desire to comment on the Bureau's Report or propose amendments to the Rules Governing Long-term Care Insurance, Chapter 200 of Title 14 of the Virginia Administrative Code, shall file written comments or proposals on or before March 14, 2014, with Joel H. Peck, Clerk, State Corporation Commission, Document Control Center, P.O. Box 2118, Richmond, Virginia 23218 and shall refer to Case No. INS-2013-00238. Any person

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## General Notices/Errata

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desiring to submit comments electronically may do so by following the instructions available on the Commission's website: <http://www.scc.virginia.gov/case>.

(6) With respect to all interested persons, including insurers writing long-term care insurance in Virginia, who desire to comment on the Bureau's Report or propose amendments to the Rules Governing Long-term Care Insurance, Chapter 200 of Title 14 of the Administrative Code, the time for filing written comments or proposals shall be extended to March 14, 2014.

(7) The Bureau shall respond to any such comments or proposed amendments to the Rules on or before May 1, 2014.

(8) This matter is continued.

AN ATTESTED COPY HEREOF shall be sent by the Clerk of the Commission to: C. Meade Browder, Jr., Senior Assistant Attorney General, Office of the Attorney General, Division of Consumer Counsel, 900 East Main Street, Second Floor, Richmond, Virginia 23219. A copy also shall be delivered to the Commission's Office of General Counsel and the Bureau of Insurance in care of Althelia P. Battle, Deputy Commissioner.

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<sup>1</sup> The Rules can be found at: <http://lis.virginia.gov/000/reg/TOC14005.HTM#C0200>.

<sup>2</sup> Commonwealth of Virginia, ex rel. State Corporation Commission, Ex Parte: In the matter of investigating long-term care insurance premium rates, Case No. INS-2012-00282, Doc. Cont. Cen. No. 121130186, Order Directing Report (Nov. 26, 2012).

<sup>3</sup> Report at 25-26. A copy of the Report may be found on the Commission's website: <http://www.scc.virginia.gov/case>, by selecting the "Docket Search" feature and searching for Case No. INS-2013-00238. The Rules are included with the Report (Appendix B).

### DEPARTMENT OF ENVIRONMENTAL QUALITY

#### Preliminary Milestones for Chesapeake Bay Restoration and the Statewide Nonpoint Source (NPS) Management Plan

Public meeting location: Webcast to each DEQ Regional Office on Tuesday, February 25, 2014, from 9:30 a.m. to 4:30 p.m. Office locations can be found at: <http://www.deq.virginia.gov/Locations.aspx> and include Abingdon, Harrisonburg, Glen Allen, Lynchburg, Roanoke, Virginia Beach, and Woodbridge.

Purpose of notice: The Virginia Department of Environmental Quality is presenting details of a continuing effort to restore water quality, a public comment opportunity, and a public meeting.

Meeting description: Public meeting to present preliminary water quality improvement milestones and the Nonpoint Source (NPS) Management Plan update. The morning session will focus on Chesapeake Bay milestone development, and

the afternoon session will focus on NPS Management Plan development and milestones.

Description of Project: DEQ is aligning Chesapeake Bay Program and NPS Management Plan milestone development and planning efforts.

Preliminary Programmatic Milestones for 2014-2015 are being developed. These may include anticipated regulatory actions, implementation of previously developed regulations, permitting actions, programmatic enhancements, new incentive programs, expanded resources/funding, or any other actions that build capacity or drive implementation.

Updating the statewide NPS Management Plan is an EPA requirement and an opportunity to identify Virginia's priorities for management of nonpoint source pollution. The data collection effort for this plan revision was initiated in July 2013, gathering NPS program descriptions including: brief program overview, program coordination and partnerships, key initiatives and implementation activities, implementation or watershed priorities, and measures of success for the Commonwealth's nonpoint source pollution control programs. The EPA's NPS plan guidance also requires the development of explicit short-term and long-term goals, objectives, and strategies for these programs to restore and protect surface and ground water.

How a decision is made: After public comments have been considered and addressed, DEQ will submit the revised Chesapeake Bay milestones and NPS Plan milestones to the U.S. Environmental Protection Agency for approval.

How to comment: DEQ accepts written comments by email, fax, or postal mail. Written comments should include the name, address, and telephone number of the person commenting and be received by DEQ during the comment period, February 25, 2014, to March 26, 2014. DEQ also accepts written comments submitted at the public meeting announced in this notice.

To review fact sheets: Reference documents are available on the milestones from the contacts below or on the DEQ website at:

Nonpoint Source Management Plan Preliminary Milestones: <http://www.deq.virginia.gov/Programs/Water/WaterQualityInformationTMDLs/NonpointSourcePollutionManagement/NonpointSourceManagementPlan.aspx>

Chesapeake Bay Preliminary Milestones: <http://www.deq.virginia.gov/Programs/Water/ChesapeakeBay/ChesapeakeBayWatershedImplementationPlan.aspx>

Contact for additional information: Rick Hill, Water Plan Writer, Department of Environmental Quality, Central Office, P.O. Box 1105, Richmond, VA 23218, telephone (804) 698-4469, FAX (804) 698-4032, or email [rick.hill@deq.virginia.gov](mailto:rick.hill@deq.virginia.gov).

**Draft Water Quality Study (TMDL) in the Pamunkey River Mainstem and Tributaries in Spotsylvania, Hanover, Louisa, New Kent, and King William Counties**

Public meetings: Meetings are offered at two convenient locations within the watershed. Two meetings will be held on Monday, February 24, 2014, at Ashland Library located at 201 South Railroad Avenue in Ashland, VA, at 2 p.m. and 6 p.m. Two meetings will also be held on Wednesday, February 26, 2014, at the Snow Branch Library located at 8740 Courthouse Road, Spotsylvania, VA at 2 p.m. and 6 p.m. All meetings are open to the public. Meeting materials and presentations are identical in terms of content. In the case of inclement weather, please contact Margaret Smigo at telephone (804) 527-5124 or email [margaret.smigo@deq.virginia.gov](mailto:margaret.smigo@deq.virginia.gov).

Purpose of notice: The Virginia Department of Environmental Quality and consultant, MapTech Inc, are presenting the draft total maximum daily load (TMDL) study to restore water quality at four public meetings within the watershed (identical content). A public comment period will follow the meetings (February 27, 2014, through March 28, 2014). The draft report will be available on the website approximately one

week prior to the meetings at <http://www.deq.virginia.gov/Programs/Water/WaterQualityInformationTMDLs/TMDL/TMDLDevelopment/DraftTMDLReports.aspx>.

Meeting description: Public meetings provide an opportunity for the public to share their knowledge of the watershed and learn about pollution affecting community waters. Meetings will feature a summary of information from the draft TMDL, including watershed land use, water quality monitoring, suspected sources of bacteria, and the reduction of source bacteria required to meet water quality standards. The presentation will be posted on the DEQ website following the meetings at <http://www.deq.virginia.gov/Programs/Water/WaterQualityInformationTMDLs/TMDL/TMDLDevelopment/DocumentationforSelectTMDLs.aspx>. The presentation from the first public meetings held in February 2013 are still available at this site, under "Pamunkey River and Tributaries – Bacteria TMDL Development."

Description of study: Virginia agencies have been working to identify sources of the bacterial contamination in the waters of the Pamunkey River and its tributaries in the following impaired waterways:

Stream	County/City	Length (mi.)	Impairment
Northeast Creek	Spotsylvania	2.74	Bacteria (Primary Contact / Swimming Use / Recreation Use)
Little River	Louisa	4.01	
Beaverdam Creek	Hanover	8.47	
Little River	Hanover	10.77	
Mill Creek	Caroline	4.39	
Pamunkey River	Caroline, Hanover, King William	12.26	
Kersey Creek (trib to Crump Creek)	Hanover	2.76	
(XJC) Crump Creek UT	Hanover	1.79	
Pollard Creek (UT to Crump Creek)	Hanover	4.06	
Crump Creek	Hanover	10.08	
(XDW) Pamunkey River UT	King William	5.51	
UT (XDX) to UT (XDW) to Pamunkey River	King William	3.85	
Pamunkey River	Hanover, King William	0.305 sq miles (estuarine - tidal)	
Jacks Creek and Tributaries	King William	21.05	
(XID) Harrison Creek UT	King William	0.16	



## General Notices/Errata

Harrison Creek	King William	2.80	
Harrison Creek	King William	0.048 sq miles (estuarine – tidal)	
Pamunkey River	King William, New Kent	3.634 sq miles (estuarine – tidal)	

These streams are impaired for failure to meet the primary contact (recreational or swimming) use because of bacteria standard violations. This standard is meant to indicate excessive bacteria levels that may pose a threat to human health if bodily exposure to these waterways by recreation, such as "primary contact" or swimming, occurs. The study reports on the sources of bacteria and recommends total maximum daily loads, or TMDLs, for the impaired waters. A TMDL is the total amount of a pollutant a water body can contain and still meet water quality standards. To restore water quality, bacterial levels need to be reduced to the TMDL amount. In addition to the TMDL, the document includes a modification to existing TMDLs within the Pamunkey River basin (developed in 2006) and references it and other existing TMDLs in the appendix. The modification is also eligible for public comment.

How a decision is made: After the public meeting and all public comments have been considered and addressed, DEQ will submit the final TMDL report to the U.S. Environmental Protection Agency and State Water Control Board for approval.

How to comment: DEQ accepts formal written comments by email, fax, or postal mail. Comments should include the name, address, and telephone number of the person commenting and be received by DEQ during the comment period, which will begin Thursday, February 27, 2014, and end Friday March 28, 2014.

Contact for comments or questions:

Mark Alling, Department of Environmental Quality, Piedmont Regional Office, 4949A Cox Road, Glen Allen, VA 23060, telephone (804) 527-5021, FAX (804)-527-5106, or email mark.alling@deq.virginia.gov, or

Kelley West, Department of Environmental Quality, Piedmont Regional Office, 4949A Cox Road, Glen Allen, VA 23060, telephone (804) 527-5029, FAX (804)-527-5106, or email kelley.west@deq.virginia.gov.

### **Development of a Water Quality Improvement Plan for Chuckatuck Creek and Brewers Creek, City of Suffolk and Isle of Wight County**

The Virginia Department of Environmental Quality (DEQ) will host a public meeting on a water quality study for Chuckatuck and Brewers Creeks, located in the City of Suffolk and Isle of Wight County, on Wednesday, February 12, 2014.

The meeting will start at 6:30 p.m. at the CE&H Ruritan Hall located at 8881 Eclipse Drive Suffolk, VA 23434. The purpose of this meeting is to provide information and discuss the study with interested local community members and local government.

Section 303(d) of the Clean Water Act and § 62.1-44.19:7 C of the Code of Virginia require DEQ to develop total maximum daily loads (TMDLs) for pollutants responsible for each impaired water contained in Virginia's § 303(d) TMDL Priority List and Report and subsequent Water Quality Assessment Report.

Chuckatuck Creek and Brewers Creek were identified in Virginia's Water Quality Assessment Integrated Report as impaired for not supporting fecal coliform criteria for shellfish waters. The impairment is based on water quality monitoring data reports of sufficient exceedances of Virginia's Water Quality Standard for bacteria.

The water quality or implementation plan follows total maximum daily load (TMDL) studies completed by the DEQ and approved by Environmental Protection Agency in 2010. The TMDL study can be found on the DEQ website at <http://www.deq.virginia.gov/portals/0/DEQ/Water/TMDL/apptmdls/shellfish/chuckbrew.pdf>. The bacteria sources identified to these impairments include failing septic systems, discharges of untreated human waste, pets, wildlife, and agricultural practices in the area. The meeting will review final TMDLs for Chuckatuck and Brewers Creeks and the implementation plan (IP) process.

The IP is developed to provide a cleanup plan that will lead to attainment of the water quality standards. Public participation and stakeholder involvement are necessary in order to develop an effective and reasonable IP. This meeting will present the findings of the TMDL study and the necessary steps in the IP development. The workgroups and steering committee will be formed in order to provide detailed information during the IP process. The public comment period on materials presented at this meeting will be February 13, 2014, to March 14, 2014.

For additional information or to submit comments: John McLeod, Virginia Department of Environmental Quality, Tidewater Regional Office, 5636 Southern Boulevard, Virginia Beach, VA 23463, telephone (757) 518-2196, or email john.mcleod@deq.virginia.gov.

### **Development of a Water Quality Improvement Plan for The Gulf, Mattawoman, Barlow, Jacobus, and Hungars Creeks in Northampton County**

The Virginia Department of Environmental Quality (DEQ) will host a public meeting on a water quality study for The Gulf, Mattawoman, Barlow, Jacobus, and Hungars Creeks, located in Northampton County, on Thursday, February 27, 2014.

The meeting will start at 6:30 p.m. at The Barrier Islands Center, 7296 Young Street, in Machipongo, VA 23405. The purpose of this meeting is to provide information and discuss the study with interested local community members and local government.

Section 303(d) of the Clean Water Act and § 62.1-44.19:7 C of the Code of Virginia require DEQ to develop total maximum daily loads (TMDLs) for pollutants responsible for each impaired water contained in Virginia's § 303(d) TMDL Priority List and Report and subsequent Water Quality Assessment Report.

The Gulf, Mattawoman, Barlow, Jacobus, and Hungars Creeks were identified in Virginia's Water Quality Assessment Integrated Report as impaired for not supporting fecal coliform criteria for shellfish waters. The impairment is based on water quality monitoring data reports of sufficient exceedances of Virginia's Water Quality Standard for bacteria.

The water quality or implementation plan follows total maximum daily load (TMDL) studies completed by the Virginia Department of Environmental Quality (DEQ) and approved by the Environmental Protection Agency in 2010. The TMDL study can be found on the DEQ website at <http://www.deq.virginia.gov/portals/0/DEQ/Water/TMDL/apptmdls/baycoast/mattawoman.pdf>. The bacteria sources identified to these impairments include failing septic systems, discharges of untreated human waste, pets, wildlife, and agricultural practices in the area. The meeting will review final TMDL for The Gulf, Mattawoman, Barlow, Jacobus, and Hungars Creeks and the implementation plan (IP) process.

The IP is developed to provide a cleanup plan that will lead to attainment of the water quality standards. Public participation and stakeholder involvement are necessary in order to develop an effective and reasonable IP. This meeting will present the findings of the TMDL study and the necessary steps in the IP development. The workgroups and steering committee will be formed in order to provide detailed information during the IP process.

The public comment period on materials presented at this meeting will be February 28, 2014, to March 31, 2014.

Contact for additional information or to submit comments: John McLeod, Virginia Department of Environmental

Quality, Tidewater Regional Office, 5636 Southern Boulevard, Virginia Beach, VA 23463, by telephone (757) 518-2196, or email [john.mcleod@deq.virginia.gov](mailto:john.mcleod@deq.virginia.gov).

### **STATE LOTTERY DEPARTMENT**

#### **Director's Orders**

The following Director's Orders of the State Lottery Department were filed with the Virginia Registrar of Regulations on January 21, 2014. The orders may be viewed at the State Lottery Department, 900 East Main Street, Richmond, VA, or at the office of the Registrar of Regulations, 201 North 9th Street, 2nd Floor, Richmond, VA.

#### Director's Order Number Twelve (14)

Virginia's Instant Game Lottery 1468 "Ace In The Hole" Final Rules for Game Operation (effective December 20, 2013)

#### Director's Order Number Thirteen (14)

Virginia's Instant Game Lottery 1369 "Money Money Money" Final Rules for Game Operation (effective December 20, 2013)

#### Director's Order Number Fourteen (14)

Virginia's Instant Game Lottery 1472 "\$4 Million Mega Multiplier" Final Rules for Game Operation (effective December 20, 2013)

#### Director's Order Number Fifteen (14)

Virginia's Instant Game Lottery 1477 "Black Cherry Doubler" Final Rules for Game Operation (effective December 20, 2013)

#### Director's Order Number Sixteen (14)

Virginia Lottery's "Power Play \$10K Bonus" Final Rules for Operation (effective January 22, 2014)

#### Director's Order Number Seventeen (14)

Virginia Lottery's "2014 Super Teacher Awards Contest" Final Rules for Game Operation (effective January 6, 2014)

#### Director's Order Number Eighteen (14)

Virginia's Instant Game Lottery 1457 "7.11.21®" Final Rules for Game Operation (effective January 3, 2014)

#### Director's Order Number Nineteen (14)

Virginia's Instant Game Lottery 1471 "Winner Take All Millionaire Edition" Final Rules for Game Operation (effective January 6, 2014)

#### Director's Order Number Twenty (14)

Virginia's Instant Game Lottery 1483 "7X The Money" Final Rules for Game Operation (effective January 6, 2014)

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## General Notices/Errata

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### Director's Order Number Twenty-One (14)

Virginia Lottery's "3-4-5 Play Sweepstakes" Final Rules for Operation (effective March 1, 2014)

### Director's Order Number Twenty-Three (14)

Virginia Lottery's "Play For Keeps Sweeps" Final Rules for Operation (effective nunc pro tunc to Monday, December 30, 2013, and shall remain in full force and effect unless amended or rescinded by further Director's Order)

### **Proposed Enforcement Action for Town of Clifton Forge**

An enforcement action has been proposed for the Town of Clifton Forge regarding operation of the town's sewage collection system. The proposed enforcement action amends an existing consent order and includes additional injunctive requirements. A description of the proposed action is available at the Department of Environmental Quality office named below or online at [www.deq.virginia.gov](http://www.deq.virginia.gov). Robert Steele will accept comments by email at [robert.steele@deq.virginia.gov](mailto:robert.steele@deq.virginia.gov), FAX at (540) 562-6725, or postal mail at Department of Environmental Quality, 3019 Peters Creek Road, Roanoke, VA 24019, from February 10, 2014, to March 12, 2014.

### **VIRGINIA CODE COMMISSION**

#### **Notice to State Agencies**

**Contact Information:** *Mailing Address:* Virginia Code Commission, General Assembly Building, 201 North 9th Street, 2nd Floor, Richmond, VA 23219; *Telephone:* Voice (804) 786-3591; FAX (804) 692-0625; *Email:* [varegs@dls.virginia.gov](mailto:varegs@dls.virginia.gov).

**Meeting Notices:** Section 2.2-3707 C of the Code of Virginia requires state agencies to post meeting notices on their websites and on the Commonwealth Calendar at <http://www.virginia.gov/connect/commonwealth-calendar>.

**Cumulative Table of Virginia Administrative Code Sections Adopted, Amended, or Repealed:** A table listing regulation sections that have been amended, added, or repealed in the *Virginia Register of Regulations* since the regulations were originally published or last supplemented in the print version of the Virginia Administrative Code is available at <http://register.dls.virginia.gov/documents/cumultab.pdf>.

**Filing Material for Publication in the Virginia Register of Regulations:** Agencies use the Regulation Information System (RIS) to file regulations and related items for publication in the *Virginia Register of Regulations*. The Registrar's office works closely with the Department of Planning and Budget (DPB) to coordinate the system with the

Virginia Regulatory Town Hall. RIS and Town Hall complement and enhance one another by sharing pertinent regulatory information.

## **ERRATA**

### **MARINE RESOURCES COMMISSION**

Title of Regulation: **4VAC20-900-25. Pertaining to Horseshoe Crab.**

Publication: 30:10 VA.R. 1293-1298 January 13, 2014

Correction to Final Regulation:

Page 1296, 4VAC20-900-25 G 8 b, at the end of the subdivision, after "as well as" strike "either a horseshoe crab endorsement license or horseshoe crab bycatch permit" and insert "a Horseshoe Crab General Category Permit"

VA.R. Doc. No. R14-3938; Filed January 27, 2014 1:19 p.m.

### **STATE WATER CONTROL BOARD**

Title of Regulation: **9VAC25-151. General Virginia Pollutant Discharge Elimination System (VPDES) Permit for Discharges of Storm Water Associated with Industrial Activity.**

Publication: 30:11 VA.R. 1467-1550 January 27, 2014

Correction to Final Regulation:

Page 1527-1529, 9VAC25-151-210 C 2, at the end of subdivisions a (4), b (4), d (2), e (9), f (4), and g (6) insert "[ and ]"

Page 1528, 9VAC25-151-210 C 2, at the end of subdivision c (1) insert "[ or ]"

Page 1529, 9VAC25-151-210 C 3, at the end of subdivisions a (3), b (3), and c (1) insert "[ and ]"

Page 1530, 9VAC25-151-210 C 4, at the end of subdivisions a (4), b (5), and d (6) insert "[ and ]"

VA.R. Doc. No. R13-3382; Filed January 23, 2014 12:48 p.m.