VIRGINIA REGISTER OF REGULATIONS

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VIRGINIA REGISTER INFORMATION PAGE

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

ADOPTION, AMENDMENT, AND REPEAL OF REGULATIONS

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

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

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

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

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

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

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

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

FAST-TRACK RULEMAKING PROCESS

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

EMERGENCY REGULATIONS

Pursuant to § 2.2-4011 of the Code of Virginia, an agency, upon consultation with the Attorney General, and at the discretion of the Governor, may adopt emergency regulations that are necessitated by an emergency situation. An agency may also adopt an emergency regulation when Virginia statutory law or the appropriation act or federal law or federal regulation requires that a regulation be effective in 280 days or less from its enactment. The emergency regulation becomes operative upon its adoption and filing with the Registrar of Regulations, unless a later date is specified. Emergency regulations are limited to no more than 18 months in duration; however, may be extended for six months under certain circumstances as provided for in § 2.2-4011 D. Emergency regulations are published as soon as possible in the *Register*.

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

STATEMENT

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

CITATION TO THE *VIRGINIA REGISTER*

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

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

PUBLICATION SCHEDULE AND DEADLINES

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

May 2017 through April 2018

Volume: Issue	Material Submitted By Noon*	Will Be Published On
33:19	April 26, 2017	May 15, 2017
33:20	May 10, 2017	May 29, 2017
33:21	May 24, 2017	June 12, 2017
33:22	June 2, 2017 **(Friday)**	June 26, 2017
33:23	June 21, 2017	July 10, 2017
33:24	July 5, 2017	July 24, 2017
33:25	July 19, 2017	August 7, 2017
33:26	August 2, 2017	August 21, 2017
34:1	August 16, 2017	September 4, 2017
34:2	August 30, 2017	September 18, 2017
34:3	September 13, 2017	October 2, 2017
34:4	September 27, 2017	October 16, 2017
34:5	October 11, 2017	October 30, 2017
34:6	October 25, 2017	November 13, 2017
34:7	November 8, 2017	November 27, 2017
34:8	November 21, 2017 **(Tuesday)**	December 11, 2017
34:9	December 6, 2017	December 25, 2017
34:10	December 19, 2017 **(Tuesday)**	January 8, 2018
34:11	January 3, 2018	January 22, 2018
34:12	January 17, 2018	February 5, 2018
34:13	January 31, 2018	February 19, 2018
34:14	February 14, 2018	March 5, 2018
34:15	February 28, 2018	March 19, 2018
34:16	March 14, 2018	April 2, 2018
34:17	March 28, 2018	April 16, 2018
34:18	April 11, 2018	April 30, 2018

*Filing deadlines are Wednesdays unless otherwise specified.

TITLE 18. PROFESSIONAL AND OCCUPATIONAL LICENSING

BOARD OF VETERINARY MEDICINE

Initial Agency Notice

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

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

Name of Petitioner: Rena Allen.

Nature of Petitioner's Request: An amendment to 18VAC150-20-172 B to replace the restriction on insertion of IV catheters by unlicensed assistants with a restriction on placement of jugular catheters, and an amendment to 18VAC150-20-172 C to allow delegation of peripheral intravenous catheters under immediate supervision of a veterinarian.

Agency Plan for Disposition of Request: The petition will be published in the Register of Regulations on May 15, 2017, and posted on Virginia Regulatory Town Hall with a request for comment until June 8, 2017. The board will consider all comment at its meeting on June 13, 2017.

Public Comment Deadline: June 8, 2017.

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

VA.R. Doc. No. R17-15; Filed April 20, 2017, 4:30 p.m.

NOTICES OF INTENDED REGULATORY ACTION

TITLE 9. ENVIRONMENT

STATE WATER CONTROL BOARD

Notice of Intended Regulatory Action

Notice is hereby given in accordance with § 2.2-4007.01 of the Code of Virginia that the State Water Control Board intends to consider amending **9VAC25-260, Water Quality Standards**. The purpose of the proposed action is to amend Virginia's antidegradation policy, part of the Water Quality Standards Regulation, by designating a portion of Laurel Fork as exceptional state waters (ESW) in 9VAC25-260-30 A 3 c. The ESW category of the antidegradation policy allows the State Water Control Board to designate waters that display exceptional environmental settings and either exceptional aquatic communities or exceptional recreational opportunities for added protection. ("Tier III" is how the public commonly refers to those waters that are protected from water quality degradation through a prohibition on new or increased point source discharges. The equivalent regulatory terms are "outstanding national resource waters" for the federal Environmental Protection Agency and "exceptional state waters" for Virginia.)

Once designated, the antidegradation policy provides that no water quality degradation would be allowed in the ESW (i.e., no new, additional, or increased point source discharge of sewage, industrial wastes, or other pollution would be allowed into waters designated as ESW). The only exception would be temporary, limited impact activities, with the provision that after a minimal period of time the waters are returned or restored to conditions equal to or better than those existing just prior to the temporary source of pollution. The goal is to protect these special waters at their present quality for use and enjoyment by future generations of Virginians.

The section of Laurel Fork under consideration for possible exceptional state waters designation is Laurel Fork in Highland County, from approximately 0.33 miles upstream of the confluence with Collins Run (Latitude N38.490051, Longitude W79.666039) downstream to a point approximately 0.5 miles upstream from the confluence of Mullenax Run (Latitude N38.508322, Longitude W79.652757).

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

Statutory Authority: § 62.1-44.15 of the Code of Virginia; 33 USC § 1251 et seq. of the Clean Water Act; 40 CFR Part 131.

Public Comment Deadline: June 14, 2017.

Agency Contact: David Whitehurst, Department of Environmental Quality, 629 East Main Street, P.O. Box 1105, Richmond, VA 23218, telephone (804) 698-4121, FAX (804) 698-4032, or email david.whitehurst@deq.virginia.gov.

VA.R. Doc. No. R17-5021; Filed April 20, 2017, 9:05 a.m.

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TITLE 12. HEALTH

STATE BOARD OF HEALTH

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 intends to consider repealing **12VAC5-31, Virginia Emergency Medical Services Regulation**, and promulgating **12VAC5-32, Virginia Emergency Medical Services Regulations**. The purpose of the proposed action is to replace the current chapter with a new chapter governing emergency medical services (EMS). The new EMS regulations will be designed for easier use by regulants and the public. Changes being considered include incorporating language to reflect current national certification levels and the testing process, updating equipment requirements for all vehicles, updating standards to reflect changes in the ambulance industry, reorganizing provisions for financial assistance for emergency medical services, and amending provisions regarding criminal history, the regional council, and Medevac. Additional changes may be proposed as a result of input received from the public.

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

Statutory Authority: §§ 32.1-12 and 32.1-111.4 of the Code of Virginia.

Public Comment Deadline: June 14, 2017.

Agency Contact: Michael Berg, Regulatory and Compliance Manager, Department of Health, 1001 Technology Park Drive, Glen Allen, VA 23059-4500, telephone (804) 888-9131, or email michael.berg@vdh.virginia.gov.

VA.R. Doc. No. R17-5100; Filed April 14, 2017, 11:46 a.m.

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

Notice of Intended Regulatory Action

Notice is hereby given in accordance with § 2.2-4007.01 of the Code of Virginia that the Board of Medical Assistance Services intends to consider amending **12VAC30-50, Amount, Duration, and Scope of Medical and Remedial Care and Services**. The purpose of the proposed action is to amend 12VAC30-50-165, Durable medical equipment (DME) and supplies suitable for use in the home. The amendments are intended to (i) update coverage and documentation requirements to better align them with best practices and Centers for Medicare and Medicaid guidance and (ii) eliminate unnecessary elements that create confusion among DME providers. Specifically, these proposed changes include elements around enteral nutrition, implantable pumps, delivery ticket components, and replacement DME after a natural disaster.

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

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

Public Comment Deadline: June 14, 2017.

Agency Contact: Emily McClellan, Regulatory Supervisor, Policy Division, Department of Medical Assistance Services, 600 East Broad Street, Suite 1300, Richmond, VA 23219, telephone (804) 371-4300, FAX (804) 786-1680, or email emily.mcclellan@dmas.virginia.gov.

VA.R. Doc. No. R17-5024; Filed April 14, 2017, 12:13 p.m.

TITLE 13. HOUSING

VIRGINIA MANUFACTURED HOUSING BOARD

Notice of Intended Regulatory Action

Notice is hereby given in accordance with § 2.2-4007.01 of the Code of Virginia that the Manufactured Housing Board intends to consider amending **13VAC6-20, Manufactured Housing Licensing and Transaction Recovery Fund Regulations**. The purpose of the proposed action is to review issues related to licensing requirements for the manufactured housing industry members that will provide better protection to consumers without imposing unnecessary regulatory burdens on the licensees. The amended regulations will better define the parameters for warranties on homes, when and what disclosures must be given to buyers, and define and implement a substantial identity of interest to restrict repeated violations. The board will receive suggestions and review other requirements or restrictions in the regulations to address any perceived problems and improve the regulations for consumers and regulants.

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

Statutory Authority: § 36-85.18 of the Code of Virginia.

Public Comment Deadline: June 14, 2017.

Agency Contact: Elizabeth Rafferty, Policy and Legislative Director, Department of Housing and Community Development, 600 East Main Street, Suite 300, Richmond, VA 23219, telephone (804) 371-7011, FAX (804) 371-7090, TTY (804) 371-7089, or email elizabeth.rafferty@dhcd.virginia.gov.

VA.R. Doc. No. R17-5104; Filed April 21, 2017, 11:40 a.m.

TITLE 18. PROFESSIONAL AND OCCUPATIONAL LICENSING

BOARD OF DENTISTRY

Notice of Intended Regulatory Action

Notice is hereby given in accordance with § 2.2-4007.01 of the Code of Virginia that the Board of Dentistry intends to consider amending **18VAC60-21, Regulations Governing the Practice of Dentistry**. The purpose of the proposed action is to consider regulations for dentists prescribing medications containing opioids and for continuing education for prescribers of controlled substances to address the opioid abuse crisis in Virginia. Regulations for the management of acute pain may include requirements for the evaluation of the patient, limitations on quantity and dosage, and recordkeeping. Management of chronic pain may require either referral to a pain management specialist or adherence to regulations of the Board of Medicine. All dentists who prescribe Schedules II through IV drugs may be required to take two hours of continuing education on pain management during the renewal cycle following the effective date of the regulations.

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

Statutory Authority: §§ 54.1-2400 and 54.1-2708.4 of the Code of Virginia.

Public Comment Deadline: June 14, 2017.

Agency Contact: Sandra Reen, Executive Director, Board of Dentistry, 9960 Mayland Drive, Suite 300, Richmond, VA 23233, telephone (804) 367-4437, FAX (804) 527-4428, or email sandra.reen@dhp.virginia.gov.

VA.R. Doc. No. R17-5064; Filed April 17, 2017, 9:25 a.m.

Notice of Intended Regulatory Action

Notice is hereby given in accordance with § 2.2-4007.01 of the Code of Virginia that the Board of Dentistry intends to consider amending **18VAC60-21, Regulations Governing the Practice of Dentistry**, **18VAC60-25, Regulations Governing the Practice of Dental Hygiene**, and **18VAC60-30, Regulations Governing the Practice of Dental Assistants**. A revision of the American Dental Association (ADA) Guidelines for Teaching the Comprehensive Control of Anxiety and Pain in Dentistry was published in October 2016. Currently, Board of Dentistry regulations specify that education and training for conscious/moderate sedation must be consistent with the ADA Guidelines. With the revision, certain training requirements and uses of terminology are now inconsistent with the guidelines, now titled "Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students."

Consequently, the board is considering (i) amending the use of the term conscious/moderate sedation throughout the chapters to refer to moderate sedation, (ii) changing the name

of the guidelines consistent with the 2016 version, and (iii) eliminating the training for a dentist to administer moderate sedation by the enteral method only, as the guidelines no longer make a distinction for enteral administration, and specifying the same training for all who administer moderate sedation.

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

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

Public Comment Deadline: June 14, 2017.

Agency Contact: Sandra Reen, Executive Director, Board of Dentistry, 9960 Mayland Drive, Suite 300, Richmond, VA 23233, telephone (804) 367-4437, FAX (804) 527-4428, or email sandra.reen@dhp.virginia.gov.

VA.R. Doc. No. R17-4975; Filed April 17, 2017, 7:52 a.m.

BOARD OF FUNERAL DIRECTORS AND EMBALMERS

Notice of Intended Regulatory Action

Notice is hereby given in accordance with § 2.2-4007.01 of the Code of Virginia that the Board of Funeral Directors and Embalmers intends to consider amending **18VAC65-20, Regulations of the Board of Funeral Directors and Embalmers**. The purpose of the proposed action is to incorporate the board's guidance on the statutory requirements for express permission to embalm a body and for refrigeration of a dead human body into the board's regulations so if necessary, compliance can be enforced through a disciplinary proceeding.

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

Statutory Authority: §§ 54.1-2400 and 54.1-2803 of the Code of Virginia.

Public Comment Deadline: June 14, 2017.

Agency Contact: Corie Tillman Wolf, Executive Director, Board of Funeral Directors and Embalmers, 9960 Mayland Drive, Suite 300, Richmond, VA 23233, telephone (804) 367-4479, FAX (804) 527-4471, or email fanbd@dhp.virginia.gov.

VA.R. Doc. No. R17-5042; Filed April 17, 2017, 8:06 a.m.

TITLE 22. SOCIAL SERVICES

DEPARTMENT FOR AGING AND REHABILITATIVE SERVICES

Notice of Intended Regulatory Action

Notice is hereby given in accordance with § 2.2-4007.01 of the Code of Virginia that the Department for Aging and Rehabilitative Services intends to consider amending **22VAC30-20, Provision of Vocational Rehabilitation Services**. The purpose of the proposed action is to reduce the priority categories for order of selection for persons determined to be eligible for services from four to three. The Rehabilitation Services Administration, the federal agency that regulates the state-federal vocational rehabilitation program, is requiring a reduction in the number of categories for the order of selection, based on a determination that the current categories II and III are not different enough to warrant being two separate categories.

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

Statutory Authority: § 51.5-131 of the Code of Virginia.

Public Comment Deadline: June 15, 2017.

Agency Contact: Vanessa S. Rakestraw, Ph.D., CRC, Policy Analyst, Department for Aging and Rehabilitative Services, 8004 Franklin Farms Drive, Richmond, VA 23229, telephone (804) 662-7612, FAX (804) 662-7663, TTY (800) 464-9950, or email vanessa.rakestraw@dars.virginia.gov.

VA.R. Doc. No. R17-4951; Filed April 14, 2017, 3:41 p.m.

REGULATIONS

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

Symbol Key

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

TITLE 1. ADMINISTRATION

OFFICE OF THE STATE INSPECTOR GENERAL

Notice of Extension of Emergency Regulation

Title of Regulation: **1VAC42-30. Fraud and Abuse Whistle Blower Reward Fund (adding 1VAC42-30-10 through 1VAC42-30-110).**

Statutory Authority: § 2.2-3014 of the Code of Virginia.

Expiration Date Extended Through: October 25, 2017.

The Governor has approved the Office of the State Inspector General (OSIG) request to extend the expiration date of the above-referenced emergency regulation for six months as provided for in § 2.2-4011 D of the Code of Virginia. Therefore, the emergency regulation will continue in effect through October 25, 2017. The emergency regulation defines the Fraud and Abuse Whistle Blower Reward Program and Fund and their administration by OSIG, including (i) eligibility requirements; (ii) amount, distribution, and process for leftover moneys at the end of the fiscal year; and (iii) the fund's establishment on the books of the Comptroller. The emergency regulation was published in 32:6 VA.R. 763-767 November 16, 2015.

Agency Contact: Mark Courtney, Regulatory Coordinator, Office of the State Inspector General, 101 North 14th Street, 7th Floor, Richmond, VA 23219, telephone (804) 625-3255 or email mark.courtney@osig.virginia.gov.

VA.R. Doc. No. R16-4186; Filed April 14, 2017, 11:18 a.m.

TITLE 4. CONSERVATION AND NATURAL RESOURCES

MARINE RESOURCES COMMISSION

Final Regulation

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

Title of Regulation: **4VAC20-450. Pertaining to the Taking of Bluefish (amending 4VAC20-450-30).**

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

Effective Date: May 1, 2017.

Agency Contact: Jennifer Farmer, Regulatory Coordinator, Marine Resources Commission, 2600 Washington Avenue, 3rd Floor, Newport News, VA 23607, telephone (757) 247-2248, or email jennifer.farmer@mrc.virginia.gov.

Summary:

The amendment increases the commercial landings quota of bluefish to 1,014,773 pounds.

4VAC20-450-30. Commercial landings quota.

A. The commercial landings of bluefish shall be limited to ~~580,287~~ 1,014,773 pounds during the current calendar year.

B. When it is projected that 95% of the commercial landings quota has been realized, a notice will be posted to close commercial harvest and landings from the bluefish fishery within five days of posting.

C. It shall be unlawful for any person to harvest or land bluefish for commercial purposes after the closure date set forth in the notice described in subsection B of this section.

VA.R. Doc. No. R17-5112; Filed April 25, 2017, 2:41 p.m.

Emergency Regulation

Title of Regulation: **4VAC20-720. Pertaining to Restrictions on Oyster Harvest (amending 4VAC20-720-15).**

Statutory Authority: §§ 28.2-201 and 28.2-210 of the Code of Virginia.

Effective Dates: April 26, 2017, through May 25, 2017.

Agency Contact: Jennifer Farmer, Regulatory Coordinator, Marine Resources Commission, 2600 Washington Avenue, 3rd Floor, Newport News, VA 23607, telephone (757) 247-2248, or email jennifer.farmer@mrc.virginia.gov.

Preamble:

The amendments remove the April 30, 2017, deadline for purchasing the oyster resource user fee and provide that the fee must be purchased yearly in order to maintain eligibility to harvest oysters from public ground in that year.

4VAC20-720-15. Control date, license moratorium, transferability, and agents.

A. The commission hereby establishes July 1, 2014, as the control date for management of all public oyster fisheries in Virginia. Participation by any individual in any public oyster fishery after the control date may not be considered in the calculation or distribution of oyster fishing rights should entry limitations be established. Any individual entering the public oyster fishery after the control date will forfeit any right to

future participation in the public oyster fishery should further entry limitations be established by the commission.

B. ~~Beginning February 23, 2016, only~~ Only individuals who have paid the oyster resource user fee described in clause (ii) of subsection A of § 28.2-541 of the Code of Virginia in ~~previous years~~ any year from 2013 through 2016 may pay that fee ~~for the current year~~ in 2017 for harvest of oysters from public ground in that year. ~~Those individuals who are eligible to pay the oyster resource user fee described in clause (ii) of subsection A of § 28.2 541 of the Code of Virginia shall do so by April 30, 2017, in 2017 and by January 1 in subsequent years in order to maintain their eligibility.~~ In any year following 2017, eligibility to pay the oyster resource user fee described in clause (ii) of subsection A of § 28.2-541 of the Code of Virginia shall be limited to those individuals who paid the oyster resource user fee for harvest of oysters from public ground in the previous year.

C. Should the number of people eligible to pay the oyster resource user fee described in clause (ii) of subsection A of § 28.2-541 of the Code of Virginia in any given year fall below 600, a random drawing shall be held to award eligibility to pay that oyster resource user fee to individuals who were not previously eligible until the number of persons eligible to pay the fee reaches 600. Any Commercial Fisherman Registration Licensee may apply for the random drawing.

D. Any person eligible to pay the oyster resource user fee described in clause (ii) of subsection A of § 28.2-541 of the Code of Virginia, or such person's legal representative, may transfer the eligibility to pay such user fee to:

1. A transferee who is the transferor's spouse, sibling, parent, child, grandparent, or grandchild and who possesses a current Commercial Fisherman Registration License and intends to participate in the public oyster fishery.

2. A transferee other than a person described in subdivision 1 of this subsection if the transferor has documented by mandatory reporting and buyers reports 40 days or more of public oyster harvest during the previous calendar year.

All transfers under this subsection shall be documented on a form provided by the Marine Resources Commission.

E. Exceptions to subsection B of this section shall only apply to those individuals who previously paid the oyster resource user fee described in clause (ii) of subsection A of § 28.2-541 of the Code of Virginia and shall be based on documented medical hardships or active military leave that prevented the fisherman from fully satisfying the requirements of subsection B of this section.

F. No person shall serve as an agent for any public oyster gear licensee.

VA.R. Doc. No. R17-5111; Filed April 25, 2017, 2:39 p.m.

Emergency Regulation

Title of Regulation: **4VAC20-910. Pertaining to Scup (Porgy) (amending 4VAC20-910-45).**

Statutory Authority: §§ 28.2-201 and 28.2-210 of the Code of Virginia.

Effective Dates: April 26, 2017, through May 25, 2017.

Agency Contact: Jennifer Farmer, Regulatory Coordinator, Marine Resources Commission, 2600 Washington Avenue, 3rd Floor, Newport News, VA 23607, telephone (757) 247-2248, or email jennifer.farmer@mrc.virginia.gov.

Preamble:

The amendment changes the commercial harvest and landing of scup for May 1 through October 31 from 13,154 pounds to 11,812 pounds.

4VAC20-910-45. Possession limits and harvest quotas.

A. During the period January 1 through April 30 of each year, it shall be unlawful for any person to do any of the following:

1. Possess aboard any vessel in Virginia more than 50,000 pounds of scup.

2. Land in Virginia more than a total of 50,000 pounds of scup during each consecutive seven-day landing period, with the first seven-day period beginning on January 1.

B. When it is projected and announced that 80% of the coastwide quota for this period has been attained, it shall be unlawful for any person to possess aboard any vessel or to land in Virginia more than a total of 1,000 pounds of scup.

C. During the period November 1 through December 31 of each year, it shall be unlawful for any person to possess aboard any vessel or to land in Virginia more than 18,000 pounds of scup.

D. During the period May 1 through October 31 of each year, the commercial harvest and landing of scup in Virginia shall be limited to ~~13,154~~ 11,812 pounds.

E. For each of the time periods set forth in this section, the Marine Resources Commission will give timely notice to the industry of calculated poundage possession limits and quotas and any adjustments thereto. It shall be unlawful for any person to possess or to land any scup for commercial purposes after any winter period coastwide quota or summer period Virginia quota has been attained and announced as such.

F. It shall be unlawful for any buyer of seafood to receive any scup after any commercial harvest or landing quota has been attained and announced as such.

G. It shall be unlawful for any person fishing with hook and line, rod and reel, spear, gig, or other recreational gear to possess more than 30 scup. When fishing is from a boat or vessel where the entire catch is held in a common hold or container, the possession limit shall be for the boat or vessel and shall be equal to the number of persons on board legally

eligible to fish multiplied by 30. The captain or operator of the boat or vessel shall be responsible for any boat or vessel possession limit. Any scup taken after the possession limit has been reached shall be returned to the water immediately.

VA.R. Doc. No. R17-5110; Filed April 25, 2017, 2:40 p.m.

TITLE 6. CRIMINAL JUSTICE AND CORRECTIONS

CRIMINAL JUSTICE SERVICES BOARD

Proposed Regulation

Title of Regulation: **6VAC20-100. Rules Relating to Compulsory Minimum Training Standards for Correctional Officers of the Department of Corrections, Division of Adult Institutions (amending 6VAC20-100-10 through 6VAC20-100-90; adding 6VAC20-100-25, 6VAC20-100-95; repealing 6VAC20-100-100, 6VAC20-100-110).**

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

Public Hearing Information: No public hearings are scheduled.

Public Comment Deadline: July 14, 2017.

Agency Contact: Barbara Peterson-Wilson, Law Enforcement Program Coordinator, Department of Criminal Justice Services, 1100 Bank Street, Richmond, VA 23219, telephone (804) 225-4503, FAX (804) 225-3853, or email barbara.peterson-wilson@dcjs.virginia.gov.

Basis: Pursuant to § 9.1-102 of the Code of Virginia, the Department of Criminal Justice Services (DCJS) and the Criminal Justice Services Board are authorized to adopt regulations to administer the regulatory program and establish compulsory minimum entry-level, in-service, and advanced training standards, as well as the time required for completion of such training, for persons employed as deputy sheriffs and jail officers by local criminal justice agencies, correctional officers employed by the Department of Corrections under the provisions of Title 53.1, and juvenile correctional officers employed at a juvenile correctional facility as the term is defined in § 66-25.3 of the Code of Virginia. Section 9.1-107 of the Code of Virginia charges the Director of DCJS with executive and administrative responsibility to carry out the specific duties imposed on DCJS under § 9.1-102. Section 9.1-112 of the Code of Virginia creates the Committee on Training (COT) under the Criminal Justice Services Board as the policy-making body responsible to the board for effecting the provisions of subdivisions 2 through 17 of § 9.1-102.

Purpose: In 2012, DCJS contracted with the National Institute of Corrections in collaboration with the Virginia Department of Corrections (DOC) to conduct a job task analysis to assist DCJS in defining minimum entry-level training standards for corrections officers. The job task analysis identified a need for enhanced training requirements. The proposed regulation will revise the minimum entry-level training standards as well as the hours needed for corrections officer compulsory minimum training standards to address the enhanced training requirements identified by the job task analysis. The performance objectives for the compulsory minimum training standards will be removed from the regulation, and individuals will be directed to the DCJS website to view the performance objectives. Additionally, language addressing the approval authority of the Criminal Justice Services Board and the COT will be added to the regulation. These proposed revisions are essential to ensure corrections officers receive the training necessary to protect the health, safety, and welfare of inmates housed in Virginia's correctional institutions, as well as that of the corrections officers.

Substance: The purpose for this intended regulatory action is to revise and update current regulations governing the compulsory minimum training standards for corrections officers employed by the DOC. Substantive changes include updating outdated language. The new substantive provisions include:

1. Adding, revising, or deleting definitions for the following terms: "academy director," "agency administrator," "approved training academy," "approved training school," "corrections officer," "Curriculum Review Committee," "full-time attendance," "school director," and "satellite facility."

2. Identifying the categories that make up the Compulsory Minimum Training Standards along with the required training hours for corrections officers. The performance objectives have been removed from the regulation to allow revisions to the training standards to be made in a more expeditious manner while still allowing a forum for public comment through the COT. This includes removal of the language addressing firearms training.

3. Adding language that identifies the approval authority for training requirements. The Criminal Justice Services Board shall be the approval authority for the training categories of the compulsory minimum training standards. The COT of the Criminal Justice Services Board shall be the approval authority for the performance outcomes, training objectives, criteria, and lesson plan guides that support the performance outcomes.

4. Adding language that would provide DCJS with the option to suspend or revoke a previously approved training. Currently DCJS's only regulatory authority is to suspend or revoke the certification of the academy.

5. Adding language which references the in-service requirements for corrections officers training and in-service for firearms identified in 6VAC20-30, Rules Relating to Compulsory In-Service Training Standards for Law-Enforcement Officers, Jailors or Custodial Officers, Courtroom Security Officers, Process Service Officers and

Officers of the Department of Corrections, Division of Operations.

6. Removing language referencing outdated documents and adoption and effective date sections that are no longer relevant.

Issues: The primary advantage to private citizens, businesses, and the Commonwealth is increased public safety. The regulation is intended to ensure corrections officers receive the appropriate training prior to assuming responsibility for the security and safety of DOC facilities and inmates. The enhanced training increases the safety of the corrections officers, inmates, and other staff working within DOC operated facilities. There are no disadvantages to the public, the Commonwealth, or DOC.

Department of Planning and Budget's Economic Impact Analysis:

Summary of the Proposed Amendments to Regulation. The Criminal Justice Services Board (Board) proposes to amend its regulation that governs training for the Department of Corrections (DOC) corrections officers to 1) update definitions, 2) remove performance objectives from the regulation and clarify that the Board's Committee on Training (COT) has authority to revise performance objectives, 3) clarify that the Board retains authority to amend training categories that will remain in the regulation and 4) increase required initial training for corrections officers from 216 hours to 600 hours of total training.

Result of Analysis. Benefits likely outweigh costs for most proposed changes. For one proposed change, there is insufficient data to ascertain whether benefits will outweigh costs.

Estimated Economic Impact. Several of the regulatory changes proposed by the Board do not change any substantive requirement or duty for any entity but, instead, are aimed at making the regulatory text easier to read and understand. Changes to the definitions in the regulation, as well as language that specifies the authority of the Board over training categories and the authority of the COT over performance objectives, fall into this category of change. No affected entity is likely to incur costs on account of changes such as these. To the extent that the current regulation contains outdated definitions, or might be otherwise confusing or opaque, these changes will benefit readers by making the regulation more easily understood.

In addition to these clarifying changes, the Board proposes several substantive changes to this regulation. The substantive changes proposed would remove performance objectives from the regulation and increase required initial training hours for corrections officers.

Currently, both performance objectives and training categories are in the regulation. Training categories are broad topics in which the Board mandates training for corrections officers while performance objectives are the sub-categories within the training categories that serve as a guide for lesson plans. For instance, the Board mandates that officers receive firearms training as one training category, and the performance objectives specify how many rounds must be fired during training as well as what types of targets that will be used and the accuracy score that an officer must achieve to be proficient. The Board proposes to remove the performance objectives from this regulation and replace them with a reference to the guidance document for performance objectives that is on the Department of Criminal Justice Services (DCJS) website.

This change may cost interested parties some small amount of extra search time to find the performance objectives on the DCJS website. Those costs are likely outweighed by the benefits that will likely accrue from the COT being able to change the performance outcomes more easily and quickly[1] when necessary to address identified training deficiencies or changes in law that affect the duties of corrections officers. Since training hours and categories will still be set in regulation, DOC is unlikely to incur additional costs on account of this change.

The Board also proposes to raise the number of training hours initially required for new corrections officers in this regulation. The current regulation requires 80 hours of field training, 120 hours of core curriculum training and 16 hours of sub-core curriculum training (216 total training hours). Board staff reports that in order to address inconsistencies in training across facilities identified by DOC, to account for training recommendations from the job task analysis conducted by the National Institute of Corrections and to implement new physical training requirements, the number of training hours were substantially increased for any new corrections officers hired after July1, 2015. By agreement with DCJS, DOC increased training for new officers hired after July 1, 2015, to include 400 academy training hours and 200 field training hours (600 total training hours). The Board now proposes to require this increased training in regulation.

Increasing training hours, particularly academy hours where new corrections officers would be away from their assigned facilities and unavailable to perform any job tasks, will likely increase costs for DOC as they will have to both pay the new officers in training and pay additional officers to complete the tasks in facilities that the new officers would be doing if they were not completing academy hours. DOC did not ask for additional money to cover these costs when training increased in 2015, so they were likely absorbed and covered by DOC's then current budget. DOC also reported that they anticipate incurring additional annual costs for ammunition ($159,213.95),[2] firearms training scoring targets ($1,216.60) and meals for corrections officers completing additional training ($33,000 to $35,000). New corrections officers may also incur additional fuel costs associated with additional trips from their assigned facilities to the training academies.

These costs would need to be weighed against the benefits that have accrued or may accrue from corrections officers receiving more training. For instance, new firearms training standards in the performance objectives guidance document referenced in the proposed regulation require new corrections officers to fire more rounds in order to become proficient, which will be more costly. Those costs, however, may be outweighed by the benefits of this change if more officers pass their firearms training the first time without having to repeat it or if firing a greater number of rounds allows them to more effectively handle any crisis in their assigned facility where firearms use is necessary. Some other benefits that may accrue on account of increasing training hours are lower turnover rates for employment of corrections officers (if corrections officers feel they are better equipped to complete their job tasks) and fewer numbers of injuries for both corrections officers and prisoners (if corrections officers are better trained to spot brewing conflicts and intervene sooner). At this time, there is insufficient data to identify the magnitude of either all the costs or all the benefits of increased training hours so benefits cannot effectively be weighed against costs.

Businesses and Entities Affected. Board staff reports that these proposed regulatory changes will affect DOC institutions, corrections officers in the employ of DOC, and all inmates in DOC prisons. Board staff further reports that there are approximately 38,760 state responsible prisoners housed in various DOC facilities and that DOC employs approximately 7,400 corrections officers.

Localities Particularly Affected. No locality will be particularly affected by these proposed regulatory changes.

Projected Impact on Employment. These proposed regulatory changes are unlikely to affect employment in the Commonwealth.

Effects on the Use and Value of Private Property. These proposed regulatory changes are unlikely to affect the use or value of private property in the Commonwealth.

Real Estate Development Costs. These proposed regulatory changes are unlikely to affect real estate development costs in the Commonwealth.

Small Businesses:

Definition. Pursuant to § 2.2-4007.04 of the Code of Virginia, small business is defined as "a business entity, including its affiliates, that (i) is independently owned and operated and (ii) employs fewer than 500 full-time employees or has gross annual sales of less than $6 million."

Costs and Other Effects. These proposed regulatory changes are unlikely to affect any small business in the Commonwealth.

Alternative Method that Minimizes Adverse Impact. No small businesses will be adversely affected by these proposed regulatory changes.

Adverse Impacts:

Businesses. Businesses in the Commonwealth are unlikely to experience any adverse impacts on account of this proposed regulation.

Localities. No localities are likely to incur costs on account of these proposed regulatory changes.

Other Entities. These proposed regulatory changes are unlikely to affect other entities in the Commonwealth.

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[1] Currently, any changes to the performance objectives have to go through a lengthy regulatory process that may take several years. Although DCJS will still have a process for public notice of, and public participation in, any future amendments to the performance objectives after they are removed from regulation, this process will likely take months instead of years.

[2] Current regulation only requires corrections officers to shoot 60 rounds of ammunition but new standards in the 2015 agreement require them to shoot 200 rounds of ammunition.

Agency's Response to Economic Impact Analysis: The Department of Criminal Justice Services concurs generally with the economic impact analysis provided by the Department of Planning and Budget.

Summary:

The proposed amendments include (i) requiring periodic in-service training and annual firearms training; (ii) clarifying the approval authority of the Criminal Justice Services Board and the board's Committee on Training (COT); (iii) for compulsory minimum training standards, replacing performance and testing objectives with categories of training and the required number of training hours for each category; (iv) authorizing the Department of Criminal Justice Services to suspend or revoke a previously approved training; (v) updating definitions; and (vi) removing outdated sections for adoption and effective dates.

CHAPTER 100
RULES RELATING TO COMPULSORY MINIMUM TRAINING STANDARDS FOR ~~CORRECTIONAL~~ CORRECTIONS OFFICERS OF THE DEPARTMENT OF CORRECTIONS, DIVISION OF ADULT INSTITUTIONS

6VAC20-100-10. Definitions.

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

"Academy director" means the chief administrative officer of a certified training academy.

"Agency administrator" means ~~any chief of police, sheriff or agency head of a state, local law enforcement agency, or~~ the director of the Department of Corrections, or his designee.

~~"Approved training school" means a training school which provides instruction of at least the minimum training standards as mandated by the board and has been approved by the department for the specific purpose of training criminal justice personnel.~~

"Board" means the Criminal Justice Services Board.

~~"Corrections facility director/manager" means the chief administrative officer of a correctional facility.~~

"Certified training academy" means a training facility in compliance with academy certification standards and operated by the state or local unit of government for the specific purpose of training criminal justice personnel.

"Committee on Training" means the standing committee of the board that is charged with reviewing proposed changes to the standards, holding public hearings, and approving changes to the standards as needed.

"Corrections officer" or "officer" means a basic corrections officer through the rank of major.

"Curriculum Review Committee" or "CRC" means the committee consisting of nine individuals representing the Department of Corrections. Two members of the committee shall represent the western region, two members shall represent the eastern region, two members shall represent the central region, and three members shall represent administration.

"Department" means the Department of Criminal Justice Services.

"Director" means the chief administrative officer of the department.

"Full-time attendance" means ~~that~~ officers in training shall attend all classes and shall not be placed on duty, on post, or on call except in cases of an emergency ~~for the duration of the school~~ while completing compulsory minimum training requirements.

~~"School director" means the chief administrative officer of an approved training school.~~

"Satellite facility" means a facility, located away from the certified academy facility, that the certified academy uses to conduct mandated training. This definition specifically excludes firing ranges, driver training sites, and physical fitness or defensive tactics sites, which may be located away from the certified academy facility. Commercial conference and training facilities such as hotels and motels, which are used for mandated training, are specifically excluded from this definition.

6VAC20-100-20. Compulsory minimum training standards; training hours.

A. Pursuant to the provisions of subdivision 9 of § ~~9-170~~ 9.1-102 of the Code of Virginia, the board establishes the ~~following as the~~ compulsory minimum training standards for full-time ~~correctional~~ and part-time corrections officers of the Department of Corrections, Division of Adult Institutions.

~~The performance objectives constituting the institutional and academy for staff development core and sub-core curricula is detailed in the document entitled, "Performance Based Training and Testing Objectives for Compulsory Minimum Training for Correctional Officers of the Department of Corrections, Division of Adult Institutions" (June, 1986), which is incorporated by reference and made a part of these regulations.~~

~~A. Basic correctional officer training - institutional training.~~

~~1. Core curriculum.~~

~~4.0. Key Control~~

~~5.0. Tool Control~~

~~6.0. Control/Account for Inmates~~

~~10.0. Search Procedures - Persons~~

~~11.0. Search Procedures - Objects~~

~~12.0. Search Procedures - Vehicles~~

~~13.0. Search Procedures - Areas~~

~~14.0. Control of Movement In and Out of Facility - Perimeter~~

~~15.0. Control of Movement In and Out of Tower~~

~~16.0. Control of Movement In and Out of Sally Port~~

~~17.0. Control of Movement In and Out of Visiting Room~~

~~18.0. Control of Movement In and Out of Gates~~

~~19.0. Radio/Telephone Communications~~

~~20.0. Control of Movement - Control Room~~

~~21.0. Control of Movement - Master Control~~

~~22.0. Maintaining Effective Security Equipment~~

~~23.0. Control of Contraband~~

~~24.0. Control of Movement Using Restraints~~

~~24.1. Identification of Restraints~~

~~24.2. Use of Restraints~~

~~25.0. Control of Inmate Movement - Internal~~

~~26.0. Transportation and Escorting~~

~~32.0. Communication of Critical Information to Correctional Officers~~

~~33.0. Communication of Critical Information to Supervisors~~

~~34.0. Enforcing Laws, Rules and Regulations~~

~~35.0. Enforcing Laws, Rules and Regulations - Behavior Adjustment~~

~~36.0. Enforcing Laws, Rules and Regulations - Adjustment Committee~~

~~37.0. Enforcing Laws, Rules - ICC~~

~~43.0. Use of Force - Firearms~~

~~44.0. Emergency Preparedness and Response - Riot or Disturbance~~

~~45.0. Emergency Preparedness and Response~~

~~46.0. Emergency Preparedness and Response - Hostage~~

~~47.0. Emergency Preparedness and Response - Minor Disturbance~~

~~48.0. Emergency Preparedness and Response - First Aid~~

~~50.0. Inmate Supervision - Providing Information~~

~~52.0. Inmate Supervision - Work/Recreation~~

~~53.0. Inmate Welfare - Receiving~~

~~54.0. Inmate Welfare - Medical Care~~

~~55.0. Inmate Welfare - Mail~~

~~56.0. Inmate Welfare - Personal Property~~

~~57.0. Inmate Welfare - Housekeeping/Laundry~~

~~.....TOTAL INSTITUTIONAL CURRICULUM HOURS - 80~~

~~B. Basic correctional officer training - academy for staff development.~~

~~1. Core curriculum.~~

~~1.0. Role of the Correctional System~~

~~2.0. Corrections Within the Criminal Justice System~~

~~3.0. Corrections As a Profession~~

~~7.0. Law-Enforcement Techniques~~

~~8.0. Secure and Safeguard of Crime Scene~~

~~9.0. Testifying~~

~~10.0. Search Procedures - Persons~~

~~23.0. Control of Contraband~~

~~23.1. Control of Drug Use~~

~~23.2. Identification of Controlled/Abused Substance~~

~~23.3. Identification of Materials Used to Achieve Intoxication~~

~~23.4. Identification of Materials Used to Make Weapons~~

~~23.5. Procedure for Handling Contraband~~

~~24.0. Control of Movement Using Restraints~~

~~24.1. Identification of Restraints~~

~~24.2. Use of Restraints~~

~~28.0. Crisis Prevention/Inmate~~

~~29.0. Crisis Prevention/I.D. of Potential Problems~~

~~30.0. Crisis Prevention/I.D. of Mentally Disturbed Inmates~~

~~31.0. Conflict Management/Crisis Intervention~~

~~34.0. Enforcing Laws, Rules and Regulations~~

~~35.0. Enforcing Laws, Rules and Regulations - Behavior Adjustment~~

~~38.0. Enforcing Laws, Rules - Grievance~~

~~39.0. Use of Force~~

~~40.0. Use of Force - Defensive Tactics~~

~~41.0. Use of Force - Baton~~

~~42.0. Use of Force - Chemical Agents~~

~~43.0. Use of Force - Firearms~~

~~44.0. Emergency Preparedness and Response - Riot or Disturbance~~

~~45.0. Emergency Preparedness and Response~~

~~46.0. Emergency Preparedness and Response - Hostage~~

~~49.0. Inmate Supervision - Interpersonal Communications~~

~~50.0. Inmate Supervision - Providing Information~~

~~51.0. Inmate Supervision - Limitations~~

~~52.0. Inmate Supervision - Work/Recreation~~

~~.....TOTAL CORE CURRICULUM HOURS - 120~~

~~2. Sub-core curriculum (required for all correctional officers who, in the performance of duties, are required to transport inmates by vehicular means).~~

~~27.0. Vehicle Operation.~~

~~.....TOTAL SUB-CORE CURRICULUM HOURS - 16~~

~~.....TOTAL CURRICULUM HOURS - 216~~

B. Academy training.

1. Category 1 - Security and Supervision.

2. Category 2 - Communication.

3. Category 3 - Safety.

4. Category 4 - Emergency Response.

5. Category 5 - Conflict and Crisis Management.

6. Category 6 - Law and Legal Issues.

7. Category 7 - Duty Assignments and Responsibilities.

8. Category 8 - Professionalism.

9. Category 9 - Firearms Training.

10. Category 10 - Physical Training.

ACADEMY TRAINING HOURS - 400.

C. Field training.

Category 11 - Field Training.

FIELD TRAINING HOURS - 200.

TOTAL MINIMUM TRAINING STANDARDS HOURS - 600.

6VAC20-100-25. Approval authority.

A. The Criminal Justice Services Board shall be the approval authority for the training categories and hours of the compulsory minimum training standards. Amendments to training categories shall be made in accordance with the provisions of the Administrative Process Act (§ 2.2-4000 et seq. of the Code of Virginia).

B. The Committee on Training of the Criminal Justice Services Board shall be the approval authority for the performance outcomes, training objectives, criteria, and lesson plan guides that support the performance outcomes. Performance outcomes, training objectives, criteria, and lesson plan guides supporting the compulsory minimum training standards may be added, deleted, or amended by the Committee on Training based upon written recommendation of a chief of police, sheriff, agency administrator, academy director, or the Curriculum Review Committee.

C. Prior to approving changes to the performance outcomes, training objectives, criteria, or lesson plan guides, the Committee on Training shall conduct a public hearing. Sixty days prior to the public hearing, the proposed changes shall be distributed to all affected parties for an opportunity to comment. Notice of changes to the performance outcomes, training objectives, criteria, and lesson plan guides shall be filed for publication in the Virginia Register of Regulations upon adoption, change, or deletion. The department shall notify each certified training academy in writing of new, revised, or deleted objectives. Such adoptions, changes, or deletions shall become effective 30 days after publication in the Virginia Register.

6VAC20-100-30. Applicability.

A. Every person employed as a full-time ~~correctional~~ or part-time corrections officer, ~~and~~ who has not met the compulsory minimum training standards for ~~correctional~~ corrections officers subsequent to ~~the effective date of these regulations,~~ (insert effective date of this section) shall meet the training standards ~~herein~~ established in this chapter unless provided otherwise in accordance with subsection B or C of this section.

B. All persons employed as full-time or part-time corrections officers prior to July 1, 2015, shall be:

1. Exempt from complying with the compulsory minimum training requirements in this chapter;

2. Required to comply with the in-service training requirements in 6VAC20-30, Rules Relating to Compulsory In-Service Training Standards for Law-Enforcement Officers, Jailors or Custodial Officers, Courtroom Security Officers, Process Service Officers and Officers of the Department of Corrections, Division of Operations; and

3. Required to complete in-service training by December 31 of the second calendar year after completing a certified training academy.

C. The director may grant an exemption or partial exemption of the compulsory minimum training standards established ~~herein~~ in this chapter, in accordance with § ~~9-173~~ 9.1-116 of the Code of Virginia.

6VAC20-100-40. Time requirement for completion of training.

A. Every ~~correctional~~ corrections officer who is required to comply with the compulsory minimum training standards shall satisfactorily complete such training within 12 months of the date of appointment unless provided otherwise in accordance with subsection B of this section.

B. The director may grant an extension of the time limit for completion of the minimum training required upon presentation of evidence by the agency administrator that the officer was unable to complete the required training within the specified time limit due to illness, injury, military service, or special duty assignment required and performed in the public interest. However, each agency administrator shall request such extension prior to expiration of any time limit.

C. Any ~~correctional~~ corrections officer who originally complied with all training requirements and later separated from ~~correctional~~ corrections officer status, ~~more than 12 months but less than~~ for a period of 24 months or less, upon reentry as a ~~correctional officer will~~ corrections officer shall be required to complete ~~all compulsory minimum training standards~~ in-service and annual firearms training set forth in ~~6VAC20-100-20 A 1~~ 6VAC20-30, Rules Relating to Compulsory In-Service Training Standards for Law-Enforcement Officers, Jailors or Custodial Officers, Courtroom Security Officers, Process Service Officers and Officers of the Department of Corrections, Division of Operations.

D. Any ~~correctional~~ corrections officer who originally complied with all training requirements and later separated from ~~correctional~~ corrections officer status, ~~in excess of~~ for a period greater than 24 months, upon reentry as a ~~correctional officer~~ corrections officer shall be required to complete all compulsory minimum training standards ~~unless provided otherwise in accordance with 6VAC20-100-20 A 1~~ required for corrections officers as set forth in this chapter.

6VAC20-100-50. How minimum training may be attained.

A. The compulsory minimum training standards shall be attained by attending and ~~satisfactorily~~ completing ~~an approved training school~~ training objectives and criteria at a certified training academy or satellite facility.

B. ~~Officers~~ Full-time attendance is required of all corrections officers attending ~~an approved training school are required to be present for all classes and~~ a certified training academy or satellite facility. Officers should not be placed on duty, on post, or on call except in cases of an emergency. In the event of such an emergency, the agency administrator or designee shall determine if it is appropriate to place officers on duty, on post, or on call and shall advise the ~~school~~ academy director within 24 hours. Officers ~~will~~ shall be responsible for any material missed during an excused absence.

~~C. All approved training schools which begin on or after January 1, 1989, shall be conducted in conformance with the Rules Relating to Compulsory Minimum Training Standards for Correctional Officers of the Department of Corrections, Division of Adult Institutions, as adopted by the board on October 7, 1987. However, the period January 1, 1988, through December 31, 1988, shall serve as a transition period wherein training schools may be approved by the department to conduct training in accordance with the Rules Relating to Compulsory Minimum Training Standards For Correctional Officers of the Department of Corrections, Division of Institutional Services, as amended by the board on February 12, 1982, or according to the Rules Relating to Compulsory Minimum Training Standards for Correctional Officers of the Department of Corrections, Division of Adult Institutions, as~~

~~adopted by the board on October 7, 1987. Every correctional officer satisfactorily completing training approved by the department under the rules amended February 12, 1982, or under the rules adopted on October 7, 1987, shall be deemed to have complied with the compulsory minimum training standards for correctional officers.~~

6VAC20-100-60. Approved training ~~schools~~ and certified training academies.

A. ~~Correctional~~ Corrections officer training ~~schools~~ shall be approved by the department prior to the first scheduled class. Approval is requested by making application to the director or the director's designee on forms provided by the department. The director or the director's designee may approve those ~~schools~~ trainings, which, on the basis of curricula, instructors, facilities, and examinations provide the required minimum training. One application for all mandated training shall be submitted prior to the beginning of each fiscal year. A curriculum listing the subject matter, performance objective by number, ~~the~~ instructors, dates, and times for the entire proposed session shall be submitted to the department ~~30 days prior to the beginning of each such proposed session~~ within the time limitations established by the department. An exemption to the ~~30 day requirement~~ established time limitations may be granted by the director for good cause shown by the ~~school~~ academy director.

B. Each ~~school~~ academy director shall be required to maintain a file of all current lesson plans and supporting material for each subject contained in the compulsory minimum training standards.

C. ~~Schools which are approved~~ Training shall be subject to inspection and review by the director or staff.

D. The department may suspend or revoke the approval of ~~an approved~~ previously sanctioned training ~~school~~ upon written notice, which shall contain the ~~reason(s)~~ reason upon which the suspension or revocation is based, to the ~~school's~~ academy's director. The ~~school's~~ academy director may request a hearing before the director or his designee. The request shall be in writing and must be received by the department within 15 business days of the date of the notice of the suspension or revocation. The ~~school's~~ academy director may appeal the decision of the director or his designee to the board. Such request shall be in writing and must be received by the board within 15 business days of the date of the decision of the director or his designee.

E. The department may suspend or revoke the ~~approval of an approved training school~~ certification of a certified training academy upon written notice, which shall contain the ~~reason(s)~~ reason upon which the suspension or revocation is based, to the ~~school's~~ academy director. The ~~school's~~ academy director may request a hearing before the director or his designee. The request shall be in writing and must be received by the department within 15 business days of the date of the notice of revocation. The ~~school's~~ academy director may appeal the decision of the director or his designee to the board. Such request shall be in writing and must be received by the board within 15 business days of the date of the decision of the director or his designee.

6VAC20-100-70. Grading.

A. ~~Each officer~~ Corrections officers shall comply with all the requirements of ~~all the performance objectives set forth in 6VAC20-100-20 and the document entitled, "Performance-Based Training and Testing Objectives for Compulsory Minimum Training for Correctional Officers of the State Department of Corrections, Division of Adult Institutions" (June, 1986)~~ this chapter. All ~~approved training schools~~ certified training academies and satellite facilities shall utilize testing procedures ~~which~~ that indicate that every corrections officer, prior to ~~satisfactory~~ completion of the certified training ~~school~~ academy, has ~~met the requirements set forth in each performance objective specified in the document entitled, "Performance-Based Training and Testing Objectives for Compulsory Minimum Training for Correctional Officers of the State Department of Corrections, Division of Adult Institutions" (June, 1986). An officer may be tested and retested as may be necessary within the time limits of 6VAC20-100-40 and in accordance with each academy's written policy.~~ attained a minimum score of 70% on all tests for each grading category identified in 6VAC20-100-20 to complete the compulsory minimum training standards. A certified training academy may require correctional officers attain a score greater than 70% on tests. An officer shall not be certified as having complied with the compulsory minimum training standards unless all applicable requirements have been met.

B. A corrections officer may be retested within the time limits of 6VAC20-100-40 and in accordance with the certified training academy's written policy.

~~B.~~ C. The ~~school~~ academy director shall submit a grade report on each officer on forms provided by the department.

~~C. The following firearms training will be required for each officer attending an approved school:~~

~~1. Nomenclature and care of service revolver;~~

~~2. Safety (on the firearms range, on duty and off duty);~~

~~3. Legal responsibilities and liabilities of firearms;~~

~~4. Service revolver (handling, firing principles)~~

~~5. Dry firing and application of basic shooting principles;~~

~~6. Prequalification shooting (60 rounds, minimum)~~

~~7. Basic Correctional Firearms Qualification Course – Minimum 70% qualification required.~~

~~8. Shotgun Qualification Course – Minimum 80% qualification required~~

~~9. Special Weapons Qualification Courses – Minimum 80% qualification required~~

~~a. .223 caliber mini-14 rifle~~

~~b. AR-15 semi-automatic rifle~~

6VAC20-100-80. Failure to comply with rules and regulations.

Any ~~correctional~~ corrections officer attending ~~an approved training school~~ a certified training academy or satellite facility shall comply with the rules and regulations promulgated by the board and any other rules and regulations within the authority of the ~~school~~ academy director. The ~~school~~ academy director shall be responsible for enforcement of all rules and regulations established to govern the conduct of attendees. If the ~~school~~ academy director considers a violation of the rules and regulations detrimental to the welfare of the ~~school~~ certified training academy or satellite facility, the ~~school~~ academy director may expel the officer ~~from the school~~. Notification of such action shall immediately be reported, in writing, to the ~~corrections facility director manager of the officer and the director~~ agency administrator or designee.

6VAC20-100-90. Administrative requirements.

A. ~~Reports shall be required from the agency administrator and school director on forms approved or provided by the department and at such times as designated by the director~~ The academy director shall complete a report using the department's electronic records management system for compulsory minimum standards and in-service training within 60 days of completion of compulsory training conducted at the certified training academy or satellite facility.

B. The ~~school~~ academy director shall~~, within 30 days upon completion of an approved training school session, comply with the following: 1.Prepare~~ prepare a grade report on each officer maintaining the original for academy records and ~~forwarding~~ forward a copy to the ~~corrections facility director/manager of the officer~~ agency administrator or his designee.

~~2. Submit~~ C. The academy director shall submit to the department a roster containing the names of those officers who have satisfactorily completed all training requirements and, if applicable, a revised curriculum for the training session.

~~C.~~ D. The ~~school~~ academy director shall furnish each instructor with a complete set of course resumes and the applicable performance objectives for the assigned subject matter.

~~D. Approved correctional officer~~ E. Certified training ~~schools~~ academies shall maintain accurate records of all tests, grades, and testing procedures. Training ~~school~~ records shall be maintained in accordance with the provisions of ~~these rules~~ this chapter and ~~§§ 42.1-76 through 42.1-91~~ The Virginia Public Records Act (§ 42.1-76 et seq. of the Code of Virginia).

6VAC20-100-95. In-service and annual firearms training.

Beginning two years after completing a certified training academy, corrections officers are required to complete a total of 40 in-service hours every two years by December 31. In-service requirements and annual firearms training shall comply with requirements of 6VAC20-30, Rules Relating to Compulsory In-Service Training Standards for Law-Enforcement Officers, Jailors or Custodial Officers, Courtroom Security Officers, Process Service Officers and Officers of the Department of Corrections, Division of Operations.

6VAC20-100-100. ~~Effective date.~~ (Repealed.)

~~These regulations shall be effective on and after January 1, 1988 and until amended or repealed.~~

6VAC20-100-110. ~~Recision of previous rules.~~ (Repealed.)

~~The Rules Relating to Compulsory Minimum Training Standards for Correctional Officers of the Department of Corrections, Division of Institutional Services, as amended on February 12, 1982, are hereby rescinded effective January 1, 1989.~~

~~FORMS (6VAC20-100)~~

~~Application for Exemption From Virginia Compulsory Minimum Training Standards, Form W-2, eff. 1/91.~~

~~Criminal Justice Training Roster, Form 41, eff. 1/93.~~

VA.R. Doc. No. R16-2873; Filed April 18, 2017, 3:56 p.m.

TITLE 12. HEALTH

STATE BOARD OF HEALTH

Proposed Regulation

Title of Regulation: **12VAC5-490. Virginia Radiation Protection Regulations: Fee Schedule (adding 12VAC5-490-50).**

Statutory Authority: § 32.1-229.1 of the Code of Virginia.

Public Hearing Information: No public hearings are scheduled.

Public Comment Deadline: July 14, 2017.

Agency Contact: Steve Harrison, Director, Division of Radiological Health, Department of Health, 109 Governor Street, Richmond, VA 23219, telephone (804) 864-8151, FAX (804) 864-8155, or email steve.harrison@vdh.virginia.gov.

Basis: Section 32.1-229.1 of the Code of Virginia authorizes the State Board of Health to set annual registration fees for x-ray device private inspectors, not to exceed $150 for such registration. Upon approval of the application, the private inspector will be included on the Commonwealth's list of qualified x-ray machine inspectors published pursuant to § 32.1-228.1 of the Code of Virginia.

Purpose: The Virginia Department of Health, Office of Radiological Health (ORH) proposes to amend 12VAC5-490, Radiation Protection Fee Schedule, by establishing a new

section, 12VAC5-490-50, Private inspector registration fees. Radiological Control Program regulations, which already require the registration of individuals who inspect x-ray producing devices in the Commonwealth, do not establish fees for their initial registration or annual renewal. Revenue recovery, as is the practice in other states using x-ray device private inspectors, will help offset administrative costs associated with document collection, review, and approval; the issuance of certificates; and the maintenance of an up-to-date private inspector directory. These fees will help offset such administrative costs that were once supported using general funds allocated to ORH but that have since been abolished.

The purpose of the Commonwealth's X-ray Program is to protect the public from unnecessary radiation due to faulty x-ray equipment or substandard practices, largely identified through inspections. Radiological Control Program regulations require the registration of private inspectors who inspect x-ray producing devices in the Commonwealth. The ORH is proposing fees for the recovery of costs associated with the verification of private inspector academic credentials and professional certifications. This single source verification of private inspector credentials can be considered similar to the licensure procedure for medical professionals and should be performed with no less diligence. These activities require significant attention and expense by ORH staff to confirm private inspector credentials so as to assure public health and worker safety since those individuals inspect and certify x-ray producing devices.

Substance: The proposed amendments establish fees for the registration and annual renewal of registration for individuals who inspect x-ray devices in the Commonwealth.

Issues: The primary advantage of this change to the public and the regulated community is that the establishment of private inspector fees will help offset administrative costs that were once paid using general funds but that have since been abolished. There are no disadvantages to the public in promulgating the proposed fee schedule. Approving the proposed fee structure will allow the Commonwealth to recover more of the costs associated with carrying out the legislative mandate, which will be the primary advantage to the agency and Commonwealth. There are no disadvantages to the agency and Commonwealth in promulgating the proposed fee schedule. Private inspectors of x-ray machines have an interest in ensuring that inspection fees by agency inspectors do not hurt their business by undercutting the private sector pricing, and § 32.1-229.2 of the Code of Virginia requires the agency to establish inspection fees in such a manner so as to minimize competition with the private inspector while recovering costs.

Small Business Impact Review Report of Findings: This proposed regulatory action serves as the report of the findings of the regulatory review pursuant to § 2.2-4007.1 of the Code of Virginia.

Department of Planning and Budget's Economic Impact Analysis:

Summary of the Proposed Amendments to Regulation. The State Board of Health (Board) proposes to amend its Virginia Radiation Protection Regulations: Fee Schedule regulation to set a registration fee for x-ray device private inspectors.

Result of Analysis. There is insufficient information to ascertain whether benefits will outweigh costs for this proposed regulation.

Estimated Economic Impact. Since 2008, x-ray device private inspectors have been required to meet the qualifications in 12VAC5-481-340[1] for registration with the Board but have not historically been charged a fee for that registration. Instead, the Board used its general fund appropriations to cover the cost of administering this registration program. In 2015, the General Assembly removed general fund support for this and other Board registration programs. In 2016, the General Assembly approved legislation that allows the Board to charge x-ray device private inspectors a fee not greater than $150 for annual registration.[2]

The Board now proposes to amend this regulation to require x-ray device private inspectors to pay an annual $150 registration fee. Board staff reports that this fee will cover the costs of staff time spent verifying registrants' education, training and occupational history as well as time spent two times per year maintaining and updating the list of registered inspectors. To the extent that requiring registration of x-ray device private inspectors provides the benefit of additional safety to the public, requiring the payment of fees to support that registration will provide the same benefit. Any benefits would need to be weighed against the additional $150 cost that these inspectors will incur each year to maintain registration.

Businesses and Entities Affected. These proposed regulatory changes will affect the 174 x-ray device private inspectors who are currently registered with the Board, as well as any x-ray device inspectors who may register in the future.

Localities Particularly Affected. No locality is likely to be particularly affected by these proposed regulatory changes.

Projected Impact on Employment. Increasing the cost of entering or remaining in a profession generally will decrease the number of individuals who choose to practice in that profession. Imposing a $150 fee on x-ray device private inspectors may slightly decrease the number of individuals who choose to be inspectors.

Effects on the Use and Value of Private Property. These proposed regulatory changes are unlikely to affect the use or value of private property in the Commonwealth.

Real Estate Development Costs. These proposed regulatory changes are unlikely to affect real estate development costs in the Commonwealth.

Small Businesses:

Definition. Pursuant to § 2.2-4007.04 of the Code of Virginia, small business is defined as "a business entity, including its affiliates, that (i) is independently owned and operated and (ii) employs fewer than 500 full-time employees or has gross annual sales of less than $6 million."

Costs and Other Effects. Board staff reports that all registered x-ray device private inspectors would qualify as small businesses. All of these businesses will incur additional annual costs of $150 per inspector on account of this proposed regulation.

Alternative Method that Minimizes Adverse Impact. There are likely no other available methods that would both meet the Board's goal of having this registration program be self-supporting and further minimize adverse impacts for registrants.

Adverse Impacts:

Businesses. Affected businesses will incur additional annual costs of $150 per inspector on account of this proposed regulation.

Localities. Localities in the Commonwealth are unlikely to see any adverse impacts on account of these proposed regulatory changes.

Other Entities. No other entities are likely to be adversely affected by these proposed changes.

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[1] http://law.lis.virginia.gov/admincode/title12/agency5/chapter481/section340/

[2] http://lis.virginia.gov/cgi-bin/legp604.exe?161+ful+CHAP0685

Agency's Response to Economic Impact Analysis: All users of x-ray machines are required to register with the department prior to the operation of x-ray equipment in the Commonwealth. The application package for this registration can be found at http://www.vdh.virginia.gov/content/uploads/sites/7/2016/10/RH-F-27-PRIVATE-INSPECTOR-APPLICATION-Modified-09-17-2014.pdf.

Further, each registered facility is required to have an inspection performed prior to any operation of x-ray equipment after a new installation or machine relocation.

Individuals who have been qualified by the department in accordance with 12VAC5-481-340, Private inspector qualifications, can perform inspections instead of a department X-Ray Program inspector. Were it not for private inspectors, there could be a delay in the timeliness of inspections as there are only seven department inspectors employed by the Commonwealth, one of whom is the X-Ray Program supervisor. These seven inspectors can accommodate only about 20% of the inspection needs of the Commonwealth, leaving the remaining 80% to the private sector. However, the private inspectors must be qualified and certified to perform and submit the inspections, as described in the above referenced regulation, to ensure a positive safety benefit exists for the public.

It is important to note that medical x-rays cause the majority of the average person's exposure to human-made radiation. The National Academies National Research Council has reported that even low doses of ionizing radiation, such as x-rays, are likely to pose some risk of adverse health effects. State registration and inspection of x-ray equipment is necessary to minimize radiation exposure to the public. The goal and objective of the x-ray program is to ensure that users of x-ray equipment have an effective radiation safety program that reduces the likelihood that individuals receive unnecessary radiation exposure. Effective controls involve the verification of the following by a qualified, certified inspector:

- The x-ray unit performs as designed. This is needed to maintain high quality images and reduce the repeat of x-ray procedures. The result is adequate diagnostic information for appropriate patient care, while minimizing radiation exposure to the patient.
- The training, education, and licensing of x-ray equipment operators are evaluated.
- Surveys of radiation levels in and around the x-ray suite are performed to ensure that regulatory limits are not exceeded. Information is collected to evaluate the potential radiation dose to radiation workers (employees) and the public.
- Radiation dose to patients is evaluated so that medical practitioners can provide patients with information about the dose from an x-ray procedure. Comparing this information between facilities can help practitioners and patients evaluate the risk and benefits of an x-ray procedure.
- Radiation safety procedures concerning a pregnant patient, a pregnant radiation worker, shielding of the patient or staff, and holding or assisting patients can be evaluated.
- Onsite evaluations can help x-ray administrators determine if the cause of poor quality images is due to the performance of the x-ray equipment.

Summary:

The proposed amendments establish fees for the initial registration and subsequent annual renewal of registration for individuals who inspect x-ray devices in the Commonwealth.

12VAC5-490-50. Private inspector registration fees.

A. Individuals included on the Commonwealth's list of qualified inspectors of x-ray machines pursuant to § 32.1-229.1 D 5 of the Code of Virginia as of November 1, 2016, shall pay annually a registration renewal fee of $150 to the Virginia Department of Health X-Ray Program to remain on the list as a qualified inspector of x-ray machines pursuant to 12VAC5-481-340.

B. Individuals requesting to be placed on the Commonwealth's list of qualified inspectors of x-ray

machines pursuant to § 32.1-229.1 D 5 of the Code of Virginia shall:

1. Request approval by the Office of Radiological Health to become a qualified inspector of x-ray machines pursuant to 12VAC5-481-340;

2. Pay an initial registration fee of $150 to the Virginia Department of Health X-Ray Program, once approved; and

3. Pursuant to subsection A of this section, pay annually a registration renewal fee of $150 to remain on the list as a qualified inspector of x-ray machines pursuant to 12VAC5-481-340.

NOTICE: The following form used in administering the regulation was filed by the agency. The form is not being published; however, online users of this issue of the Virginia Register of Regulations may click on the name of the form with a hyperlink to access it. The form is also available from the agency contact or may be viewed at the Office of the Registrar of Regulations, General Assembly Building, 2nd Floor, Richmond, Virginia 23219.

FORMS (12VAC5-490)

Application to be Listed as a Private Inspector of X-ray Machines, RH-F-27 (eff. 9/2014)

VA.R. Doc. No. R17-4856; Filed April 14, 2017, 11:48 a.m.

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

Final Regulation

Title of Regulation: **12VAC30-40. Eligibility Conditions and Requirements (amending 12VAC30-40-290; adding 12VAC30-40-370).**

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

Effective Date: June 15, 2017.

Agency Contact: Emily McClellan, Regulatory Supervisor, Policy Division, Department of Medical Assistance Services, 600 East Broad Street, Suite 1300, Richmond, VA 23219, telephone (804) 371-4300, FAX (804) 786-1680, or email emily.mcclellan@dmas.virginia.gov.

Summary:

Pursuant to Item 307 T of Chapter 665 of the 2015 Acts of Assembly (and continued as Item 313 Q of Chapter 780 of the 2016 Acts of Assembly), the amendments require that payments made to compensate individuals who were involuntarily sterilized pursuant to the Virginia Eugenical Sterilization Act and who are living as of February 1, 2015, (i) are disregarded for the purpose of Medicaid eligibility determinations and (ii) increase the basic personal needs allowance.

Summary of Public Comments and Agency's Response: No public comments were received by the promulgating agency.

12VAC30-40-290. More liberal methods of treating resources under § 1902(r)(2) of the Act: § 1902(f) states.

A. Resources to meet burial expenses. Resources set aside to meet the burial expenses of an applicant/recipient or that individual's spouse are excluded from countable assets. In determining eligibility for benefits for individuals, disregarded from countable resources is an amount not in excess of $3,500 for the individual and an amount not in excess of $3,500 for his spouse when such resources have been set aside to meet the burial expenses of the individual or his spouse. The amount disregarded shall be reduced by:

1. The face value of life insurance on the life of an individual owned by the individual or his spouse if the cash surrender value of such policies has been excluded from countable resources; and

2. The amount of any other revocable or irrevocable trust, contract, or other arrangement specifically designated for the purpose of meeting the individual's or his spouse's burial expenses.

B. Cemetery plots. Cemetery plots are not counted as resources regardless of the number owned.

C. Life rights. Life rights to real property are not counted as a resource. The purchase of a life right in another individual's home is subject to transfer of asset rules. See 12VAC30-40-300.

D. Reasonable effort to sell.

1. For purposes of this section, "current market value" is defined as the current tax assessed value. If the property is listed by a realtor, then the realtor may list it at an amount higher than the tax assessed value. In no event, however, shall the realtor's list price exceed 150% of the assessed value.

2. A reasonable effort to sell is considered to have been made:

a. As of the date the property becomes subject to a realtor's listing agreement if:

(1) It is listed at a price at current market value; and

(2) The listing realtor verifies that it is unlikely to sell within 90 days of listing given the particular circumstances involved (e.g., owner's fractional interest; zoning restrictions; poor topography; absence of road frontage or access; absence of improvements; clouds on title, right of way or easement; local market conditions); or

b. When at least two realtors refuse to list the property. The reason for refusal must be that the property is unsaleable at current market value. Other reasons for refusal are not sufficient; or

c. When the applicant has personally advertised his property at or below current market value for 90 days by use of a "Sale By Owner" sign located on the property and by other reasonable efforts, such as newspaper

advertisements, or reasonable inquiries with all adjoining landowners or other potential interested purchasers.

3. Notwithstanding the fact that the recipient made a reasonable effort to sell the property and failed to sell it, and although the recipient has become eligible, the recipient must make a continuing reasonable effort to sell by:

a. Repeatedly renewing any initial listing agreement until the property is sold. If the list price was initially higher than the tax-assessed value, the listed sales price must be reduced after 12 months to no more than 100% of the tax-assessed value.

b. In the case where at least two realtors have refused to list the property, the recipient must personally try to sell the property by efforts described in subdivision 2 c of this subsection for 12 months.

c. In the case of a recipient who has personally advertised his property for a year without success (the newspaper advertisements and "for sale" sign do not have to be continuous; these efforts must be done for at least 90 days within a 12-month period), the recipient must then:

(1) Subject his property to a realtor's listing agreement at price or below current market value; or

(2) Meet the requirements of subdivision 2 b of this subsection which are that the recipient must try to list the property and at least two realtors refuse to list it because it is unsaleable at current market value; other reasons for refusal to list are not sufficient.

4. If the recipient has made a continuing effort to sell the property for 12 months, then the recipient may sell the property between 75% and 100% of its tax assessed value and such sale shall not result in disqualification under the transfer of property rules. If the recipient requests to sell his property at less than 75% of assessed value, he must submit documentation from the listing realtor, or knowledgeable source if the property is not listed with a realtor, that the requested sale price is the best price the recipient can expect to receive for the property at this time. Sale at such a documented price shall not result in disqualification under the transfer of property rules. The proceeds of the sale will be counted as a resource in determining continuing eligibility.

5. Once the applicant has demonstrated that his property is unsaleable by following the procedures in subdivision 2 of this subsection, the property is disregarded in determining eligibility starting the first day of the month in which the most recent application was filed, or up to three months prior to this month of application if retroactive coverage is requested and the applicant met all other eligibility requirements in the period. A recipient must continue his reasonable efforts to sell the property as required in subdivision 3 of this subsection.

E. Automobiles. Ownership of one motor vehicle does not affect eligibility. If more than one vehicle is owned, the individual's equity in the least valuable vehicle or vehicles must be counted. The value of the vehicles is the wholesale value listed in the National Automobile Dealers Official Used Car Guide (NADA) Book, Eastern Edition (update monthly). In the event the vehicle is not listed, the value assessed by the locality for tax purposes may be used. The value of the additional motor vehicles is to be counted in relation to the amount of assets that could be liquidated that may be retained.

F. Life, retirement, and other related types of insurance policies. Life, retirement, and other related types of insurance policies with face values totaling $1,500 or less on any one person 21 years old and over are not considered resources. When the face values of such policies of any one person ~~exceeds~~ exceed $1,500, the cash surrender value of the policies is counted as a resource.

G. Long-term care partnership insurance policy (partnership policy). Resources equal to the amount of benefits paid on the insured's behalf by the long-term care insurer through a Virginia issued long-term care partnership insurance policy shall be disregarded. A long-term care partnership insurance policy shall meet the following requirements:

1. The policy is a qualified long-term care partnership insurance policy as defined in § 7702B(b) of the Internal Revenue Code of 1986.

2. The policy meets the requirements of the National Association of Insurance Commissioners (NAIC) Long-Term Care Insurance Model Regulation and Long-Term Care Insurance Model Act as those requirements are set forth in § 1917(b)(5)(A) of the Social Security Act (42 USC § 1396p).

3. The policy was issued no earlier than May 1, 2007.

4. The insured individual was a resident of a partnership state when coverage first became effective under the policy. If the policy is later exchanged for a different long-term care policy, the individual was a resident of a partnership state when coverage under the earliest policy became effective.

5. The policy meets the inflation protection requirements set forth in § 1917(b)(1)(C)(iii)(IV) of the Social Security Act.

6. The Insurance Commissioner requires the issuer of the partnership policy to make regular reports to the federal Secretary of Health and Human Services that include notification of the date benefits provided under the policy were paid and the amount paid, the date the policy terminates, and such other information as the secretary determines may be appropriate to the administration of such partnerships. Such information shall also be made available to the Department of Medical Assistance Services upon request.

7. The state does not impose any requirement affecting the terms or benefits of a partnership policy that the state does not also impose on nonpartnership policies.

8. The policy meets all the requirements of the Bureau of Insurance of the State Corporation Commission described in 14VAC5-200.

H. Reserved.

I. Resource exemption for Aid to Dependent Children categorically and medically needy (the Act §§ 1902(a)(10)(A)(i)(III), (IV), (VI), (VII); §§ 1902(a)(10)(A)(ii)(VIII), (IX); § 1902(a)(10)(C)(i)(III)). For ADC-related cases, both categorically and medically needy, any individual or family applying for or receiving assistance may have or establish one interest-bearing savings or investment account per assistance unit not to exceed $5,000 if the applicant, applicants, recipient or recipients designate that the account is reserved for purposes related to self-sufficiency. Any funds deposited in the account shall be exempt when determining eligibility for medical assistance for so long as the funds and interest remain on deposit in the account. Any amounts withdrawn and used for purposes related to self-sufficiency shall be exempt. For purposes of this section, purposes related to self-sufficiency shall include, but are not limited to, (i) paying for tuition, books, and incidental expenses at any elementary, secondary, or vocational school, or any college or university; (ii) for making down payment on a primary residence; or (iii) for establishment of a commercial operation that is owned by a member of the medical assistance unit.

J. Disregard of resources. The Commonwealth of Virginia will disregard all resources for qualified children covered under §§ 1902(a)(10)(A)(i)(I), 1902(a)(10)(A)(i)(III), 1902(a)(10)(A)(ii)(VIII), and 1905(n) of the Social Security Act.

K. Household goods and personal effects. The Commonwealth of Virginia will disregard the value of household goods and personal effects. Household goods are items of personal property customarily found in the home and used in connection with the maintenance, use and occupancy of the premises as a home. Examples of household goods are furniture, appliances, televisions, carpets, cooking and eating utensils and dishes. Personal effects are items of personal property that are worn or carried by an individual or that have an intimate relation to the individual. Examples of personal property include clothing, jewelry, personal care items, prosthetic devices and educational or recreational items such as books, musical instruments, or hobby materials.

L. Determining eligibility based on resources. When determining Medicaid eligibility, an individual shall be eligible in a month if his countable resources were at or below the resource standard on any day of such month.

M. Working individuals with disabilities eligible for assistance under § 1902(a)(10)(A)(ii)(XV) of the Act who wish to increase their personal resources while maintaining eligibility for Medicaid shall establish Work Incentive (WIN) accounts. The Commonwealth will disregard up to the current annual SSI (Social Security Act, § 1619(b)) threshold amount (as established for Virginia by the Social Security Administration) held in WIN accounts for workers with disabilities eligible for assistance under § 1902(a)(10)(A)(ii)(XV) of the Act. To be eligible for this resource disregard, WIN accounts are subject to the following provisions:

1. Deposits to this account shall derive solely from the individual's income earned after electing to enroll in the Medicaid Buy-In (MBI) program.

2. The balance of this account shall not exceed the current annual SSI (Social Security Act § 1619(b)) threshold amount (as established for Virginia by the Social Security Administration).

3. This account will be held separate from nonexempt resources in accounts for which prior approval has been obtained from the department, and for which the owner authorizes regular monitoring and reporting including deposits, withdrawals, and other information deemed necessary by the department for the proper administration of this provision.

4. A spouse's resources will not be deemed to the applicant when determining whether or not the individual meets the financial eligibility requirements for eligibility under this section.

5. Resources accumulated in the Work Incentive account shall be disregarded in determining eligibility for aged, blind, and disabled Medicaid-covered groups for one year after the individual leaves the Medicaid Buy-In program.

6. In addition, excluded from the resource and asset limit include amounts deposited in the following types of IRS-approved accounts established as WIN accounts: retirement accounts, medical savings accounts, medical reimbursement accounts, education accounts and independence accounts. Assets retained in these WIN accounts shall be disregarded for all future Medicaid eligibility determinations for aged, blind, or disabled Medicaid-covered groups.

N. For all aged, blind, or disabled individuals, both categorically needy and medically needy, the Commonwealth shall disregard as resources amounts received as payment for involuntary sterilization under the Virginia Eugenical Sterilization Act, beyond the allowable nine-month exclusion by the SSI program's resource methodologies.

12VAC30-40-370. Variations from the basic personal needs allowance.

For victims of Virginia's eugenical program, the Commonwealth shall, in addition to the basic personal needs allowance (PNA), increase the basic PNA by amounts received as payments for involuntary sterilization under the Virginia Eugenical Sterilization Act.

VA.R. Doc. No. R16-4351; Filed April 14, 2017, 12:09 p.m.

Fast-Track Regulation

Title of Regulation: **12VAC30-40. Eligibility Conditions and Requirements (amending 12VAC30-40-250).**

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: June 14, 2017.

Effective Date: June 29, 2017.

Agency Contact: Emily McClellan, Regulatory Supervisor, Policy Division, Department of Medical Assistance Services, 600 East Broad Street, Suite 1300, Richmond, VA 23219, telephone (804) 371-4300, FAX (804) 786-1680, or email emily.mcclellan@dmas.virginia.gov.

Basis: Section 32.1-325 of the Code of Virginia grants to the Board of Medical Assistance Services the authority to administer and amend the Plan for Medical Assistance, and § 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.

Purpose: The purpose of this action is to implement the changes required by Chapter 567 of the 2016 Acts of Assembly, which states that DMAS shall provide Medicaid coverage to auxiliary grant recipients living in approved supportive housing. Additionally, DMAS shall "seek to amend the state plan for medical assistance under Title XIX of the Social Security Act, and any waivers thereof, to implement the necessary changes pursuant to the provisions of this act."

Currently, the only approved residential settings for auxiliary grant recipients are assisted living facilities and adult foster homes. Chapter 567 adds supportive housing as an approved residential setting for auxiliary grant recipients. A new payment category (reasonable classification) is added to 12VAC30-40-250 in the state plan to achieve this purpose. Maximum rates for homes in the existing payment categories are updated to reflect the current rates.

The amendments provide Medicaid coverage to individuals residing in approved supportive housing and add supportive housing as a third approved residential setting option for auxiliary grant recipients, who automatically qualify for Medicaid. This action will allow auxiliary grant recipients to reside in a setting best suited to their needs. The amendments improve clarity for the public.

Rationale for Using Fast-Track Rulemaking Process: This regulatory action is being promulgated as a fast-track rulemaking action because it is not expected to be controversial. Further, there will be no fiscal or budgetary impact to DMAS, as the funds for this amendment are already provided in the agency's appropriations. As this action provides Medicaid coverage to individuals residing in assisted living housing, members of the public are expected to support these regulatory changes that may positively impact a disadvantaged population.

Substance: With respect to eligibility conditions and requirements, these regulatory amendments will provide Medicaid coverage to individuals residing in approved supportive housing.

Issues: The advantage of this regulatory action is that it enhances Medicaid eligibility by providing a comprehensive service plan of care for auxiliary grant recipients living in approved supportive housing. This action is advantageous to the public. This action does not generate a disadvantage to the public or to the Commonwealth.

Department of Planning and Budget's Economic Impact Analysis:

Summary of the Proposed Amendments to Regulation. On behalf of the Board of Medical Assistance Services, the Director of the Department of Medical Assistance Services proposes to amend the regulation to reflect that Chapter 567 of the 2016 Acts of Assembly (Chapter 567)[1] added supportive housing[2] as a third approved residential setting for auxiliary grant[3] recipients.

Result of Analysis. The proposed amendment creates a net benefit.

Estimated Economic Impact. Prior to Chapter 567, the only approved residential settings for auxiliary grant recipients were assisted living facilities and adult foster homes. The legislation adds supportive housing as a third approved residential setting option for auxiliary grant recipients. Auxiliary grant recipients automatically qualify for Medicaid. The proposed amendment does not in practice affect who qualifies for Medicaid, or where they may reside. Nevertheless, amending the regulation is moderately beneficial in that it improves clarity for the public.

Businesses and Entities Affected. The proposed amendment affects readers of this regulation who may have been misled into thinking that assisted living facilities and adult foster homes were the only approved residential settings for auxiliary grant recipients. Chapter 567 capped the number of auxiliary grant recipients in supportive housing at 60.

Localities Particularly Affected. The proposed amendment does not disproportionately affect specific localities.

Projected Impact on Employment. The proposed amendment does not affect total employment.

Effects on the Use and Value of Private Property. The proposed amendment does not significantly affect the use and value of private property.

Real Estate Development Costs. The proposed amendment does not affect real estate development costs.

Small Businesses:

Definition. Pursuant to § 2.2-4007.04 of the Code of Virginia, small business is defined as "a business entity, including its affiliates, that (i) is independently owned and operated and (ii) employs fewer than 500 full-time employees or has gross annual sales of less than $6 million."

Costs and Other Effects. The proposed amendment does not affect costs for small businesses.

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

Adverse Impacts:

Businesses. The proposed amendment does not adversely affect businesses.

Localities. The proposed amendment does not adversely affect localities.

Other Entities. The proposed amendment does not adversely affect other entities.

[2]"Supportive housing" is defined in Code of Virginia § 51.5-160 as "a residential setting with access to supportive services for an auxiliary grant recipient in which tenancy … is provided or facilitated by a provider licensed to provide mental health community support services, intensive community treatment, programs of assertive community treatment, supportive in-home services, or supervised living residential services that has entered into an agreement with the Department of Behavioral Health and Developmental Services."

[3]The Auxiliary Grants Program is a program to supplement income of an individual receiving Supplemental Security Income (SSI) or an adult who would be eligible for SSI except for excess income, who resides in an assisted living facility, adult foster care, or now due to Chapter 567, supportive housing.

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

Summary:

Pursuant to Chapter 567 of the 2016 Acts of Assembly, the amendments establish Medicaid coverage for auxiliary grant recipients residing in approved supportive housing.

[1]See http://leg1.state.va.us/cgi-bin/legp504.exe?161+ful+CHAP0567

12VAC30-40-250. Standards for optional state supplementary payments.

Payment Category (Reasonable Classification)	Administered by		Income Level		Income Disregards Employed
			Gross	Net	
	Federal	State	1 person/Couple	2 person/Couple	
~~(1)~~	~~(2)~~		~~(3)~~	~~(4)~~	~~(5)~~
~~a)~~ 1. Aged, blind, disabled in domiciliary facilities	X		300% of ~~SSI~~ Supplemental Security Income (SSI) payment limit	~~Rate of home up to specified maximum of $815 per month for allowance for an individual (effective 11/1/00). Maximum for homes in Planning District 8 Increased by 15%.~~ Maximum rates for homes are determined by the General Assembly and are published in the annual state Appropriations Act.	Disregards of SSI Program
~~b)~~ 2. Aged, blind, disabled in approved adult foster care homes	X		300% of SSI payment limit	~~Approved rate for home up to a maximum of $508. Maximum for homes in Planning District 8 increased by 15%.~~ Maximum rates for homes are determined by the General Assembly and are published in the annual state Appropriations Act.	Disregards of SSI Program

3. Aged, blind, disabled in approved supportive housing	X	300% of SSI payment limit	Maximum rates for homes are determined by the General Assembly and are published in the annual state Appropriations Act.	Disregards of SSI Program

VA.R. Doc. No. R17-4994; Filed April 14, 2017, 12:07 p.m.

Fast-Track Regulation

Title of Regulation: **12VAC30-50. Amount, Duration, and Scope of Medical and Remedial Care Services (amending 12VAC30-50-210).**

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: June 14, 2017.

Effective Date: June 29, 2017.

Agency Contact: Emily McClellan, Regulatory Supervisor, Policy Division, Department of Medical Assistance Services, 600 East Broad Street, Suite 1300, Richmond, VA 23219, telephone (804) 371-4300, FAX (804) 786-1680, or email emily.mcclellan@dmas.virginia.gov.

Basis: Section 32.1-325 of the Code of Virginia grants to the Board of Medical Assistance Services the authority to administer and amend the Plan for Medical Assistance, and § 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.

Purpose: This regulatory action permits DMAS to cover insect repellant for Medicaid enrollees of childbearing age if the repellant is prescribed by an authorized health professional. Covering insect repellant could prevent Zika transmission and avert babies being born with microcephaly and other severe brain defects who could eventually need expensive waiver services. Covering insect repellant has significant public health benefits and downstream cost savings in that insect repellant can prevent infection during the early stages of pregnancy when Zika has the most catastrophic impact on fetal development.

Individuals of childbearing age have been defined as women and men aged 14 through 44 years, based on Virginia Department of Health guidelines.

Rationale for Using Fast-Track Rulemaking Process: The fast-track rulemaking process is being utilized to promulgate this change in regulatory language as the change is expected to be a noncontroversial amendment to existing regulations. This regulatory action will represent a significant public health benefit at a relatively low cost. Increasing access to repellant for the fee-for-service (FFS) population will help prevent infection by the Zika virus during the early stages of pregnancy when Zika has the most catastrophic impact on fetal development. Covering repellant in FFS will represent a cost savings because pregnant women are often in FFS during their first and second trimesters.

Substance: An informational bulletin issued by the Centers for Medicare and Medicaid Services entitled "Medicaid Benefits Available for the Prevention, Detection, and Response to the Zika Virus" that was issued on June 1, 2016, permits coverage of insect repellant with a prescription and specifies that repellants would be eligible for federal matching funds.

Ohio currently covers insect repellants as durable medical equipment. Louisiana covers insect repellants under the pharmacy benefit if local mosquito-borne transmission has occurred. Before the emergency regulation took effect, Virginia Premier was the only Medicaid health plan in Virginia that covered insect repellants with a prescription for all of its Medicaid members.

There are approximately 4,700 pregnant women in fee-for-service Medicaid and FAMIS in any given month, and additional women are covered by Medicaid managed care. Many of these women are in the early stages of pregnancy. Covering insect repellant has significant public health benefits and downstream cost savings in that insect repellant can prevent infection during the early stages of pregnancy when Zika has the most catastrophic impact on fetal development.

These regulations will cover insect repellants that have been evaluated and registered by the U.S. Environmental Protection Agency (EPA) for effectiveness. More specifically, these include EPA-registered insect repellants with one of the following active ingredients: DEET, picaridin, IR3535, oil of lemon eucalyptus, or para-menthane-diol.

Issues: The Centers for Medicare and Medicaid Services has encouraged state Medicaid programs to cover insect repellants when prescribed by an authorized health professional. The primary advantage to the public and to the Commonwealth from covering insect repellant for pregnant women in fee-for-service Medicaid and Medicaid managed care plans is that this coverage could prevent Zika transmission and prevent children born with microcephaly and other severe brain defects. Investing in the coverage of insect repellant now could prevent a child from being born with microcephaly who could eventually need expensive intellectual disability waiver or other waiver services.

It is evidenced that mosquito-borne Zika infections are now originating in the United States, and there is a threat that

Virginia residents may soon be subject to locally-based Zika infection. The lack of access to insect repellant for Medicaid enrollees in Virginia has created an urgent situation that necessitates the implementation of regulations to address this emerging public health threat. Infection by the Zika virus during the early stages of pregnancy can have a catastrophic impact on fetal development, thereby positioning insect repellant as a critical need for Medicaid enrollees of childbearing age. Further regulatory action is needed for DMAS to speedily address the increased likelihood of Zika virus transmission in Virginia and specifically for Medicaid and FAMIS enrollees.

There are no disadvantages to the public or the Commonwealth related to this regulatory action.

Department of Planning and Budget's Economic Impact Analysis:

Summary of the Proposed Amendments to Regulation. The proposed regulation will make permanent an emergency regulation providing Medicaid coverage for insect repellents prescribed to individuals of childbearing age and all pregnant women to prevent transmission of the Zika virus.

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

Estimated Economic Impact. On June 1, 2016, the Centers for Medicare and Medicaid Services issued guidelines describing Medicaid benefits available for prevention, detection, and response to the Zika virus and permitted coverage of insect repellents with a prescription. The Zika virus is spread to people primarily through the bite of an infected mosquito. The Zika virus can also be sexually transmitted between partners regardless of gender. Infection by the Zika virus during the early stages of pregnancy may cause babies to be born with microcephaly (i.e., an unusually small head, often accompanied by brain damage). Other problems have been detected in fetuses and infants infected with Zika virus, such as defects of the eye, hearing deficits, and impaired growth. Protection against mosquito bites is one of the major means of prevention in addition to mosquito control and contraceptives.

Upon request by the Department of Medical Assistance Services (DMAS) citing 48 confirmed cases of Zika virus infection in the Commonwealth, the Governor approved the issuance of an emergency regulation on August 12, 2016, to provide coverage for mosquito repellents to men and women between the reproductive ages of 14 through 44 years and all pregnant women. Approved repellents are those that have been evaluated and registered by the Environmental Protection Agency containing specific active ingredients. In addition, the repellent must be prescribed by an authorized health professional. However, recipients are advised to call their doctors or health care providers and ask them to send a prescription for the mosquito repellent to their pharmacy and not to request an office visit unless there is a medical necessity or it is required by the health care provider.

According to DMAS, there are approximately 4,700 pregnant women in Fee-for-Service Medicaid and FAMIS programs in any given month many of whom are at the early stages of pregnancy. Last year from middle of August to end of November, DMAS paid $383.21 for 39 claims, or $9.83 per claim.[1] DMAS expects a higher utilization in the upcoming year because the coverage will start at the beginning of May rather than the middle of August, and the awareness of Zika risks and its coverage will likely be greater this year.

The main economic benefit of the proposed coverage is the prevention of children being born with microcephaly and other birth defects. A catastrophic impact on fetal development as a result of Zika virus infection could necessitate utilization of expensive ID/D Waiver or other waiver services later on. Avoidance of any such costs through prevention is the main economic benefit of this proposed regulation.

Businesses and Entities Affected. The insect repellents can be prescribed to Medicaid recipients between the ages of 14 through 44 years and all pregnant women under the proposed regulation. In the last Zika season, there were 39 claims paid.

Localities Particularly Affected. The proposed regulation applies statewide.

Projected Impact on Employment. No significant impact on employment is expected.

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

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

Small Businesses:

Definition. Pursuant to § 2.2-4007.04 of the Code of Virginia, small business is defined as "a business entity, including its affiliates, that (i) is independently owned and operated and (ii) employs fewer than 500 full-time employees or has gross annual sales of less than $6 million."

Costs and Other Effects. The coverage of insect repellents by public funds would theoretically lead to increased sales at pharmacies some of which are small businesses. However, the magnitude of this effect based on last year's data was negligible (i.e., $383.21).

Alternative Method that Minimizes Adverse Impact. No adverse impact on small businesses is expected.

Adverse Impacts:

Businesses. The proposed amendments do not have an adverse impact on non-small businesses.

Localities. The proposed amendments will not adversely affect localities.

Other Entities. The proposed amendments will not adversely affect other entities.

[1]Normally Medicaid pays a dispensing fee per prescription. The dispensing fee was $3.75 prior to 1/9/2017 and now is $10.65. However, a pharmacy may not bill more than its usual and customary price and therefore may not be able to bill for the dispensing fee. In other words, a pharmacy would not be paid more than what a cash paying customer would pay for a repellent.

Agency's Response to Economic Impact Analysis: The agency has reviewed the economic impact analysis prepared by the Department of Planning and Budget and raises no issues with this analysis.

Summary:

The amendment provides Medicaid coverage for mosquito repellants prescribed by an authorized health professional for individuals of childbearing age and all pregnant women to prevent the transmission of the Zika virus.

12VAC30-50-210. Prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist.

A. Prescribed drugs.

1. Drugs for which Federal Financial Participation is not available, pursuant to the requirements of § 1927 of the Social Security Act (OBRA 90 § 4401), shall not be covered.

2. Nonlegend drugs shall be covered by Medicaid in the following situations:

a. Insulin, syringes, and needles for diabetic patients;

b. Diabetic test strips for Medicaid recipients under 21 years of age;

c. Family planning supplies;

d. Designated categories of nonlegend drugs for Medicaid recipients in nursing homes; ~~and~~

e. Designated drugs prescribed by a licensed prescriber to be used as less expensive therapeutic alternatives to covered legend drugs; and

f. U.S. Environmental Protection Agency-registered insect repellents with one of the following active ingredients: DEET, picaridin, IR3535, oil of lemon eucalyptus, or p-Menthane-3,8-diol for all Medicaid members of reproductive age (ages 14 through 44 years) and all pregnant women, when prescribed by an authorized health professional.

3. Legend drugs are covered for a maximum of a 34-day supply per prescription per patient with the exception of the drugs or classes of drugs identified in 12VAC30-50-520. FDA-approved drug therapies and agents for weight loss, when preauthorized, will be covered for recipients who meet the strict disability standards for obesity established by the Social Security Administration in effect on April 7, 1999, and whose condition is certified as life threatening, consistent with Department of Medical Assistance Services' medical necessity requirements, by the treating physician. For prescription orders for which quantity exceeds a 34-day supply, refills may be dispensed in sufficient quantity to fulfill the prescription order within the limits of federal and state laws and regulations.

4. Prescriptions for Medicaid recipients for multiple source drugs subject to 42 CFR 447.332 shall be filled with generic drug products unless the physician or other ~~practitioners~~ practitioner so licensed and certified to prescribe drugs certifies in his own handwriting "brand necessary" for the prescription to be dispensed as written or unless the drug class is subject to the Preferred Drug List.

5. New drugs shall be covered in accordance with the Social Security Act § 1927(d) (OBRA 90 § 4401).

6. The number of refills shall be limited pursuant to § 54.1-3411 of the Drug Control Act.

7. Drug prior authorization.

a. Definitions. The following words and terms used in ~~these regulations~~ this subdivision 7 shall have the following meanings unless the context clearly indicates otherwise:

"Clinical data" means drug monographs as well as any pertinent clinical studies, including peer review literature.

"Complex drug regimen" means treatment or course of therapy that typically includes multiple medications, co-morbidities ~~and/or~~, or caregivers.

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

"Drug" shall have the same meaning, unless the context otherwise dictates or the board otherwise provides by regulation, as provided in the Drug Control Act (§ 54.1-3400 et seq. of the Code of Virginia).

"Emergency supply" means 72-hour supplies of the prescribed medication that may be dispensed if the prescriber cannot readily obtain authorization, or if the physician is not available to consult with the pharmacist, including after hours, weekends, holidays and the pharmacist, in his professional judgment consistent with current standards of practice, feels that the patient's health would be compromised without the benefit of the drug, or other criteria defined by the Pharmacy and Therapeutics Committee and DMAS.

"Nonpreferred drugs" means those drugs that were reviewed by the Pharmacy and Therapeutics Committee and not included on the preferred drug list. Nonpreferred drugs may be prescribed but require authorization prior to dispensing to the patient.

"Pharmacy and Therapeutics Committee," "P&T Committee" or "committee" means the committee formulated to review therapeutic classes, conduct clinical reviews of specific drugs, recommend additions or deletions to the preferred drug list, and perform other functions as required by the department.

"Preferred drug list" or "PDL" means the list of drugs that meet the safety, clinical efficacy, and pricing standards employed by the P&T Committee and adopted by the department for the Virginia Medicaid fee-for-service program. Most drugs on the PDL may be

prescribed and dispensed in the Virginia Medicaid fee-for-service program without prior authorization; however, some drugs as recommended by the Pharmacy and Therapeutics Committee may require authorization prior to dispensing to the patient.

"Prior authorization," as it relates to the PDL, means the process of review by a clinical pharmacist of legend drugs that are not on the preferred drug list, or other drugs as recommended by the Pharmacy and Therapeutics Committee, to determine if medically justified.

"State supplemental rebate" means any cash rebate that offsets Virginia Medicaid expenditure and that supplements the federal rebate. State supplemental rebate amounts shall be calculated in accordance with the Virginia Supplemental Drug Rebate Agreement Contract and Addenda.

"Therapeutic class" means a grouping of medications sharing the same Specific Therapeutic Class Code (GC3) within the Federal Drug Data File published by First Data Bank, Inc.

"Utilization review" means the prospective and retrospective processes employed by the agency to evaluate the medical necessity of reimbursing for certain covered services.

b. Medicaid Pharmacy and Therapeutics Committee.

(1) The department shall utilize a Pharmacy and Therapeutics Committee to assist in the development and ongoing administration of the preferred drug list and other pharmacy program issues. The committee may adopt bylaws that set out its make-up and functioning. A quorum for action of the committee shall consist of seven members.

(2) Vacancies on the committee shall be filled in the same manner as original appointments. DMAS shall appoint individuals for the committee that assures a cross-section of the physician and pharmacy community and remains compliant with General Assembly membership guidelines.

(3) Duties of the committee. The committee shall receive and review clinical and pricing data related to the drug classes. The committee's medical and pharmacy experts shall make recommendations to DMAS regarding various aspects of the pharmacy program. For the preferred drug list program, the committee shall select those drugs to be deemed preferred that are safe, clinically effective, as supported by available clinical data, and meet pricing standards. Cost effectiveness or any pricing standard shall be considered only after a drug is determined to be safe and clinically effective.

(4) As the ~~United States~~ U.S. Food and Drug Administration (FDA) approves new drug products, the department shall ensure that the Pharmacy and Therapeutics Committee will evaluate the drug for clinical effectiveness and safety. Based on clinical information and pricing standards, the P&T Committee will determine if the drug will be included in the PDL or require prior authorization.

(a) If the new drug product falls within a drug class previously reviewed by the P&T Committee, until the review of the new drug is completed, it will be classified as nonpreferred, requiring prior authorization in order to be dispensed. The new drug will be evaluated for inclusion in the PDL no later than at the next review of the drug class.

(b) If the new drug product does not fall within a drug class previously reviewed by the P&T Committee, the new drug shall be treated in the same manner as the other drugs in its class.

(5) To the extent feasible, the Pharmacy and Therapeutics Committee shall review all drug classes included in the preferred drug list at least every 12 months and may recommend additions to and deletions from the PDL.

(6) In formulating its recommendations to the department, the committee shall not be deemed to be formulating regulations for the purposes of the Administrative Process Act (§ 2.2-4000 et seq. of the Code of Virginia).

(7) Immunity. The members of the committee and the staff of the department and the contractor shall be immune, individually and jointly, from civil liability for any act, decision, or omission done or made in performance of their duties pursuant to this subsection while serving as a member of such board, committee, or staff provided that such act, decision, or omission is not done or made in bad faith or with malicious intent.

c. Pharmacy prior authorization program. Pursuant to § 1927 of the Act and 42 CFR 440.230, the department shall require the prior authorization of certain specified legend drugs. For those therapeutic classes of drugs subject to the PDL program, drugs with nonpreferred status included in the DMAS drug list shall be subject to prior authorization. The department also may require prior authorization of other drugs only if recommended by the P&T Committee. Providers who are licensed to prescribe legend drugs shall be required to obtain prior authorization for all nonpreferred drugs or other drugs as recommended by the P&T Committee.

(1) Prior authorization shall consist of prescription review by a licensed pharmacist or pharmacy technician to ensure that all predetermined clinically appropriate criteria, as established by the P&T Committee relative to each therapeutic class, have been met before the prescription may be dispensed. Prior authorization shall be obtained through a call center staffed with appropriate clinicians, or through written or electronic

communications (e.g., faxes, mail). Responses by telephone or other telecommunications device within 24 hours of a request for prior authorization shall be provided. The dispensing of 72-hour emergency supplies of the prescribed drug may be permitted and dispensing fees shall be paid to the pharmacy for such emergency supply.

(2) The preferred drug list program shall include: (i) provisions for an expedited review process of denials of requested prior authorization by the department; (ii) consumer and provider education; (iii) training and information regarding the preferred drug list both prior to implementation as well as ongoing communications, to include computer and website access to information and multilingual material.

(3) Exclusion of protected groups from pharmacy preferred drug list prior authorization requirements. The following groups of Medicaid eligibles shall be excluded from pharmacy prior authorization requirements: individuals enrolled in hospice care, services through PACE or pre-PACE programs; persons having comprehensive third party insurance coverage; minor children who are the responsibility of the juvenile justice system; and refugees who are not otherwise eligible in a Medicaid covered group.

d. State supplemental rebates. The department has the authority to seek supplemental rebates from pharmaceutical manufacturers. The contract regarding supplemental rebates shall exist between the manufacturer and the Commonwealth. Rebate agreements between the Commonwealth and a pharmaceutical manufacturer shall be separate from the federal rebates and in compliance with federal law, §§ 1927(a)(1) and 1927(a)(4) of the Social Security Act. All rebates collected on behalf of the Commonwealth shall be collected for the sole benefit of the state share of costs. One hundred percent of the supplemental rebates collected on behalf of the state shall be remitted to the state. Supplemental drug rebates received by the Commonwealth in excess of those required under the national drug rebate agreement will be shared with the federal government on the same percentage basis as applied under the national drug rebate agreement.

e. Pursuant to 42 USC § 1396r-8(b)(3)(D), information disclosed to the department or to the committee by a pharmaceutical manufacturer or wholesaler which discloses the identity of a specific manufacturer or wholesaler and the pricing information regarding the drugs by such manufacturer or wholesaler is confidential and shall not be subject to the disclosure requirements of the Virginia Freedom of Information Act (§ 2.2-3700 et seq. of the Code of Virginia).

f. Appeals for denials of prior authorization shall be addressed pursuant to 12VAC30-110, Part I, Client Appeals.

8. Coverage of home infusion therapy. This service shall be covered consistent with the limits and requirements set out within home health services (12VAC30-50-160). Multiple applications of the same therapy (e.g., two antibiotics on the same day) shall be covered under one service day rate of reimbursement. Multiple applications of different therapies (e.g., chemotherapy, hydration, and pain management on the same day) shall be a full service day rate methodology as provided in pharmacy services reimbursement.

B. Dentures. Dentures are provided only as a result of EPSDT and subject to medical necessity and preauthorization requirements specified under Dental Services.

C. Prosthetic devices.

1. Prosthetic services shall mean the replacement of missing arms, legs, eyes, and breasts and the provision of any internal (implant) body part. Nothing in this regulation shall be construed to refer to orthotic services or devices or organ transplantation services.

2. Artificial arms and legs, and their necessary supportive attachments, implants and breasts are provided when prescribed by a physician or other licensed practitioner of the healing arts within the scope of their professional licenses as defined by state law. This service, when provided by an authorized vendor, must be medically necessary and preauthorized for the minimum applicable component necessary for the activities of daily living.

3. Eye prostheses are provided when eyeballs are missing regardless of the age of the recipient or the cause of the loss of the eyeball. Eye prostheses are provided regardless of the function of the eye.

D. Eyeglasses. Eyeglasses shall be reimbursed for all recipients younger than 21 years of age according to medical necessity when provided by practitioners as licensed under the Code of Virginia.

VA.R. Doc. No. R17-4835; Filed April 14, 2017, 11:57 a.m.

Proposed Regulation

Titles of Regulations: **12VAC30-50. Amount, Duration, and Scope of Medical and Remedial Care Services (amending 12VAC30-50-130).**

12VAC30-120. Waivered Services (amending 12VAC30-120-900, 12VAC30-120-935).

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: July 14, 2017.

Agency Contact: Emily McClellan, Regulatory Supervisor, Policy Division, Department of Medical Assistance Services,

600 East Broad Street, Suite 1300, Richmond, VA 23219, telephone (804) 371-4300, FAX (804) 786-1680, or email emily.mcclellan@dmas.virginia.gov.

Basis: Section 32.1-325 of the Code of Virginia grants to the Board of Medical Assistance Services the authority to administer and amend the Plan for Medical Assistance, and § 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.

Pursuant to § 2.2-4011 A of the Code of Virginia, DMAS certified that an emergency exists affecting the health, safety, and welfare of Medicaid individuals who are electing to use consumer-directed services but who are not being adequately or appropriately supported by services facilitators, and the Governor of Virginia authorized the emergency regulations. These proposed permanent regulations follow the emergency regulations pursuant to § 2.2-4007.05 of the Code of Virginia.

Purpose: In select Medicaid home and community based services (HCBS) waivers and through the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program (for personal care only), enrolled individuals with a need for personal assistance, respite, or companion services may receive these services using the consumer-directed (CD) model of service delivery, the agency-directed (AD) model of service delivery, or a combination of both. The CD model differs from the AD model by offering the individual the option to be the employer (hiring, training, scheduling, and firing) of attendants who are the individual's employees. Unlike the AD model, there is no home health agency involved in the selection and management of personal care attendants; the individual enrolled in the waiver is the employer. If the individual is unable to perform employer functions, or is younger than 18 years of age, and still elects to receive CD care, then a family member or caregiver must serve as the employer of record (EOR).

Individuals in the Elderly or Disabled with Consumer Direction (EDCD) Waiver have the option of CD services if criteria are met. The EPSDT program children also have the option of CD personal care services.

Individuals choosing CD services in the waivers stated receive support from a CD services facilitator in conjunction with CD services. The CD services facilitator is responsible for assessing the individual's particular needs for a requested CD service, assisting in the development of the plan of care, assuring service authorizations are submitted for care needs, providing training to the individual and family/caregiver on their responsibilities as an employer, and providing ongoing support of the CD services. The services facilitator provides necessary supportive services that are designed to assist the individual in his employment duties. Services facilitators are essential to the health, safety, and welfare of this vulnerable population receiving CD services.

Substance: The regulations that are affected by this action are: Amount, Duration, and Scope of Services Early and Periodic Screening, Diagnosis, and Treatment (12VAC30-50-130) and Waiver Services for the Elderly or Disabled with Consumer Direction (12VAC30-120-900 and 12VAC30-120-935).

Individuals enrolled in certain home and community-based waivers or who receive personal care through EPSDT may choose between receiving services through a Medicaid enrolled provider agency or by using the consumer-directed model. Individuals who prefer to receive their personal care services through an agency are the beneficiaries of a number of administrative type functions, the most important of which is the preparation of an individualized service plan (ISP) and the monitoring of those services to ensure quality and appropriateness. This ISP sets out all the services (types, frequency, amount, duration) that the individual requires and that his physician has ordered.

The consumer-directed model differs from agency-directed services by allowing the Medicaid-enrolled individual to develop his or her own service plan and self-monitor the quality of those services. To receive CD services, the individual or another designated individual must act as the employer of record. The EOR hires, trains, and supervises the attendant or attendants. A minor child (younger than 18 years of age) is required to have an EOR. Services facilitation is a service that assists the individual (and the individual's family or caregiver, as appropriate) in arranging for, directing, and managing services provided through the consumer-directed model.

Currently, there is no process to verify that potential or enrolled services facilitators are qualified to perform or possess the knowledge, skills, and abilities related to the duties they must fulfill as outlined in current regulations. Consumer-directed services facilitators are not licensed by any governing body, nor do they have any degree or training requirements established in regulation. Other types of Virginia Medicaid-enrolled providers are required by the Commonwealth to have degrees, meet licensing requirements, or demonstrate certifications as precursors to being Medicaid-enrolled providers.

The regulations will provide the basis for the department to ensure qualified services facilitators are enrolled as service providers and receive reimbursement under the EDCD waiver and through EPSDT. These regulations are also needed to ensure that enrolled services facilitator providers employ staff who also meet these qualifications. The regulations will ensure that services facilitators have the training and expertise to effectively address the needs of those individuals who are enrolled in home and community-based waivers who direct their own care. As part of the process, DMAS used the participatory approach and has obtained input from stakeholders into the design of these regulations.

The regulations will positively impact those choosing to direct their own care under the home and community-based waiver and through EPSDT by ensuring the services facilitators are qualified and can be responsive to the needs of the population.

For both the Elderly or Disabled with Consumer Direction (EDCD) waiver as well as personal care services covered under the authority of the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program, the proposed amendments require that (i) service facilitators (SFs) complete DMAS-approved consumer-directed service facilitator training and pass the corresponding competency assessment with a score of at least 80% and (ii) new SFs (a) possess either a minimum of an associate's degree or higher from an accredited college in a health or human services field or be a registered nurse currently licensed to practice in the Commonwealth and possess a minimum of two years of satisfactory direct care experience supporting individuals with disabilities or older adults or (b) possess a bachelor's degree or higher in a non-health or human services field and have a minimum of three years of satisfactory direct care experience supporting individuals with disabilities or older adults.

For the EPSDT program, the proposed amendments require that (i) all consumer-directed personal care services have an SF, (ii) if the SF is not a registered nurse, that the SF inform the primary health care provider for the individual who is enrolled in the waiver that services are being provided and request consultation with the primary health care provider, as needed, (iii) the SF have a satisfactory work record as evidenced by two references from prior job experiences from any human services work, (iv) the SF submit to a criminal background check, and (v) the SF submit to a search of the Virginia Department of Social Services (VDSS) Child Protective Services Central Registry. These five items are already required under the EDCD waiver. Additionally, the proposed regulation includes amendments that improve the clarity of current requirements.

Issues: Currently, there is no process to verify that potential or enrolled services facilitators are qualified to perform or possess the knowledge, skills, and abilities related to the duties they must fulfill as outlined in current regulations. Consumer-directed services facilitators are not licensed by any governing body, nor are any degree or training requirements established in regulation. The primary advantage of this regulatory action to Medicaid individuals is that services facilitators will now have to meet established criteria and demonstrate specific knowledge, skills, and abilities in order to be reimbursed by Medicaid for services facilitation. Other types of Virginia Medicaid-enrolled providers are required by the Commonwealth to have degrees, meet licensing requirements, or demonstrate certifications as precursors to being Medicaid-enrolled providers. There are no disadvantages to the Commonwealth in the establishment of these standards and criteria as citizens will receive better care.

Department of Planning and Budget's Economic Impact Analysis:

Summary of the Proposed Amendments to Regulation. Pursuant to Item 307 XXX of the 2012 Appropriation Act,[1,2] and on behalf of the Board of Medical Assistance Services, the Director (Director) of the Department of Medical Assistance Services (DMAS) proposes several amendments to the regulation with the aim of strengthening the qualifications and responsibilities of consumer-directed services facilitators (SFs) to ensure the health, safety and welfare of Medicaid home and community-based waiver participants. The proposal was first implemented in an emergency regulation, which expires on July 10, 2017. The Director is now proposing to make the amendments permanent.

For both the Elderly or Disabled with Consumer Direction (EDCD) waiver as well as personal care services covered under the authority of the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program, the Director proposes to require that: 1) SFs complete DMAS-approved consumer-directed SF training and pass the corresponding competency assessment with a score of at least 80%, and 2) new SFs possess a) a minimum of either an associate's degree or higher from an accredited college in a health or human services field or be a registered nurse currently licensed to practice in the Commonwealth and possess a minimum of two years of satisfactory direct care experience supporting individuals with disabilities or older adults or b) possess a bachelor's degree or higher in a non-health or human services field and have a minimum of three years of satisfactory direct care experience supporting individuals with disabilities or older adults.

For the EPSDT program, the Director proposes to require that: 1) there be SFs for all consumer-directed personal care services, 2) if the SF is not a registered nurse (RN), that the SF inform the primary health care provider for the individual who is enrolled in the waiver that services are being provided and request consultation with the primary health care provider, as needed, 3) the SF have a satisfactory work record as evidenced by two references from prior job experiences from any human services work, 4) the SF submit to a criminal background check, and 5) the SF submit to a search of the Virginia Department of Social Services (VDSS) Child Protective Services Central Registry. These five items are already required under the EDCD waiver. Additionally, the proposed regulation includes amendments that improve the clarity of current requirements.

Result of Analysis. For the majority of the proposed amendments the benefits clearly exceed the costs. For other proposed changes it is less certain.

Estimated Economic Impact.

Background:

Individuals enrolled in certain home and community-based waiver programs or who receive personal care through

EPSDT may choose between receiving services through a Medicaid enrolled provider agency or by using the consumer-directed model. Individuals who prefer to receive their personal care services through an agency are the beneficiaries of a number of administrative type functions, the most important of which is the preparation of plan of care and the monitoring of those services to ensure quality and appropriateness. This plan of care sets out all the services (types, frequency, amount, duration) that the individual requires and that his physician has ordered.

To receive consumer-directed (CD) services, the individual receiving services or another designated individual must act as the employer of record. The employer of record hires, trains, and supervises attendants. Services facilitation is a service that assists the individual (and the individual's family or caregiver, as appropriate) in arranging for, directing, and managing services provided through the consumer-directed model.

Individuals choosing CD services may receive support from an SF in conjunction with the CD services. The SF is responsible for assessing the individual's particular needs for a requested CD service, assisting in the development of the plan of care, assuring service authorizations are submitted for care needs, providing training to the individual and family/caregiver on their responsibilities as an employer, and providing ongoing support of the CD services. The SF provides necessary supportive services that are designed to assist the individual in his employment duties.

Currently, the DMAS quality management review process verifies that potential or enrolled SFs are qualified to perform or possess the knowledge, skills, and abilities related to the duties they must fulfill as outlined in current regulations. Consumer-directed SFs are not licensed by any governing body, nor do they have any degree or training requirements established in regulation. Other types of Virginia Medicaid-enrolled providers are required by the Commonwealth to have degrees, meet licensing requirements, or demonstrate certifications as precursors to being Medicaid-enrolled providers.

Training and Competency Assessment:

The Director proposes to require that all SFs complete DMAS-approved consumer-directed services facilitator training and pass the corresponding competency assessment with a score of at least 80%. The training is an online, web-based curriculum containing five modules. It is available at any time of day and may be taken at any location that has access to the Internet. No fee is charged. DMAS and the Partnership for People with Disabilities will track and produce training certificates for each services facilitator successfully completing the training. The only recordkeeping requirement is the retention of the training certificates and documented education, knowledge, skills, and abilities in each services facilitator's personnel record and submission of the certificate at the time of application for enrollment or renewal as a Medicaid provider. DMAS estimates that the training and assessment should take approximately four hours to complete. To the extent that the training is well designed to prepare individuals to become competent SFs and the assessment accurately assesses competence, the benefit of this proposed requirement likely exceeds the time and recordkeeping costs expended.

College Education and Experience:

The Director proposes to require that prior to enrollment by DMAS as a consumer-directed SF, all new applicants possess, at a minimum, either an associate's degree or higher from an accredited college in a health or human services field or be a registered nurse currently licensed to practice in Commonwealth and possess a minimum of two years of satisfactory direct care experience supporting individuals with disabilities or older adults; or possess a bachelor's degree or higher in a non-health or human services field and have a minimum of three years of satisfactory direct care experience supporting individuals with disabilities or older adults. Whether costs exceed the benefits of requiring a college degree are indeterminate. Someone without a college degree who meets all other requirements, including completing the DMAS-approved consumer-directed services facilitator training and passing the corresponding competency assessment, could arguably be as competent as an SF as someone with a college degree.

Requirement to Have a Services Facilitator:

According to DMAS, of the thousands of individuals receiving consumer-directed personal care services, all had an SF prior to the emergency regulation going into effect. Thus the proposal to require that there be SFs for all consumer-directed personal care services in EPSDT does not have a current impact. The proposal would preclude any potential individuals in the future from receiving consumer-directed personal care services under EPSDT without an SF, even if that were to be their preference. The benefit of the services and reduced risk of administrative problems likely exceeds the potential small cost of the elimination of that option.

If the Services Facilitator Is Not a Registered Nurse:

For EPSDT, the Director proposes to require that if the SF is not an RN, then the SF must inform the primary health care provider for the individual who is enrolled in the waiver that services are being provided within 30 days from the start of such services and request consultation with the primary health care provider, as needed. This must be done after the SF secures written permission from the individual to contact the primary health care provider. The documentation of this written permission to contact the primary health care provider must be retained in the individual's medical record. All contacts with the primary health care provider must be documented in the individual's medical record. This proposal would create some additional time cost for the SF, but the benefit of coordinated care with the primary health care provider likely exceeds the small time cost.

References:

For EPSDT, the Director proposes to require that the SF have a satisfactory work record as evidenced by two references from prior job experiences from any human services work; such references shall not include any evidence of abuse, neglect, or exploitation of the elderly or persons with disabilities or children. According to DMAS, most if not all SFs who serve EPSDT program recipients also serve EDCD clients. SFs who serve EDCD clients must have already met this requirement. For any current or future SFs who do not serve EDCD clients, this proposal introduces some time cost; but the benefit of reducing the likelihood of an abusive person being paid to care for someone who is vulnerable likely exceeds the cost.

Criminal Background Check and Child Protective Services Central Registry Search

For EPSDT, the Director proposes to require that the SF submit to a criminal background check being conducted. The results of such check must contain no record of conviction of barrier crimes as set forth in § 32.1-162.9:1 of the Code of Virginia. Proof that the criminal record check was conducted shall be maintained in the record of the SF. DMAS will not reimburse the provider for any services provided by a services facilitator who has been convicted of committing a barrier crime as set forth in § 32.1-162.9:1 of the Code of Virginia. Also the Director proposes to require that SFs submit to a search of the VDSS Child Protective Services Central Registry which results in no founded complaint. The Virginia State Police charge a $15 fee for a criminal background check that does not include fingerprinting,[3] while VDSS currently charges $10 for a Child Protective Services Central Registry search of nonvolunteers.[4] As referenced above, most if not all SFs who serve EPSDT program recipients also serve EDCD clients; and SFs who serve EDCD clients must have already met these requirements. The proposals would affect any current or future SFs who do not serve EDCD clients. Given the benefit of reducing the likelihood of an abusive person being paid to care for someone vulnerable, the benefits of these proposed requirements likely exceed the cost.

Businesses and Entities Affected. The proposed amendments affect individuals who receive consumer-directed Medicaid personal care services and the 540 Medicaid-enrolled services facilitators and agencies.[5] Most of these businesses qualify as small businesses.[6]

Localities Particularly Affected. The proposed amendments do not disproportionately affect specific localities.

Projected Impact on Employment. The proposed amendments do not significantly affect total employment.

Effects on the Use and Value of Private Property. The proposed amendments do not significantly affect the use and value of private property.

Real Estate Development Costs. The proposed amendments do not affect real estate development costs.

Small Businesses:

Definition. Pursuant to § 2.2-4007.04 of the Code of Virginia, small business is defined as "a business entity, including its affiliates, that (i) is independently owned and operated and (ii) employs fewer than 500 full-time employees or has gross annual sales of less than $6 million."

Costs and Other Effects. Several of the proposed amendments increase costs for small businesses that provide consumer directed services facilitators for Medicaid home and community-based waiver participants. The proposal to require that SFs have a college degree limits the pool of candidates who can work as an SF. This may increase labor costs for small firms. The proposed requirements for: 1) SFs who are not an RN, 2) references, 3) criminal background checks, 4) Child Protective Services Central Registry searches, and 5) training and competency assessments all increase staff time requirements. The proposed required criminal background checks and Child Protective Services Central Registry searches cost $25 in fees for each SF who has not already had this done.[7]

Alternative Method that Minimizes Adverse Impact. Not requiring a college degree to be an SF would likely reduce labor costs for at least some of the small firms providing services for Medicaid home and community-based waiver participants. Given that someone without a college degree who meets all other requirements, including completing the DMAS-approved consumer-directed services facilitator training and passing the corresponding competency assessment, could arguably be as competent as an SF as someone with a college degree, eliminating this requirement could potentially reduce the adverse impact for small businesses without putting the public at risk.

Adverse Impacts:

Businesses. Several of the proposed amendments increase costs for businesses that provide consumer directed services facilitators for Medicaid home and community-based waiver participants. The proposal to require that SFs have a college degree limits the pool of candidates who can work as an SF. This may increase labor costs for firms. The proposed requirements for: 1) SFs who are not an RN, 2) references, 3) criminal background checks, 4) Child Protective Services Central Registry searches, and 5) training and competency assessments all increase staff time requirements. The proposed required criminal background checks and Child Protective Services Central Registry searches cost $25 in fees for each SF who has not already had this done.[8]

Localities. The proposed amendments do not adversely affect localities.

Other Entities. Several of the proposed amendments increase costs for individuals to become an SF. The proposal to require that SFs have a college degree requires individuals who do not already have a degree to expend the months or years[9] and likely thousands of dollars necessary to complete a degree. The proposed requirements for: 1) SFs who are not an

RN, 2) references, 3) criminal background checks, 4) Child Protective Services Central Registry searches, and 5) training and competency assessments all increase required time expended for individuals who are or seek to become SFs. The proposed required criminal background checks and Child Protective Services Central Registry searches cost $25 in fees for each SF who has not already had this done.[10]

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[1]"The Department of Medical Assistance Services shall amend its regulations, subject to the federal Centers for Medicare and Medicaid Services approval, to strengthen the qualifications and responsibilities of the Consumer Directed Service Facilitator to ensure the health, safety and welfare of Medicaid home- and community-based waiver enrollees. The department shall have the authority to promulgate emergency regulations to implement this change effective July 1, 2012."

[2]Identical language has been continued in Item 307 XXX of the 2013 Appropriation Act, Item 301 FFF of the 2014 Appropriation Act, Item 301 FFF of the 2015 Appropriation Act, and Item 306 XX of the 2016 Appropriation Act.

[3]Source: Virginia State Police

[4]Source: Virginia Department of Social Services

[5]Data source: Department of Medical Assistance Services

[6]Source: Department of Medical Assistance Services

[7]Fee sources: Virginia State Police and Virginia Department of Social Services

[8]Ibid

[9]There are many people who started college but did not finish. For these individuals the costs in time and tuition would be less than for people who have no college credits.

[10]Fee sources: Virginia State Police and Virginia Department of Social Services

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

Summary:

The proposed amendments (i) require services facilitators for all persons in the Elderly or Disabled with Consumer Direction Waiver receiving consumer-directed personal care services; (ii) revise several definitions for consistency with other home and community-based services waivers, and (iii) establish qualifications, education, and training for services facilitators pursuant to Item 301 FFF of Chapter 665 of the 2015 Acts of Assembly and Item 306 XX of Chapter 780 of the Acts of Assembly.

12VAC30-50-130. Nursing facility services, EPSDT, including school health services, and family planning.

A. Nursing facility services (other than services in an institution for mental diseases) for individuals 21 years of age or older. Service must be ordered or prescribed and directed or performed within the scope of a license of the practitioner of the healing arts.

B. Early and periodic screening and diagnosis of individuals under 21 years of age, and treatment of conditions found.

1. Payment of medical assistance services shall be made on behalf of individuals under 21 years of age, who are Medicaid eligible, for medically necessary stays in acute care facilities, and the accompanying attendant physician care, in excess of 21 days per admission when such services are rendered for the purpose of diagnosis and treatment of health conditions identified through a physical examination.

2. Routine physicals and immunizations (except as provided through EPSDT) are not covered except that well-child examinations in a private physician's office are covered for foster children of the local social services departments on specific referral from those departments.

3. Orthoptics services shall only be reimbursed if medically necessary to correct a visual defect identified by an EPSDT examination or evaluation. The department shall place appropriate utilization controls upon this service.

4. Consistent with the Omnibus Budget Reconciliation Act of 1989 § 6403, early and periodic screening, diagnostic, and treatment services means the following services: screening services, vision services, dental services, hearing services, and such other necessary health care, diagnostic services, treatment, and other measures described in Social Security Act § 1905(a) to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services and which are medically necessary, whether or not such services are covered under the State Plan and notwithstanding the limitations, applicable to recipients ages 21 and over, provided for by § 1905(a) of the Social Security Act.

5. Community mental health services. These services in order to be covered (i) shall meet medical necessity criteria based upon diagnoses made by LMHPs who are practicing within the scope of their licenses and (ii) are reflected in provider records and on providers' claims for services by recognized diagnosis codes that support and are consistent with the requested professional services.

a. Definitions. The following words and terms when used in this section shall have the following meanings unless the context clearly indicates otherwise:

"Activities of daily living" means personal care activities and includes bathing, dressing, transferring, toileting, feeding, and eating.

"Adolescent or child" means the individual receiving the services described in this section. For the purpose of the use of these terms, adolescent means an individual 12-20 years of age; a child means an individual from birth up to 12 years of age.

"Behavioral health services administrator" or "BHSA" means an entity that manages or directs a behavioral health benefits program under contract with DMAS.

"Care coordination" means collaboration and sharing of information among health care providers, who are involved with an individual's health care, to improve the care.

"Certified prescreener" means an employee of the local community services board or behavioral health authority, or its designee, who is skilled in the assessment and treatment of mental illness and has completed a certification program approved by the Department of Behavioral Health and Developmental Services.

"Clinical experience" means providing direct behavioral health services on a full-time basis or equivalent hours of part-time work to children and adolescents who have diagnoses of mental illness and includes supervised internships, supervised practicums, and supervised field experience for the purpose of Medicaid reimbursement of (i) intensive in-home services, (ii) day treatment for children and adolescents, (iii) community-based residential services for children and adolescents who are younger than 21 years of age (Level A), or (iv) therapeutic behavioral services (Level B). Experience shall not include unsupervised internships, unsupervised practicums, and unsupervised field experience. The equivalency of part-time hours to full-time hours for the purpose of this requirement shall be as established by DBHDS in the document entitled Human Services and Related Fields Approved Degrees/Experience, issued March 12, 2013, revised May 3, 2013.

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

"DMAS" means the Department of Medical Assistance Services and its contractor or contractors.

"EPSDT" means early and periodic screening, diagnosis, and treatment.

"Human services field" means the same as the term is defined by DBHDS in the document entitled Human Services and Related Fields Approved Degrees/Experience, issued March 12, 2013, revised May 3, 2013.

"Individual service plan" or "ISP" means the same as the term is defined in 12VAC30-50-226.

"Licensed mental health professional" or "LMHP" means a licensed physician, licensed clinical psychologist, ~~licensed psychiatric nurse practitioner,~~ licensed professional counselor, licensed clinical social worker, licensed substance abuse treatment practitioner, licensed marriage and family therapist, or certified psychiatric clinical nurse specialist.

"LMHP-resident" or "LMHP-R" means the same as "resident" as defined in (i) 18VAC115-20-10 for licensed professional counselors; (ii) 18VAC115-50-10 for licensed marriage and family therapists; or (iii) 18VAC115-60-10 for licensed substance abuse treatment practitioners. An LMHP-resident shall be in continuous compliance with the regulatory requirements of the applicable counseling profession for supervised practice and shall not perform the functions of the LMHP-R or be considered a "resident" until the supervision for specific clinical duties at a specific site has been preapproved in writing by the Virginia Board of Counseling. For purposes of Medicaid reimbursement to their supervisors for services provided by such residents, they shall use the title "Resident" in connection with the applicable profession after their signatures to indicate such status.

"LMHP-resident in psychology" or "LMHP-RP" means the same as an individual in a residency, as that term is defined in 18VAC125-20-10, program for clinical psychologists. An LMHP-resident in psychology shall be in continuous compliance with the regulatory requirements for supervised experience as found in 18VAC125-20-65 and shall not perform the functions of the LMHP-RP or be considered a "resident" until the supervision for specific clinical duties at a specific site has been preapproved in writing by the Virginia Board of Psychology. For purposes of Medicaid reimbursement by supervisors for services provided by such residents, they shall use the title "Resident in Psychology" after their signatures to indicate such status.

"LMHP-supervisee in social work," "LMHP-supervisee," or "LMHP-S" means the same as "supervisee" as defined in 18VAC140-20-10 for licensed clinical social workers. An LMHP-supervisee in social work shall be in continuous compliance with the regulatory requirements for supervised practice as found in 18VAC140-20-50 and shall not perform the functions of the LMHP-S or be considered a "supervisee" until the supervision for specific clinical duties at a specific site is preapproved in writing by the Virginia Board of Social Work. For purposes of Medicaid reimbursement to their supervisors for services provided by supervisees, these persons shall use the title "Supervisee in Social Work" after their signatures to indicate such status.

"Progress notes" means individual-specific documentation that contains the unique differences particular to the individual's circumstances, treatment, and progress that is also signed and contemporaneously dated by the provider's professional staff who have prepared the notes. Individualized and member-specific progress notes are part of the minimum documentation requirements and shall convey the individual's status, staff interventions, and, as appropriate, the individual's progress, or lack of progress, toward goals and objectives in the ISP. The progress notes shall also include, at a minimum, the name of the service rendered, the date of the service rendered, the signature and credentials of the person who rendered the service, the setting in which the service was rendered, and the amount of time or units/hours required to deliver the service. The content of

each progress note shall corroborate the time/units billed. Progress notes shall be documented for each service that is billed.

"Psychoeducation" means (i) a specific form of education aimed at helping individuals who have mental illness and their family members or caregivers to access clear and concise information about mental illness and (ii) a way of accessing and learning strategies to deal with mental illness and its effects in order to design effective treatment plans and strategies.

"Psychoeducational activities" means systematic interventions based on supportive and cognitive behavior therapy that emphasizes an individual's and his family's needs and focuses on increasing the individual's and family's knowledge about mental disorders, adjusting to mental illness, communicating and facilitating problem solving and increasing coping skills.

"Qualified mental health professional-child" or "QMHP-C" means the same as the term is defined in 12VAC35-105-20.

"Qualified mental health professional-eligible" or "QMHP-E" means the same as the term is defined in 12VAC35-105-20 and consistent with the requirements of 12VAC35-105-590.

"Qualified paraprofessional in mental health" or "QPPMH" means the same as the term is defined in 12VAC35-105-20 and consistent with the requirements of 12VAC35-105-1370.

"Service-specific provider intake" means the face-to-face interaction in which the provider obtains information from the child or adolescent, and parent or other family member or members, as appropriate, about the child's or adolescent's mental health status. It includes documented history of the severity, intensity, and duration of mental health care problems and issues and shall contain all of the following elements: (i) the presenting issue/reason for referral, (ii) mental health history/hospitalizations, (iii) previous interventions by providers and timeframes and response to treatment, (iv) medical profile, (v) developmental history including history of abuse, if appropriate, (vi) educational/vocational status, (vii) current living situation and family history and relationships, (viii) legal status, (ix) drug and alcohol profile, (x) resources and strengths, (xi) mental status exam and profile, (xii) diagnosis, (xiii) professional summary and clinical formulation, (xiv) recommended care and treatment goals, and (xv) the dated signature of the LMHP, LMHP-supervisee, LMHP-resident, or LMHP-RP.

"Services provided under arrangement" means the same as defined in 12VAC30-130-850.

b. Intensive in-home services (IIH) to children and adolescents under age 21 shall be time-limited interventions provided in the individual's residence and when clinically necessary in community settings. All interventions and the settings of the intervention shall be defined in the Individual Service Plan. All IIH services shall be designed to specifically improve family dynamics, provide modeling, and the clinically necessary interventions that increase functional and therapeutic interpersonal relations between family members in the home. IIH services are designed to promote psychoeducational benefits in the home setting of an individual who is at risk of being moved into an out-of-home placement or who is being transitioned to home from an out-of-home placement due to a documented medical need of the individual. These services provide crisis treatment; individual and family counseling; communication skills (e.g., counseling to assist the individual and his parents or guardians, as appropriate, to understand and practice appropriate problem solving, anger management, and interpersonal interaction, etc.); care coordination with other required services; and 24-hour emergency response.

(1) These services shall be limited annually to 26 weeks. Service authorization shall be required for Medicaid reimbursement prior to the onset of services. Services rendered before the date of authorization shall not be reimbursed.

(2) Service authorization shall be required for services to continue beyond the initial 26 weeks.

(3) Service-specific provider intakes shall be required at the onset of services and ISPs shall be required during the entire duration of services. Services based upon incomplete, missing, or outdated service-specific provider intakes or ISPs shall be denied reimbursement. Requirements for service-specific provider intakes and ISPs are set out in this section.

(4) These services may only be rendered by an LMHP, LMHP-supervisee, LMHP-resident, LMHP-RP, a QMHP-C, or a QMHP-E.

c. Therapeutic day treatment (TDT) shall be provided two or more hours per day in order to provide therapeutic interventions. Day treatment programs, limited annually to 780 units, provide evaluation; medication education and management; opportunities to learn and use daily living skills and to enhance social and interpersonal skills (e.g., problem solving, anger management, community responsibility, increased impulse control, and appropriate peer relations, etc.); and individual, group and family counseling.

(1) Service authorization shall be required for Medicaid reimbursement.

(2) Service-specific provider intakes shall be required at the onset of services and ISPs shall be required during the entire duration of services. Services based upon incomplete, missing, or outdated service-specific

provider intakes or ISPs shall be denied reimbursement. Requirements for service-specific provider intakes and ISPs are set out in this section.

(3) These services may be rendered only by an LMHP, LMHP-supervisee, LMHP-resident, LMHP-RP, a QMHP-C, or a QMHP-E.

d. Community-based services for children and adolescents under 21 years of age (Level A) pursuant to 42 CFR 440.031(d).

(1) Such services shall be a combination of therapeutic services rendered in a residential setting. The residential services will provide structure for daily activities, psychoeducation, therapeutic supervision, care coordination, and psychiatric treatment to ensure the attainment of therapeutic mental health goals as identified in the individual service plan (plan of care). Individuals qualifying for this service must demonstrate medical necessity for the service arising from a condition due to mental, behavioral or emotional illness that results in significant functional impairments in major life activities in the home, school, at work, or in the community. The service must reasonably be expected to improve the child's condition or prevent regression so that the services will no longer be needed. The application of a national standardized set of medical necessity criteria in use in the industry, such as McKesson InterQual® Criteria or an equivalent standard authorized in advance by DMAS, shall be required for this service.

(2) In addition to the residential services, the child must receive, at least weekly, individual psychotherapy that is provided by an LMHP, LMHP-supervisee, LMHP-resident, or LMHP-RP.

(3) Individuals shall be discharged from this service when other less intensive services may achieve stabilization.

(4) Authorization shall be required for Medicaid reimbursement. Services that were rendered before the date of service authorization shall not be reimbursed.

(5) Room and board costs shall not be reimbursed. DMAS shall reimburse only for services provided in facilities or programs with no more than 16 beds.

(6) These residential providers must be licensed by the Department of Social Services, Department of Juvenile Justice, or Department of Behavioral Health and Developmental Services under the Standards for Licensed Children's Residential Facilities (22VAC40-151), Regulation Governing Juvenile Group Homes and Halfway Houses (6VAC35-41), or Regulations for Children's Residential Facilities (12VAC35-46).

(7) Daily progress notes shall document a minimum of seven psychoeducational activities per week. Psychoeducational programming must include~~, but is not limited to,~~ development or maintenance of daily living skills, anger management, social skills, family living skills, communication skills, stress management, and any care coordination activities.

(8) The facility/group home must coordinate services with other providers. Such care coordination shall be documented in the individual's medical record. The documentation shall include who was contacted, when the contact occurred, and what information was transmitted.

(9) Service-specific provider intakes shall be required at the onset of services and ISPs shall be required during the entire duration of services. Services based upon incomplete, missing, or outdated service-specific provider intakes or ISPs shall be denied reimbursement. Requirements for intakes and ISPs are set out in 12VAC30-60-61.

(10) These services may only be rendered by an LMHP, LMHP-supervisee, LMHP-resident, LMHP-RP, a QMHP-C, a QMHP-E, or a QPPMH.

e. Therapeutic behavioral services (Level B) pursuant to 42 CFR 440.130(d).

(1) Such services must be therapeutic services rendered in a residential setting that provide structure for daily activities, psychoeducation, therapeutic supervision, care coordination, and psychiatric treatment to ensure the attainment of therapeutic mental health goals as identified in the individual service plan (plan of care). Individuals qualifying for this service must demonstrate medical necessity for the service arising from a condition due to mental, behavioral or emotional illness that results in significant functional impairments in major life activities in the home, school, at work, or in the community. The service must reasonably be expected to improve the child's condition or prevent regression so that the services will no longer be needed. The application of a national standardized set of medical necessity criteria in use in the industry, such as McKesson InterQual® Criteria, or an equivalent standard authorized in advance by DMAS shall be required for this service.

(2) Authorization is required for Medicaid reimbursement. Services that are rendered before the date of service authorization shall not be reimbursed.

(3) Room and board costs shall not be reimbursed. Facilities that only provide independent living services are not reimbursed. DMAS shall reimburse only for services provided in facilities or programs with no more than 16 beds.

(4) These residential providers must be licensed by the Department of Behavioral Health and Developmental Services (DBHDS) under the Regulations for Children's Residential Facilities (12VAC35-46).

(5) Daily progress notes shall document that a minimum of seven psychoeducational activities per week occurs. Psychoeducational programming must include~~, but is not limited to,~~ development or maintenance of daily living skills, anger management, social skills, family living skills, communication skills, and stress management. This service may be provided in a program setting or a community-based group home.

(6) The individual must receive, at least weekly, individual psychotherapy and, at least weekly, group psychotherapy that is provided as part of the program.

(7) Individuals shall be discharged from this service when other less intensive services may achieve stabilization.

(8) Service-specific provider intakes shall be required at the onset of services and ISPs shall be required during the entire duration of services. Services that are based upon incomplete, missing, or outdated service-specific provider intakes or ISPs shall be denied reimbursement. Requirements for intakes and ISPs are set out in 12VAC30-60-61.

(9) These services may only be rendered by an LMHP, LMHP-supervisee, LMHP-resident, LMHP-RP, a QMHP-C, a QMHP-E, or a QPPMH.

(10) The facility/group home shall coordinate necessary services with other providers. Documentation of this care coordination shall be maintained by the facility/group home in the individual's record. The documentation shall include who was contacted, when the contact occurred, and what information was transmitted.

6. Inpatient psychiatric services shall be covered for individuals younger than age 21 for medically necessary stays in inpatient psychiatric facilities described in 42 CFR 440.160(b)(1) and (b)(2) for the purpose of diagnosis and treatment of mental health and behavioral disorders identified under EPSDT when such services are rendered by (i) a psychiatric hospital or an inpatient psychiatric program in a hospital accredited by the Joint Commission on Accreditation of Healthcare Organizations or (ii) a psychiatric facility that is accredited by the Joint Commission on Accreditation of Healthcare Organizations or the Commission on Accreditation of Rehabilitation Facilities. Inpatient psychiatric hospital admissions at general acute care hospitals and freestanding psychiatric hospitals shall also be subject to the requirements of 12VAC30-50-100, 12VAC30-50-105, and 12VAC30-60-25. Inpatient psychiatric admissions to residential treatment facilities shall also be subject to the requirements of Part XIV (12VAC30-130-850 et seq.) of 12VAC30-130.

a. The inpatient psychiatric services benefit for individuals younger than 21 years of age shall include services defined at 42 CFR 440.160 that are provided under the direction of a physician pursuant to a certification of medical necessity and plan of care developed by an interdisciplinary team of professionals and shall involve active treatment designed to achieve the child's discharge from inpatient status at the earliest possible time. The inpatient psychiatric services benefit shall include services provided under arrangement furnished by Medicaid enrolled providers other than the inpatient psychiatric facility, as long as the inpatient psychiatric facility (i) arranges for and oversees the provision of all services, (ii) maintains all medical records of care furnished to the individual, and (iii) ensures that the services are furnished under the direction of a physician. Services provided under arrangement shall be documented by a written referral from the inpatient psychiatric facility. For purposes of pharmacy services, a prescription ordered by an employee or contractor of the facility who is licensed to prescribe drugs shall be considered the referral.

b. Eligible services provided under arrangement with the inpatient psychiatric facility shall vary by provider type as described in this subsection. For purposes of this section, emergency services means the same as is set out in 12VAC30-50-310 B.

(1) State freestanding psychiatric hospitals shall arrange for, maintain records of, and ensure that physicians order these services: (i) pharmacy services and (ii) emergency services.

(2) Private freestanding psychiatric hospitals shall arrange for, maintain records of, and ensure that physicians order these services: (i) medical and psychological services including those furnished by physicians, licensed mental health professionals, and other licensed or certified health professionals (i.e., nutritionists, podiatrists, respiratory therapists, and substance abuse treatment practitioners); (ii) outpatient hospital services; (iii) physical therapy, occupational therapy, and therapy for individuals with speech, hearing, or language disorders; (iv) laboratory and radiology services; (v) vision services; (vi) dental, oral surgery, and orthodontic services; (vii) transportation services; and (viii) emergency services.

(3) Residential treatment facilities, as defined at 42 CFR 483.352, shall arrange for, maintain records of, and ensure that physicians order these services: (i) medical and psychological services, including those furnished by physicians, licensed mental health professionals, and other licensed or certified health professionals (i.e., nutritionists, podiatrists, respiratory therapists, and substance abuse treatment practitioners); (ii) pharmacy services; (iii) outpatient hospital services; (iv) physical therapy, occupational therapy, and therapy for individuals with speech, hearing, or language disorders; (v) laboratory and radiology services; (vi) durable medical equipment; (vii) vision services; (viii) dental,

oral surgery, and orthodontic services; (ix) transportation services; and (x) emergency services.

c. Inpatient psychiatric services are reimbursable only when the treatment program is fully in compliance with (i) 42 CFR Part 441 Subpart D, specifically 42 CFR 441.151(a) and (b) and 441.152 through 441.156, and (ii) the conditions of participation in 42 CFR Part 483 Subpart G. Each admission must be preauthorized and the treatment must meet DMAS requirements for clinical necessity.

d. Service limits may be exceeded based on medical necessity for individuals eligible for EPSDT.

7. Hearing aids shall be reimbursed for individuals younger than 21 years of age according to medical necessity when provided by practitioners licensed to engage in the practice of fitting or dealing in hearing aids under the Code of Virginia.

8. Addiction and recovery treatment services shall be covered under EPSDT consistent with 12VAC30-130-5000 et seq.

9. Services facilitators shall be required for all consumer-directed personal care services consistent with the requirements set out in 12VAC30-120-935.

C. School health services.

1. School health assistant services are repealed effective July 1, 2006.

2. School divisions may provide routine well-child screening services under the State Plan. Diagnostic and treatment services that are otherwise covered under early and periodic screening, diagnosis and treatment services, shall not be covered for school divisions. School divisions to receive reimbursement for the screenings shall be enrolled with DMAS as clinic providers.

a. Children enrolled in managed care organizations shall receive screenings from those organizations. School divisions shall not receive reimbursement for screenings from DMAS for these children.

b. School-based services are listed in a recipient's individualized education program (IEP) and covered under one or more of the service categories described in § 1905(a) of the Social Security Act. These services are necessary to correct or ameliorate defects of physical or mental illnesses or conditions.

3. Service providers shall be licensed under the applicable state practice act or comparable licensing criteria by the Virginia Department of Education, and shall meet applicable qualifications under 42 CFR Part 440. Identification of defects, illnesses or conditions and services necessary to correct or ameliorate them shall be performed by practitioners qualified to make those determinations within their licensed scope of practice, either as a member of the IEP team or by a qualified practitioner outside the IEP team.

a. Service providers shall be employed by the school division or under contract to the school division.

b. Supervision of services by providers recognized in subdivision 4 of this subsection shall occur as allowed under federal regulations and consistent with Virginia law, regulations, and DMAS provider manuals.

c. The services described in subdivision 4 of this subsection shall be delivered by school providers, but may also be available in the community from other providers.

d. Services in this subsection are subject to utilization control as provided under 42 CFR Parts 455 and 456.

e. The IEP shall determine whether or not the services described in subdivision 4 of this subsection are medically necessary and that the treatment prescribed is in accordance with standards of medical practice. Medical necessity is defined as services ordered by IEP providers. The IEP providers are qualified Medicaid providers to make the medical necessity determination in accordance with their scope of practice. The services must be described as to the amount, duration and scope.

4. Covered services include:

a. Physical therapy, occupational therapy and services for individuals with speech, hearing, and language disorders, performed by, or under the direction of, providers who meet the qualifications set forth at 42 CFR 440.110. This coverage includes audiology services.

b. Skilled nursing services are covered under 42 CFR 440.60. These services are to be rendered in accordance to the licensing standards and criteria of the Virginia Board of Nursing. Nursing services are to be provided by licensed registered nurses or licensed practical nurses but may be delegated by licensed registered nurses in accordance with the regulations of the Virginia Board of Nursing, especially the section on delegation of nursing tasks and procedures. The licensed practical nurse is under the supervision of a registered nurse.

(1) The coverage of skilled nursing services shall be of a level of complexity and sophistication (based on assessment, planning, implementation and evaluation) that is consistent with skilled nursing services when performed by a licensed registered nurse or a licensed practical nurse. These skilled nursing services shall include, but not necessarily be limited to dressing changes, maintaining patent airways, medication administration/monitoring and urinary catheterizations.

(2) Skilled nursing services shall be directly and specifically related to an active, written plan of care developed by a registered nurse that is based on a written order from a physician, physician assistant or nurse practitioner for skilled nursing services. This order shall be recertified on an annual basis.

c. Psychiatric and psychological services performed by licensed practitioners within the scope of practice are defined under state law or regulations and covered as physicians' services under 42 CFR 440.50 or medical or other remedial care under 42 CFR 440.60. These outpatient services include individual medical psychotherapy, group medical psychotherapy coverage, and family medical psychotherapy. Psychological and neuropsychological testing are allowed when done for purposes other than educational diagnosis, school admission, evaluation of an individual with intellectual disability prior to admission to a nursing facility, or any placement issue. These services are covered in the nonschool settings also. School providers who may render these services when licensed by the state include psychiatrists, licensed clinical psychologists, school psychologists, licensed clinical social workers, professional counselors, psychiatric clinical nurse specialists, marriage and family therapists, and school social workers.

d. Personal care services are covered under 42 CFR 440.167 and performed by persons qualified under this subsection. The personal care assistant is supervised by a DMAS recognized school-based health professional who is acting within the scope of licensure. This practitioner develops a written plan for meeting the needs of the child, which is implemented by the assistant. The assistant must have qualifications comparable to those for other personal care aides recognized by the Virginia Department of Medical Assistance Services. The assistant performs services such as assisting with toileting, ambulation, and eating. The assistant may serve as an aide on a specially adapted school vehicle that enables transportation to or from the school or school contracted provider on days when the student is receiving a Medicaid-covered service under the IEP. Children requiring an aide during transportation on a specially adapted vehicle shall have this stated in the IEP.

e. Medical evaluation services are covered as physicians' services under 42 CFR 440.50 or as medical or other remedial care under 42 CFR 440.60. Persons performing these services shall be licensed physicians, physician assistants, or nurse practitioners. These practitioners shall identify the nature or extent of a child's medical or other health related condition.

f. Transportation is covered as allowed under 42 CFR 431.53 and described at State Plan Attachment 3.1-D (12VAC30-50-530). Transportation shall be rendered only by school division personnel or contractors. Transportation is covered for a child who requires transportation on a specially adapted school vehicle that enables transportation to or from the school or school contracted provider on days when the student is receiving a Medicaid-covered service under the IEP. Transportation shall be listed in the child's IEP. Children requiring an aide during transportation on a specially adapted vehicle shall have this stated in the IEP.

g. Assessments are covered as necessary to assess or reassess the need for medical services in a child's IEP and shall be performed by any of the above licensed practitioners within the scope of practice. Assessments and reassessments not tied to medical needs of the child shall not be covered.

5. DMAS will ensure through quality management review that duplication of services will be monitored. School divisions have a responsibility to ensure that if a child is receiving additional therapy outside of the school, that there will be coordination of services to avoid duplication of service.

D. Family planning services and supplies for individuals of child-bearing age.

1. Service must be ordered or prescribed and directed or performed within the scope of the license of a practitioner of the healing arts.

2. Family planning services shall be defined as those services that delay or prevent pregnancy. Coverage of such services shall not include services to treat infertility or services to promote fertility. Family planning services shall not cover payment for abortion services and no funds shall be used to perform, assist, encourage, or make direct referrals for abortions.

3. Family planning services as established by § 1905(a)(4)(C) of the Social Security Act include annual family planning exams; cervical cancer screening for women; sexually transmitted infection (STI) testing; lab services for family planning and STI testing; family planning education, counseling, and preconception health; sterilization procedures; nonemergency transportation to a family planning service; and U.S. Food and Drug Administration approved prescription and over-the-counter contraceptives, subject to limits in 12VAC30-50-210.

Part IX

Elderly or Disabled with Consumer Direction Waiver

12VAC30-120-900. Definitions.

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

"Adult day health care " or "ADHC" means long-term maintenance or supportive services offered by a DMAS-enrolled community-based day care program providing a variety of health, therapeutic, and social services designed to meet the specialized needs of those waiver individuals who are elderly or who have a disability and who are at risk of

placement in a nursing facility (NF). The program shall be licensed by the Virginia Department of Social Services (VDSS) as an adult day care center (ADCC). The services offered by the center shall be required by the waiver individual in order to permit the individual to remain in his home rather than entering a nursing facility. ADHC can also refer to the center where this service is provided.

"Agency-directed model of service" means a model of service delivery where an agency is responsible for providing direct support staff, for maintaining individuals' records, and for scheduling the dates and times of the direct support staff's presence in the individuals' homes for personal and respite care.

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

"Annually" means a period of time covering 365 consecutive calendar days or 366 consecutive days in the case of leap years.

"Appeal" means the process used to challenge actions regarding services, benefits, and reimbursement provided by Medicaid pursuant to 12VAC30-110 and 12VAC30-20-500 through 12VAC30-20-560.

"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 enable waiver individuals who are participating in the Money Follows the Person demonstration program pursuant to Part XX (12VAC30-120-2000 et seq.) 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.

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

"CD" means consumer-directed.

"CMS" means the Centers for Medicare and Medicaid Services, which is the unit of the U.S. Department of Health and Human Services that administers the Medicare and Medicaid programs.

"Cognitive impairment" means a severe deficit in mental capability that affects a waiver individual's areas of functioning such as thought processes, problem solving, judgment, memory, or comprehension that interferes with such things as reality orientation, ability to care for self, ability to recognize danger to self or others, or impulse control.

~~"Conservator" means a person appointed by a court to manage the estate and financial affairs of an incapacitated individual.~~

"Consumer-directed attendant" means a person who provides, via the consumer-directed model of services, personal care, companion services, or respite care, or any combination of these three services, who is also exempt from workers' compensation.

"Consumer-directed (CD) model of service" means the model of service delivery for which the ~~waiver~~ individual enrolled in the waiver or the individual's employer of record, as appropriate, ~~are~~ is responsible for hiring, training, supervising, and firing of the ~~person or persons~~ attendant or attendants who ~~actually~~ render the services that are reimbursed by DMAS.

"Consumer-directed services facilitator," "CD services facilitator," or "facilitator" means the DMAS-enrolled provider who is responsible for supporting the individual and family/caregiver by ensuring the development and monitoring of the consumer-directed services plan of care, providing attendant management training, and completing ongoing review activities as required by DMAS for consumer-directed personal care and respite services.

"DARS" means the Department for Aging and Rehabilitative Services.

"Day" means, for the purposes of reimbursement, 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.

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

"DMAS" means the Department of Medical Assistance Services.

"DMAS staff" means persons employed by the Department of Medical Assistance Services.

"Elderly or Disabled with Consumer Direction Waiver" or "EDCD Waiver" means the CMS-approved waiver that covers a range of community support services offered to waiver individuals who are elderly or who have a disability who would otherwise require a nursing facility level of care.

"Employer of record" or "EOR" means the person who performs the functions of the employer in the consumer-

directed model of service delivery. The EOR may be the individual enrolled in the waiver, a family member, caregiver, or another person.

"Environmental modifications" or "EM" means physical adaptations to an individual's primary home or primary vehicle or work site, when the work site modification exceeds reasonable accommodation requirements of the Americans with Disabilities Act (42 USC § 1201 et seq.), which are necessary to ensure the individual's health and safety or enable functioning with greater independence and shall be of direct medical or remedial benefit to individuals who are participating in the Money Follows the Person demonstration program pursuant to Part XX (12VAC30-120-2000 et seq.). Such physical adaptations shall not be authorized for Medicaid payment when the adaptation is being used to bring a substandard dwelling up to minimum habitation standards.

"Fiscal/employer agent" means a state agency or other entity as determined by DMAS that meets the requirements of 42 CFR 441.484 and the Virginia Public Procurement Act, § 2.2-4300 et seq. of the Code of Virginia.

"Guardian" means a person appointed by a court to manage the personal affairs of an incapacitated individual pursuant to Chapter 20 (§ 64.2-2000 et seq.) of Title 64.2 of the Code of Virginia.

"Health, safety, and welfare standard" means, for the purposes of this waiver, that an individual's right to receive an EDCD Waiver service is dependent on a determination that the waiver individual needs the service based on appropriate assessment criteria and a written plan of care, including having a backup plan of care, that demonstrates medical necessity and that services can be safely provided in the community or through the model of care selected by the individual.

"Home and community-based waiver services" or "waiver services" means the range of community support 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" or "waiver individual" means the person who has applied for and been approved to receive these waiver services.

"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 appropriate service needs.

"Level of care" or "LOC" means the specification of the minimum amount of assistance an individual requires in order to receive services in an institutional setting under the State Plan 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 such that, in the absence of an official license, the entity or person is debarred from performing the activity or service.

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

"Live-in caregiver" means a personal caregiver who resides in the same household as the individual who is receiving waiver services.

"Long-term care" or "LTC" means a variety of services that help individuals with health or personal care needs and activities of daily living 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 and assisted living facilities.

"Medicaid Long-Term Care (LTC) Communication Form" or "DMAS-225" means the form used by the long-term care provider to report information about changes in an individual's eligibility and financial circumstances.

"Medication monitoring" means an electronic device, which is only available in conjunction with Personal Emergency Response Systems, that enables certain waiver individuals who are at risk of institutionalization to be reminded to take their medications at the correct dosages and times.

"Money Follows the Person" or "MFP" means the demonstration program, as set out in 12VAC30-120-2000 and 12VAC30-120-2010.

"Participating provider" or "provider" means an entity that meets the standards and requirements set forth by DMAS and has a current, signed provider participation agreement, including managed care organizations, with DMAS.

"Patient pay amount" means the portion of the individual's income that must be paid as his share of the long-term care services and is calculated by the local department of social services based on the individual's documented monthly income and permitted deductions.

"Personal care agency" means a participating provider that provides personal care services.

"Personal care aide" or "aide" means a person employed by an agency who provides personal care or unskilled respite services. The aide shall have successfully completed an educational curriculum of at least 40 hours of study related to the needs of individuals who are either elderly or who have disabilities as further set out in 12VAC30-120-935. Such successful completion may be evidenced by the existence of a certificate of completion, which is provided to DMAS during provider audits, issued by the training entity.

"Personal care attendant" or "attendant" means a person who provides personal care or respite services that are directed by a consumer, family member/caregiver, or employer of record under the CD model of service delivery.

"Personal care services" means a range of support services necessary to enable the waiver individual to remain at or return home rather than enter a nursing facility and that includes assistance with activities of daily living (ADLs), instrumental activities of daily living (IADLs), access to the community, self-administration of medication, or other medical needs, supervision, and the monitoring of health status and physical condition. Personal care services shall be provided by aides, within the scope of their licenses/certificates, as appropriate, under the agency-directed model or by personal care attendants under the CD model of service delivery.

"Personal emergency response system" or "PERS" means an electronic device and monitoring service that enables certain waiver individuals, who are at least 14 years of age, at risk of institutionalization to secure help in an emergency. PERS services shall be limited to those waiver individuals who live alone or who are alone for significant parts of the day and who have no regular caregiver for extended periods of time.

"PERS provider" means a certified home health or a personal care agency, a durable medical equipment provider, a hospital, or a PERS manufacturer that has the responsibility to furnish, install, maintain, test, monitor, and service PERS equipment, direct services (i.e., installation, equipment maintenance, and services calls), and PERS monitoring. PERS providers may also provide medication monitoring.

"Plan of care" or "POC" means the written plan developed collaboratively by the waiver individual and the waiver individual's family/caregiver, as appropriate, and the provider related solely to the specific services necessary for the individual to remain in the community while ensuring his health, safety, and welfare.

"Preadmission screening" means the process to~~:~~ (i) evaluate the functional, nursing, and social supports of individuals referred for preadmission screening for certain long-term care services requiring NF eligibility; (ii) assist individuals in determining what specific services the ~~individuals need~~ individual needs; (iii) evaluate whether a service or a combination of existing community services are available to meet ~~the individuals'~~ individual needs; and (iv) provide a list to individuals of appropriate providers for Medicaid-funded nursing facility or home and community-based care for those individuals who meet nursing facility level of care.

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

"Primary caregiver" means the person who consistently assumes the primary role of providing direct care and support of the waiver individual to live successfully in the community without receiving compensation for providing such care. Such person's name, if applicable, shall be documented by the RN or services facilitator in the waiver individual's record. Waiver individuals are not required to have a primary caregiver in order to participate in the EDCD waiver.

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

"Respite care agency" means a participating provider that renders respite services.

"Respite services" means services provided to waiver individuals who are unable to care for themselves that are furnished on a short-term basis because of the absence of or need for the relief of the unpaid primary caregiver who normally provides the care.

"Service authorization" or "Srv Auth" means the process of approving either by DMAS, its service authorization contractor, or DMAS-designated entity, for the purposes of reimbursement for a service for the individual before it is rendered or reimbursed.

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

"Services facilitation" means a service that assists the waiver individual (or family/caregiver, as appropriate) in ~~arranging for,~~ directing, training, and managing services provided through the consumer-directed model of service.

"Services facilitator" means a DMAS-enrolled provider ~~or~~, a DMAS-designated entity, or a person who is employed or contracted by a DMAS-enrolled services facilitator that is responsible for supporting the individual and the individual's family/caregiver or EOR, as appropriate, by ensuring the development and monitoring of the CD services plans of care, providing employee management training, and completing ongoing review activities as required by DMAS for consumer-directed personal care and respite services. Services facilitator shall be deemed to mean the same thing as consumer-directed services facilitator.

"Skilled respite services" means temporary skilled nursing services that are provided to waiver individuals who need such services and that are performed by a LPN for the relief of the unpaid primary caregiver who normally provides the care.

"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.

"Transition coordinator" means the person defined in 12VAC30-120-2000 who facilitates MFP transition.

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

"VDH" means the Virginia Department of Health.

"VDSS" means the Virginia Department of Social Services.

"Virginia Uniform Assessment Instrument" or "UAI" means the standardized multidimensional comprehensive assessment that is completed by the Preadmission Screening Team or approved hospital discharge planner that assesses an individual's physical health, mental health, and psycho/social and functional abilities to determine if the individual meets the nursing facility level of care.

"Weekly" means a span of time covering seven consecutive calendar days.

12VAC30-120-935. Participation standards for specific covered services.

A. The personal care providers, respite care providers, ADHC providers, and CD services facilitators shall develop an individualized POC that addresses the waiver individual's service needs. Such plan shall be developed in collaboration with the waiver individual or the individual's family/caregiver/EOR, as appropriate.

B. Agency providers shall employ appropriately licensed professional staff who can provide the covered waiver services required by the waiver individuals. Providers shall require that the supervising RN/LPN be available by phone at all times that the LPN/attendant and consumer-directed services facilitators, as appropriate, are providing services to the waiver individual.

C. Agency staff (RN, LPNs, or aides) or CD ~~employees (attendants)~~ attendants shall not be reimbursed by DMAS for services rendered to waiver individuals when the agency staff or the CD ~~employee~~ attendant is either (i) the spouse of the waiver individual or (ii) the parent (biological, adoptive, legal guardian) or other legal guardian of the minor child waiver individual.

1. Payment shall not be made for services furnished by other family members living under the same roof as the individual enrolled in the waiver receiving services unless there is objective written documentation completed by the consumer-directed services facilitator as to why no other provider is available to render the personal services. The consumer-directed services facilitator shall initially make this determination and document it fully in the individual's record.

2. Family members who are approved to be reimbursed for providing personal services shall meet the same qualifications as all other CD attendants.

D. Failure to provide the required services, conduct the required reviews, and meet the documentation standards as stated ~~herein~~ in this section may result in DMAS charging audited providers with overpayments and requiring the return of the overpaid funds.

E. In addition to meeting the general conditions and requirements, home and community-based services participating providers shall also meet the following requirements:

1. ADHC services provider. In order to provide these services, the ~~ADCC~~ adult day care center (ADCC) shall:

a. Make available a copy of the current VDSS license for ~~DMAS'~~ DMAS review and verification purposes prior to the provider applicant's enrollment as a Medicaid provider;

b. Adhere to ~~VDSS'~~ the ADCC standards of VDSS as defined in 22VAC40-60 including~~, but not limited to,~~ provision of activities for waiver individuals; and

c. Employ the following:

(1) A director who shall be responsible for overall management of the center's programs and employees pursuant to 22VAC40-60-320. The director shall be the provider contact person for DMAS and the designated Srv Auth contractor and shall be responsible for responding to communication from DMAS and the designated Srv Auth contractor. The director shall be responsible for ensuring the development of the POCs for waiver individuals. The director shall assign either himself, the activities director if there is one, RN, or therapist to act as the care coordinator for each waiver individual and shall document in the individual's medical record the identity of the care coordinator. The care coordinator shall be responsible for management of the waiver individual's POC and for its review with the program aides and any other staff, as necessary.

(2) A RN who shall be responsible for administering to and monitoring the health needs of waiver individuals. The RN may also contract with the center. The RN shall be responsible for the planning and implementation of the POC involving multiple services where specialized health care knowledge may be needed. The RN shall be present a minimum of eight hours each month at the center. DMAS may require the RN's presence at the center for more than this minimum standard depending on the number of waiver individuals who are in attendance and according to the medical and nursing needs of the waiver individuals who attend the center. Although DMAS does not require that the RN be a full-time staff position, there shall be a RN available, either in person or by telephone, to the center's waiver individuals and staff during all times that the center is in operation. The RN shall be responsible for:

(a) Providing periodic evaluation, at least every 90 days, of the nursing needs of each waiver individual;

(b) Providing the nursing care and treatment as documented in ~~individuals' POCs~~ the waiver individual's POC; and

(c) Monitoring, recording, and administering of prescribed medications or supervising the waiver individual in self-administered medication.

(3) Personal care aides who shall be responsible for overall care of waiver individuals such as assistance with

ADLs, social/recreational activities, and other health and therapeutic-related activities. Each program aide hired by the provider shall be screened to ensure compliance with training and skill mastery qualifications required by DMAS. The aide shall, at a minimum, have the following qualifications:

(a) Be 18 years of age or older;

(b) Be able to read and write in English to the degree necessary to perform the tasks expected and create and maintain the required waiver individual documentation of services rendered;

(c) Be physically able to perform the work and have the skills required to perform the tasks required in the waiver individual's POC;

(d) Have a valid social security number issued to the program aide by the Social Security Administration;

(e) Have satisfactorily completed an educational curriculum as set out in clauses (i), (ii), and (iii) of this subdivision E 1 c 3 (e). Documentation of successful completion shall be maintained in the aide's personnel file and be available for review by ~~DMAS'~~ DMAS staff. Prior to assigning a program aide to a waiver individual, the center shall ensure that the aide has either (i) registered with the Board of Nursing as a certified nurse aide; (ii) graduated from an approved educational curriculum as listed by the Board of Nursing; or (iii) completed the provider's educational curriculum, at least 40 hours in duration, as taught by an RN who is licensed in the Commonwealth or who holds a multi-state licensing privilege.

(4) The ADHC coordinator who shall coordinate, pursuant to 22VAC40-60-695, the delivery of the activities and services as prescribed in the waiver ~~individuals' POCs~~ individual's POC and keep such plans updated, record 30-day progress notes concerning each waiver individual, and review the waiver ~~individuals'~~ individual's daily records each week. If a waiver individual's condition changes more frequently, more frequent reviews and recording of progress notes shall be required to reflect the individual's changing condition.

2. Recreation and social activities responsibilities. The center shall provide planned recreational and social activities suited to the waiver ~~individuals'~~ individual's needs and interests and designed to encourage physical exercise, prevent deterioration of each waiver individual's condition, and stimulate social interaction.

3. The center shall maintain all records of each Medicaid individual. These records shall be reviewed periodically by DMAS staff or its designated agent who is authorized by DMAS to review these files. At a minimum, these records shall contain, but shall not necessarily be limited to:

a. DMAS required forms as specified in the center's provider-appropriate guidance documents;

b. Interdisciplinary POCs developed, in collaboration with the waiver individual or family/caregiver, or both as may be appropriate, by the center's director, RN, and therapist, as may be appropriate, and any other relevant support persons;

c. Documentation of interdisciplinary staff meetings that shall be held at least every three months to reassess each waiver individual and evaluate the adequacy of the POC and make any necessary revisions;

d. At a minimum, 30-day goal-oriented progress notes recorded by the designated ADHC care coordinator. If a waiver individual's condition and treatment POC changes more often, progress notes shall be written more frequently than every 30 days;

e. The daily record of services provided shall contain the specific services delivered by center staff. The record shall also contain the arrival and departure times of the waiver individual and shall be signed weekly by either the director, activities director, RN, or therapist employed by the center. The record shall be completed on a daily basis, neither before nor after the date of services delivery. At least once a week, a staff member shall chart significant comments regarding care given to the waiver individual. If the staff member writing comments is different from the staff signing the weekly record, that staff member shall sign the weekly comments. A copy of this record shall be given weekly to the waiver individual or family/caregiver, and it shall also be maintained in the waiver individual-specific medical record; and

f. All contacts shall be documented in the waiver individual's medical record, including correspondence made to and from the individual with family/caregivers, physicians, DMAS, the designated Srv Auth contractor, formal and informal services providers, and all other professionals related to the waiver individual's Medicaid services or medical care.

F. Agency-directed personal care services. The personal care provider agency shall hire or contract with and directly supervise a RN who provides ongoing supervision of all personal care aides and LPNs. LPNs may supervise, pursuant to their licenses, personal care aides based upon RN assessment of the waiver ~~individuals'~~ individual's health, safety, and welfare needs.

1. The RN supervisor shall make an initial home assessment visit on or before the start of care for all individuals admitted to personal care, when a waiver individual is readmitted after being discharged from services, or if he is transferred from another provider, ADHC, or from a CD services program.

2. During a home visit, the RN supervisor shall evaluate, at least every 90 days, the LPN supervisor's performance and the waiver individual's needs to ensure the LPN supervisor's abilities to function competently and shall

provide training as necessary. This shall be documented in the waiver individual's record. A reassessment of the individual's needs and review of the POC shall be performed and documented during these visits.

3. The RN/LPN supervisor shall also make supervisory visits based on the assessment and evaluation of the care needs of waiver individuals as often as needed and as defined in this subdivision to ensure both quality and appropriateness of services.

a. The personal care provider agency shall have the responsibility of determining when supervisory visits are appropriate for the waiver individual's health, safety, and welfare. Supervisory visits shall be at least every 90 days. This determination must be documented in the waiver ~~individuals'~~ individual's records by the RN on the initial assessment and in the ongoing assessment records.

b. If DMAS determines that the waiver individual's health, safety, or welfare is in jeopardy, DMAS may require the provider's RN or LPN supervisor to supervise the personal care aides more frequently than once every 90 days. These visits shall be conducted at this designated increased frequency until DMAS determines that the waiver individual's health, safety, or welfare is no longer in jeopardy. This shall be documented by the provider and entered into the individual's record.

c. 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's/caregiver's, or both, satisfaction with the type and amount of services discussed.

d. If the supervising RN/LPN must be delayed in conducting the regular supervisory visit, such delay shall be documented in the waiver individual's record with the reasons for the delay. Such supervisory visits shall be conducted within 15 calendar days of the waiver individual's first availability.

e. A RN/LPN supervisor shall be available to the personal care aide for conferences pertaining to waiver individuals being served by the aide.

(1) The RN/LPN supervisor shall be available to the aide by telephone at all times that the aide is providing services to waiver individuals.

(2) The RN/LPN supervisor shall evaluate the personal care aide's performance and the waiver individual's needs to identify any insufficiencies in the personal care aide's abilities to function competently and shall provide training as indicated. This shall be documented in the waiver individual's record.

f. Licensed practical nurses (LPNs). As permitted by his license, the LPN may supervise personal care aides. To ensure both quality and appropriateness of services, the LPN supervisor shall make supervisory visits of the aides as often as needed, but no fewer visits than provided in a waiver ~~individuals' POCs~~ individual's POC as developed by the RN in collaboration with ~~individuals~~ the individual and the ~~individuals'~~ individual's family/caregivers, or both, as appropriate.

(1) During visits to the waiver individual's home, a LPN-supervisor shall observe, evaluate, and document the adequacy and appropriateness of personal care services, the individual's current functioning status 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.

(2) The LPN supervisor shall evaluate the personal care aide's performance and the waiver individual's needs to identify any insufficiencies in the aide's abilities to function competently and shall provide training as required to resolve the insufficiencies. This shall be documented in the waiver individual's record and reported to the RN supervisor.

(3) An LPN supervisor shall be available to personal care aides for conferences pertaining to waiver individuals being served by them.

g. Personal care aides. The agency provider may employ and the RN/LPN supervisor shall directly supervise personal care aides who provide direct care to waiver individuals. Each aide hired to provide personal care shall be evaluated by the provider agency to ensure compliance with qualifications and skills required by DMAS pursuant to 12VAC30-120-930.

4. Payment shall not be made for services furnished by family members or caregivers who are living under the same roof as the waiver individual receiving services, unless there is objective written documentation as to why ~~there are~~ no other ~~providers~~ provider or ~~aides~~ aide is available to provide the care. The provider shall initially make this determination and document it fully in the waiver individual's record.

5. Required documentation for a waiver ~~individuals'~~ individual's records. The provider shall maintain all records for each individual receiving personal care services. These records shall be separate from those of non-home and community-based care services, such as companion or home health services. These records shall be reviewed periodically by DMAS or its designated agent. At a minimum, the record shall contain:

a. All personal care aides' records (DMAS-90) to include (i) the specific services delivered to the waiver individual by the aide; (ii) the personal care aide's actual daily arrival and departure times; (iii) the aide's weekly

comments or observations about the waiver individual, including observations of the individual's physical and emotional condition, daily activities, and responses to services rendered; and (iv) any other information appropriate and relevant to the waiver individual's care and need for services.

b. The personal care aide's and individual's or responsible caregiver's signatures, including the date, shall be recorded on these records verifying that personal care services have been rendered during the week of the service delivery.

(1) An employee of the provider shall not sign for the waiver individual unless he is a family member or unpaid caregiver of the waiver individual.

(2) Signatures, times, and dates shall not be placed on the personal care aide record earlier than the last day of the week in which services were provided nor later than seven calendar days from the date of the last service.

G. Agency-directed respite care services.

1. To be approved as a respite care provider with DMAS, the respite care agency provider shall:

a. Employ or contract with and directly supervise either a RN or LPN, or both, who will provide ongoing supervision of all respite care aides/LPNs, as appropriate. A RN shall provide supervision to all direct care and supervisory LPNs.

(1) When respite care services are received on a routine basis, the minimum acceptable frequency of the required RN/LPN supervisor's visits shall not exceed every 90 days, based on the initial assessment. If ~~an~~ a waiver individual is also receiving personal care services, the respite care RN/LPN supervisory visit may coincide with the personal care RN/LPN supervisory visits. However, the RN/LPN supervisor shall document supervision of respite care separately from the personal care documentation. For this purpose, the same individual record may be used with a separate section for respite care documentation.

(2) When respite care services are not received on a routine basis but are episodic in nature, a RN/LPN supervisor shall conduct the home supervisory visit with the aide/LPN on or before the start of care. The RN/LPN shall review the utilization of respite services either every six months or upon the use of half of the approved respite hours, whichever comes first. If a waiver individual is also receiving personal care services, the respite care RN/LPN supervisory visit may coincide with the personal care RN/LPN supervisory visit.

(3) During visits to the waiver individual's home, the RN/LPN supervisor shall observe, evaluate, and document the adequacy and appropriateness of respite care services to the waiver individual's current functioning status and medical and social needs. The aide's/LPN's record shall be reviewed along with the waiver individual's or family's/caregiver's, or both, satisfaction with the type and amount of services discussed.

(4) Should the required RN/LPN supervisory visit be delayed, the reason for the delay shall be documented in the waiver individual's record. This visit shall be completed within 15 days of the waiver individual's first availability.

b. Employ or contract with aides to provide respite care services who shall meet the same education and training requirements as personal care aides.

c. Not hire respite care aides for ~~DMAS'~~ DMAS reimbursement for services that are rendered to waiver individuals when the aide is either (i) the spouse of the waiver individual or (ii) the parent (biological, adoptive, legal guardian) or other guardian of the minor child waiver individual.

d. Employ an LPN to perform skilled respite care services. Such services shall be reimbursed by DMAS under the following circumstances:

(1) The waiver individual shall have a documented need for routine skilled respite care that cannot be provided by unlicensed personnel, such as an aide. These waiver individuals would typically require a skilled level of care involving, for example but not necessarily limited to, ventilators for assistance with breathing or either nasogastric or gastrostomy feedings;

(2) No other person in the waiver individual's support system is willing and able to supply the skilled component of the individual's care during the primary caregiver's absence; and

(3) The waiver individual is unable to receive skilled nursing visits from any other source that could provide the skilled care usually given by the caregiver.

e. Document in the waiver individual's record the circumstances that require the provision of services by an LPN. At the time of the LPN's service, the LPN shall also provide all of the services normally provided by an aide.

2. Payment shall not be made for services furnished by other family members or caregivers who are living under the same roof as the waiver individual receiving services unless there is objective written documentation as to why ~~here are~~ no other ~~providers~~ provider or ~~aides~~ aide is available to provide the care. The provider shall initially make this determination and document it fully in the waiver individual's record.

3. Required documentation for a waiver ~~individuals'~~ individual's records. The provider shall maintain all records for each waiver individual receiving respite services. These records shall be separate from those of non-home and community-based care services, such as companion or home health services. These records shall be

reviewed periodically either by the DMAS staff or a contracted entity who is authorized by DMAS to review these files. At a minimum these records shall contain:

a. Forms as specified in the DMAS guidance documents.

b. All respite care LPN/aide records shall contain:

(1) The specific services delivered to the waiver individual by the LPN/aide;

(2) The respite care LPN's/aide's daily arrival and departure times;

(3) Comments or observations recorded weekly about the waiver individual. LPN/aide comments shall include~~, but shall not be limited to,~~ observation of the waiver individual's physical and emotional condition, daily activities, the individual's response to services rendered, and documentation of vital signs if taken as part of the POC.

c. All respite care LPN records (DMAS-90A) shall be reviewed and signed by the supervising RN and shall contain:

(1) The respite care LPN/aide's and waiver individual's or responsible family/caregiver's signatures, including the date, verifying that respite care services have been rendered during the week of service delivery as documented in the record.

(2) An employee of the provider shall not sign for the waiver individual unless he is a family member or unpaid caregiver of the waiver individual.

(3) Signatures, times, and dates shall not be placed on the respite care LPN/aide record earlier than the last day of the week in which services were provided. Nor shall signatures be placed on the respite care LPN/aide records later than seven calendar days from the date of the last service.

H. Consumer-directed (CD) services facilitation for personal care and respite services.

1. Any services rendered by attendants prior to dates authorized by DMAS or the ~~Srv Auth~~ service authorization contractor shall not be eligible for Medicaid reimbursement and shall be the responsibility of the waiver individual.

2. If the services facilitator is not an RN, then the services facilitator shall inform the primary health care provider for the individual who is enrolled in the waiver that services are being provided within 30 days from the start of such services and request consultation with the primary health care provider, as needed. This shall be done after the services facilitator secures written permission from the individual to contact the primary health care provider. The documentation of this written permission to contact the primary health care provider shall be retained in the individual's medical record. All contacts with the primary health care provider shall be documented in the individual's medical record.

~~2.~~ 3. The ~~CD~~ consumer-directed services facilitator, whether employed or contracted by a DMAS enrolled services facilitator, shall meet the following qualifications:

a. To be enrolled as a Medicaid ~~CD~~ consumer-directed services facilitator and maintain provider status, the ~~CD~~ consumer-directed services facilitator shall have sufficient knowledge, skills, and abilities to perform the activities required of such providers. In addition, the ~~CD~~ consumer-directed services facilitator shall have the ability to maintain and retain business and professional records sufficient to fully and accurately document the nature, scope, and details of the services provided.

b. Effective January 11, 2016, all consumer-directed services facilitators shall:

(1) Have a satisfactory work record as evidenced by two references from prior job experiences from any human services work; such references shall not include any evidence of abuse, neglect, or exploitation of older adults or persons with disabilities or children;

(2) Submit to a criminal background check being conducted. The results of such check shall contain no record of conviction of barrier crimes as set forth in § 32.1-162.9:1 of the Code of Virginia. Proof that the criminal record check was conducted shall be maintained in the record of the services facilitator. In accordance with 12VAC30-80-130, DMAS shall not reimburse the provider for any services provided by a services facilitator who has been convicted of committing a barrier crime as set forth in § 32.1-162.9:1 of the Code of Virginia;

(3) Submit to a search of the VDSS Child Protective Services Central Registry that results in no founded complaint; and

(4) Not be debarred, suspended, or otherwise excluded from participating in federal health care programs, as listed on the federal List of Excluded Individuals/Entities (LEIE) database at http://www.olg.hhs.govfraud/exclusions/exclusions%20list.asp.

c. The services facilitator shall not be compensated for services provided to the individual enrolled in the waiver effective on the date in which the record check verifies that the services facilitator (i) has been convicted of barrier crimes described in § 32.1-162.9:1 of the Code of Virginia, (ii) has a founded complaint confirmed by the VDSS Child Protective Services Central Registry, or (iii) is found to be listed on LEIE.

d. Effective January 11, 2016, all consumer-directed services facilitators shall possess the required degree and experience, as follows:

(1) Prior to initial enrollment by the department as a consumer-directed services facilitator or being hired by a Medicaid-enrolled services facilitator provider, all new applicants shall possess, at a minimum, either (i) an associate's degree from an accredited college in a health or human services field or be a registered nurse currently licensed to practice in the Commonwealth and possess a minimum of two years of satisfactory direct care experience supporting individuals with disabilities or older adults; or (ii) a bachelor's degree in a non-health or human services field and possess a minimum of three years of satisfactory direct care experience supporting individuals with disabilities or older adults.

(2) Persons who are consumer-directed services facilitators prior to January 11, 2016, shall not be required to meet the degree and experience requirements of subdivision 3 d (1) of this subsection unless required to submit a new application to be a consumer-directed services facilitator after January 11, 2016.

e. Effective April 10, 2016, all consumer-directed services facilitators shall complete required training and competency assessments. Satisfactory competency assessment results shall be kept in the service facilitator's record.

(1) All new consumer-directed consumer directed services facilitators shall complete the DMAS-approved consumer-directed services facilitator training and pass the corresponding competency assessment with a score of at least 80% prior to being approved as a consumer-directed services facilitator or being reimbursed for working with waiver individuals.

(2) Persons who are consumer-directed services facilitators prior to January 11, 2016, shall be required to complete the DMAS-approved consumer-directed services facilitator training and pass the corresponding competency assessment with a score of at least 80% in order to continue being reimbursed for or working with waiver individuals for the purpose of Medicaid reimbursement.

f. Failure to satisfy the competency assessment requirements and meet all other requirements shall result in a retraction of Medicaid payment or the termination of the provider agreement, or both.

g. Failure to satisfy the competency assessment requirements and meet all other requirements may also result in the termination of a CD services facilitator employed by or contracted with a Medicaid enrolled services facilitator provider.

h. As a component of the renewal of the Medicaid provider agreement, all CD services facilitators shall pass the competency assessment every five years and achieve a score of at least 80%.

i. The consumer-directed services facilitator shall have access to a computer with Internet access that meets the security standards of Subpart C of 45 CFR Part 164 for the electronic exchange of information. Electronic exchange of information shall include, for example, checking individual eligibility, submission of service authorizations, submission of information to the fiscal employer agent, and billing for services.

~~b. It is preferred that the CD services facilitator possess, at a minimum, an undergraduate degree in a human services field or be a registered nurse currently licensed to practice in the Commonwealth. In addition, it is preferable that the CD services facilitator have at least two years of satisfactory experience in a human services field working with individuals who are disabled or elderly.~~

j. The ~~CD~~ consumer-directed services facilitator must possess a combination of work experience and relevant education that indicates possession of the following knowledge, skills, and abilities ~~described below in this subdivision H 2 b~~. Such knowledge, skills, and abilities must be documented on the ~~CD~~ consumer-directed services facilitator's application form, found in supporting documentation, or be observed during a job interview. Observations during the interview must be documented. The knowledge, skills, and abilities include:

(1) Knowledge of:

(a) Types of functional limitations and health problems that may occur in ~~individuals who are elderly~~ older adults or individuals with disabilities, as well as strategies to reduce limitations and health problems;

(b) Physical care that may be required by ~~individuals who are elderly~~ older adults or individuals with disabilities, such as transferring, bathing techniques, bowel and bladder care, and the approximate time those activities normally take;

(c) Equipment and environmental modifications that may be required by ~~individuals who are elderly~~ older adults or individuals with disabilities that reduce the need for human help and improve safety;

(d) Various long-term care program requirements, including nursing facility and assisted living facility placement criteria, Medicaid waiver services, and other federal, state, and local resources that provide personal care and respite services;

(e) Elderly or Disabled with Consumer-Direction Waiver requirements, as well as the administrative duties for which the services facilitator will be responsible;

(f) How to conduct assessments (including environmental, psychosocial, health, and functional factors) and their uses in services planning;

(g) Interviewing techniques;

(h) The individual's right to make decisions about, direct the provisions of, and control his consumer-directed services, including hiring, training, managing, approving the time sheets of, and firing an aide;

(i) The principles of human behavior and interpersonal relationships; and

(j) General principles of record documentation.

(2) Skills in:

(a) Negotiating with individuals, family/caregivers, and service providers;

(b) Assessing, supporting, observing, recording, and reporting behaviors;

(c) Identifying, developing, or providing services to individuals who are ~~elderly~~ older adults or individuals with disabilities; and

(d) Identifying services within the established services system to meet the individual's needs.

(3) Abilities to:

(a) Report findings of the assessment or onsite visit, either in writing or an alternative format for individuals who have visual impairments;

(b) Demonstrate a positive regard for individuals and their families;

(c) Be persistent and remain objective;

(d) Work independently, performing position duties under general supervision;

(e) Communicate effectively orally and in writing; and

(f) Develop a rapport and communicate with individuals from diverse cultural backgrounds.

~~c. If the CD services facilitator is not a RN, the CD services facilitator shall inform the waiver individual's primary health care provider that services are being provided and request consultation as needed. These contacts shall be documented in the waiver individual's record.~~

~~3.~~ 4. Initiation of services and service monitoring.

a. For ~~CD services~~ consumer-directed model of service, the ~~CD~~ consumer-directed services facilitator shall make an initial comprehensive ~~in home~~ home visit at the primary residence of the ~~waiver~~ individual to collaborate with the ~~waiver~~ individual or the individual's family/caregiver, as appropriate, to identify the individual's needs, assist in the development of the ~~POC~~ plan of care with the waiver individual ~~or~~ and individual's family/caregiver, as appropriate, and provide ~~employer of record (EOR) employee~~ EOR management training within seven days of the initial visit. The initial comprehensive home visit shall be conducted only once upon the ~~waiver~~ individual's entry into ~~CD~~ consumer-directed services. If the ~~waiver~~ individual changes, either voluntarily or involuntarily, the ~~CD~~ consumer-directed services facilitator, the new ~~CD~~ consumer-directed services facilitator ~~must~~ shall complete a reassessment visit in lieu of ~~an initial~~ a comprehensive visit.

b. After the initial comprehensive visit, the ~~CD~~ services facilitator shall continue to monitor the ~~POC~~ plan of care on an as-needed basis, but in no event less frequently than every 90 days for personal care, and shall conduct face-to-face meetings with the ~~waiver~~ individual and may include the family/caregiver. The ~~CD~~ services facilitator shall review the utilization of ~~CD~~ consumer-directed respite services, either every six months or upon the use of half of the approved respite services hours, whichever comes first, and shall conduct a face-to-face meeting with the ~~waiver~~ individual and may include the family/caregiver. Such monitoring reviews shall be documented in the individual's medical record.

c. During visits with the ~~waiver~~ individual, the ~~CD~~ services facilitator shall observe, evaluate, and consult with the individual/EOR and may include the family/caregiver, and document the adequacy and appropriateness of ~~CD~~ consumer-directed services with regard to the ~~waiver~~ individual's current functioning, cognitive status, and medical and social needs. The ~~CD~~ consumer-directed services facilitator's written summary of the visit shall include~~, but shall not necessarily be limited to~~ at a minimum:

(1) ~~A discussion~~ Discussion with the waiver individual or family/caregiver/EOR, as appropriate, concerning whether the service is adequate to meet the waiver individual's needs;

(2) Any suspected abuse, neglect, or exploitation and to whom it was reported;

(3) Any special tasks performed by the consumer-directed attendant and the consumer-directed attendant's qualifications to perform these tasks;

(4) The ~~waiver~~ individual's or family/caregiver's/EOR's satisfaction with the service;

(5) Any hospitalization or change in medical condition, functioning, or cognitive status; and

(6) The presence or absence of the consumer-directed attendant in the home during the ~~CD~~ consumer-directed services facilitator's visit.

~~4.~~ 5. DMAS, its designated contractor, or the fiscal/employer agent shall request a criminal record check and a check of the VDSS Child Protective Services Central Registry if the waiver individual is a minor child, in accordance with 12VAC30-120-930, pertaining to the consumer-directed attendant on behalf of the waiver individual and report findings of these records checks to the EOR.

~~5.~~ 6. The ~~CD~~ consumer-directed services facilitator shall review and verify copies of timesheets during the face-to-face visits to ensure that the hours approved in the ~~POC~~

plan of care are being provided and are not exceeded. If discrepancies are identified, the ~~CD~~ consumer-directed services facilitator shall discuss these with the ~~waiver~~ individual or EOR to resolve discrepancies and shall notify the fiscal/employer agent. The ~~CD~~ consumer-directed services facilitator shall also review the ~~waiver~~ individual's ~~POC~~ plan of care to ensure that the ~~waiver~~ individual's needs are being met. Failure to conduct such reviews and verifications of timesheets and maintain the documentation of these reviews shall result in a recovery by DMAS of payments made in accordance with 12VAC30-80-130.

~~6.~~ 7. The ~~CD~~ services facilitator shall maintain records of each ~~waiver~~ individual that he serves. At a minimum, these records shall contain:

a. Results of the initial comprehensive home visit completed prior to or on the date services are initiated and subsequent reassessments and changes to the supporting documentation;

b. The personal care ~~POC~~ plan of care. Such plans shall be reviewed by the provider every 90 days, annually, and more often as needed, and modified as appropriate. The respite services ~~POC~~ plan of care shall be included in the record and shall be reviewed by the provider every six months or when half of the approved respite service hours have been used whichever comes first. For the annual review and in cases where either the personal care or respite care ~~POC~~ plan of care is modified, the ~~POC~~ plan of care shall be reviewed with the ~~waiver~~ individual, the family/caregiver, and EOR, as appropriate;

c. ~~CD~~ The consumer-directed services facilitator's dated notes documenting any contacts with the ~~waiver~~ individual or family/caregiver/EOR and visits to the individual;

d. All contacts, including correspondence, made to and from the ~~waiver~~ individual, EOR, family/caregiver, physicians, DMAS, the designated ~~Srv Auth~~ service authorization contractor, formal and informal services provider, and all other professionals related to the individual's Medicaid services or medical care;

e. All employer management training provided to the ~~waiver~~ individual or EOR to include, ~~but not necessarily be limited to~~ for example, (i) the individual's or EOR's receipt of training on their responsibilities for the accuracy of the consumer-directed attendant's timesheets and (ii) the availability of the Consumer-Directed Waiver Services Employer Manual available at www.dmas.virginia.gov;

f. All documents signed by the ~~waiver~~ individual or EOR, as appropriate, that acknowledge the responsibilities as the employer; and

g. The DMAS required forms as specified in the agency's waiver-specific guidance document.

Failure to maintain all required documentation shall result in action by DMAS to recover payments made in accordance with 12VAC30-80-130. Repeated instances of failure to maintain documentation may result in cancellation of the Medicaid provider agreement.

~~7. Payment shall not be made for services furnished by other family members or caregivers who are living under the same roof as the waiver individual receiving services unless there is objective written documentation by the CD services facilitator as to why there are no other providers or aides available to provide the required care.~~

8. In instances when ~~either~~ the ~~waiver~~ individual is consistently unable either to hire ~~and~~ or retain the employment of a personal care consumer-directed attendant to provide ~~CD~~ consumer-directed personal care or respite services such as, ~~but not limited to~~ for example, a pattern of discrepancies with the consumer-directed attendant's timesheets, the ~~CD~~ consumer-directed services facilitator shall make arrangements, after conferring with DMAS, to have the needed services transferred to an agency-directed services provider of the individual's choice or discuss with the ~~waiver~~ individual or family/caregiver/EOR, or both, other service options.

9. Waiver individual, family/caregiver, and EOR responsibilities.

a. The ~~waiver~~ individual shall be authorized for ~~CD services~~ the consumer-directed model of service, and the EOR shall successfully complete ~~consumer/employee management~~ EOR management training performed by the ~~CD~~ consumer-directed services facilitator before the individual or EOR shall be permitted to hire ~~an~~ a consumer-directed attendant for Medicaid reimbursement. Any ~~services~~ service that may be rendered by ~~an~~ a consumer-directed attendant prior to authorization by Medicaid shall not be eligible for reimbursement by Medicaid. ~~Waiver individuals~~ Individuals who are eligible for ~~CD~~ consumer-directed services shall have the capability to hire and train their own consumer-directed attendants and supervise the consumer-directed attendants' ~~performance~~ performances. ~~Waiver~~ In lieu of handling their consumer-directed attendants themselves, individuals may have a family/caregiver or other designated person serve as the EOR on their behalf. The EOR shall be prohibited from also being the Medicaid-reimbursed consumer-directed attendant for respite or personal care or the services facilitator for the ~~waiver~~ individual.

b. ~~Waiver individuals~~ Individuals shall acknowledge that they will not knowingly continue to accept ~~CD~~ consumer-directed personal care services when the service is no longer appropriate or necessary for their care needs and shall inform the services facilitator of their change in care needs. If ~~CD~~ the consumer-directed model of services continue after services have been

terminated by DMAS or the designated ~~Srv Auth~~ service authorization contractor, the ~~waiver~~ individual shall be held liable for the consumer-directed attendant compensation.

c. ~~Waiver individuals~~ Individuals shall notify the ~~CD~~ consumer-directed services facilitator of all hospitalizations or admissions, ~~such as but not necessarily limited to~~ for example, any rehabilitation facility, rehabilitation unit, or ~~NF~~ nursing facility as ~~CD~~ consumer-directed attendant services shall not be reimbursed during such admissions. Failure to do so may result in the ~~waiver~~ individual being held liable for ~~attendant~~ the consumer-directed employee compensation.

~~d. Waiver individuals shall not employ attendants for DMAS reimbursement for services rendered to themselves when the attendant is the (i) spouse of the waiver individual; (ii) parent (biological, adoptive, legal guardian) or other guardian of the minor child waiver individual; or (iii) family/caregiver or caregivers/EOR who may be directing the waiver individual's care.~~

I. Personal emergency response systems. In addition to meeting the general conditions and requirements for home and community-based waiver participating providers as specified in 12VAC30-120-930, PERS providers must also meet the following qualifications and requirements:

1. A PERS provider shall be ~~either~~, but not necessarily be limited to, a personal care agency, a durable medical equipment provider, a licensed home health provider, or a PERS manufacturer. All such providers shall have the ability to provide PERS equipment, direct services (i.e., installation, equipment maintenance, and service calls), and PERS monitoring;

2. The PERS provider shall provide an emergency response center with fully trained operators who are capable of (i) receiving signals for help from an individual's PERS equipment 24 hours a day, 365 or 366 days per year, as appropriate; (ii) determining whether an emergency exists; and (iii) notifying an emergency response organization or an emergency responder that the PERS individual needs emergency help;

3. A PERS provider shall comply with all applicable Virginia statutes, all applicable regulations of DMAS, and all other governmental agencies having jurisdiction over the services to be performed;

4. The PERS provider shall have the primary responsibility to furnish, install, maintain, test, and service the PERS equipment, as required, to keep it fully operational. The provider shall replace or repair the PERS device within 24 hours of the waiver individual's notification of a malfunction of the console unit, activating devices, or medication monitoring unit and shall provide temporary equipment, as may be necessary for the waiver individual's health, safety, and welfare, while the original equipment is being repaired or replaced;

5. The PERS provider shall install, consistent with the manufacturer's instructions, all PERS equipment into a waiver individual's functioning telephone line or system within seven days of the request of such installation unless there is appropriate documentation of why this timeframe cannot be met. The PERS provider shall furnish all supplies necessary to ensure that the system is installed and working properly. The PERS provider shall test the PERS device monthly, or more frequently if needed, to ensure that the device is fully operational;

6. The PERS installation shall include local seize line circuitry, which guarantees that the unit shall have priority over the telephone connected to the console unit should the telephone be off the hook or in use when the unit is activated;

7. A PERS provider shall maintain a data record for each waiver individual at no additional cost to DMAS or the waiver individual. The record shall document all of the following:

a. Delivery date and installation date of the PERS equipment;

b. Waiver individual/caregiver signature verifying receipt of the PERS equipment;

c. Verification by a test that the PERS device is operational and the waiver individual is still using it monthly or more frequently as needed;

d. Waiver individual contact information, to be updated annually or more frequently as needed, as provided by the individual or the individual's caregiver/EOR;

e. A case log documenting the waiver individual's utilization of the system, all contacts, and all communications with the individual, caregiver/EOR, and responders;

f. Documentation that the waiver individual is able to use the PERS equipment through return demonstration; and

g. Copies of all equipment checks performed on the PERS unit;

8. The PERS provider shall have backup monitoring capacity in case the primary system cannot handle incoming emergency signals;

9. The emergency response activator shall be capable of being activated either by breath, touch, or some other means and shall be usable by waiver individuals who are visually or hearing impaired or physically disabled. The emergency response communicator shall be capable of operating without external power during a power failure at the waiver individual's home for a minimum period of 24 hours. The emergency response console unit shall also be able to self-disconnect and redial the backup monitoring site without the waiver individual resetting the system in the event it cannot get its signal accepted at the response center;

10. PERS providers shall be capable of continuously monitoring and responding to emergencies under all conditions, including power failures and mechanical malfunctions. It shall be the PERS provider's responsibility to ensure that the monitoring agency and the monitoring agency's equipment meet the following requirements. The PERS provider shall be capable of simultaneously responding to multiple signals for help from the waiver individuals' PERS equipment. The PERS provider's equipment shall include the following:

a. A primary receiver and a backup receiver, which shall be independent and interchangeable;

b. A backup information retrieval system;

c. A clock printer, which shall print out the time and date of the emergency signal, the waiver individual's identification code, and the emergency code that indicates whether the signal is active, passive, or a responder test;

d. A backup power supply;

e. A separate telephone service;

f. A toll-free number to be used by the PERS equipment in order to contact the primary or backup response center; and

g. A telephone line monitor, which shall give visual and audible signals when the incoming telephone line is disconnected for more than 10 seconds;

11. The PERS provider shall maintain detailed technical and operation manuals that describe PERS elements, including the installation, functioning, and testing of PERS equipment; emergency response protocols; and recordkeeping and reporting procedures;

12. The PERS provider shall document and furnish within 30 days of the action taken, a written report for each emergency signal that results in action being taken on behalf of the waiver individual. This excludes test signals or activations made in error. This written report shall be furnished to (i) the personal care provider; (ii) the respite care provider; (iii) the CD services facilitation provider; (iv) in cases where the individual only receives ADHC services, to the ADCC provider; or (v) to the transition coordinator for the service in which the individual is enrolled; and

13. The PERS provider shall obtain and keep on file a copy of the most recently completed DMAS-225 form. Until the PERS provider obtains a copy of the DMAS-225 form, the PERS provider shall clearly document efforts to obtain the completed DMAS-225 form from the personal care provider, respite care provider, CD services facilitation provider, or ADCC provider.

J. Assistive technology (AT) and environmental modification (EM) services. AT and EM shall be provided only to waiver individuals who also participate in the MFP demonstration program by providers who have current provider participation agreements with DMAS.

1. AT shall be rendered by providers having a current provider participation agreement with DMAS as durable medical equipment and supply providers. An independent, professional consultation shall be obtained, as may be required, from qualified professionals who are knowledgeable of that item for each AT request prior to approval by either DMAS or the Srv Auth contractor and may include training on such AT by the qualified professional. Independent, professional consultants shall include, but shall not necessarily be limited to, speech/language therapists, physical therapists, occupational therapists, physicians, behavioral therapists, certified rehabilitation specialists, or rehabilitation engineers. Providers that supply AT for a waiver individual may not perform assessment/consultation, write specifications, or inspect the AT for that individual. Providers of services shall not be (i) spouses of the waiver individual or (ii) parents (biological, adoptive, foster, or legal guardian) of the waiver individual. AT shall be delivered within 60 days from the start date of the authorization. The AT provider shall ensure that the AT functions properly.

2. In addition to meeting the general conditions and requirements for home and community-based waiver services participating providers as specified in 12VAC30-120-930, as appropriate, environmental modifications shall be provided in accordance with all applicable state or local building codes by contractors who have provider agreements with DMAS. Providers of services shall not be (i) the spouse of the waiver individual or (ii) the parent (biological, adoptive, foster, or legal guardian) of the waiver individual who is a minor child. Modifications shall be completed within a year of the start date of the authorization.

3. Providers of AT and EM services shall not be permitted to recover equipment that has been provided to waiver individuals whenever the provider has been charged, by either DMAS or its designated service authorization agent, with overpayments and is therefore being required to return payments to DMAS.

K. Transition coordination. This service shall be provided consistent with 12VAC30-120-2000 and 12VAC30-120-2010.

L. Transition services. This service shall be provided consistent with 12VAC30-120-2000 and 12VAC30-120-2010.

VA.R. Doc. No. R16-3805; Filed April 14, 2017, 1:37 p.m.

Fast-Track Regulation

Title of Regulation: **12VAC30-70. Methods and Standards for Establishing Payment Rates - Inpatient Hospital Services (amending 12VAC30-70-50, 12VAC30-70-221, 12VAC30-70-301).**

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: June 14, 2017.

Effective Date: June 29, 2017.

Agency Contact: Emily McClellan, Regulatory Supervisor, Policy Division, Department of Medical Assistance Services, 600 East Broad Street, Suite 1300, Richmond, VA 23219, telephone (804) 371-4300, FAX (804) 786-1680, or email emily.mcclellan@dmas.virginia.gov.

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

Based on authority under Item 301 WWW of Chapter 3 of the 2014 Acts of Assembly and Item 301 WWW of Chapter 665 of the 2015 Acts of Assembly, this regulatory action replaces the existing disproportionate share hospital (DSH) payment methodologies for all inpatient hospital services. The changes referencing the state's DSH allotment are consistent with the federal law changes contained in § 1923(f) of the Social Security Act.

Purpose: The purpose of this action is to replace the current disproportionate share hospital payment methodologies for hospitals providing care to Medicaid members with a sustainable payment methodology. The current methodology is unsustainable given the current state budget and federal DSH allotments for Medicaid states, including the allotment reductions mandated by the Patient Protection and Affordable Care Act (Affordable Care Act), Public Law 111-148.

In addition, this action more equitably distributes the available funding and provides for annual revisions to reflect changes in the disproportionate share costs incurred by hospitals.

This action does not directly affect the health, safety, and welfare of citizens of the Commonwealth.

Rationale for Using Fast-Track Rulemaking Process: This regulatory action is promulgated as a fast-track rulemaking action as the changes are noncontroversial. The changes were based on recommendations of the Hospital Payment Policy Advisory Council. The Centers for Medicare and Medicaid Services (CMS) has reviewed and approved the changes.

Substance: The section of the State Plan for Medical Assistance that is affected by this action is Methods and Standards for Establishing Payment Rates - Inpatient Hospital Services (12VAC30-70-50 - Hospital reimbursement system; 12VAC30-70-221 - General; 12VAC30-70-301 - Payment to disproportionate share hospitals).

The DSH methodology in effect prior to July 1, 2014, calculates DSH payments based on operating reimbursement multiplied by Medicaid utilization in excess of specific utilization thresholds. Over time, this methodology has produced unsustainable growth in DSH reimbursement, resulting in budget changes to freeze DSH payment levels or otherwise adjust DSH payments to available funding on an ad hoc basis.

The new methodology multiplies eligible DSH days in a base year by the DSH per diem for all hospitals except Type One hospitals. DSH will be calculated annually based on updated data.

Eligible DSH days for each hospital except Type One hospitals are any Medicaid inpatient acute, psychiatric, and rehabilitation days in a base year in excess of 14% Medicaid utilization. Additional eligible DSH days for each hospital are Medicaid days in excess of 28% Medicaid utilization. Additional eligible DSH days provide additional DSH reimbursement for hospitals with very high Medicaid utilization. DSH days for out-of-state enrolled hospitals is prorated by the percentage of Medicaid utilization that is for Virginia Medicaid members. In addition, eligible DSH days for out-of-state hospitals with less than 12% Virginia Medicaid utilization are reduced by 50%.

Medicare also uses Medicaid days to calculate Medicare DSH, but Virginia's definition of Medicaid days differed from Medicare, and Virginia developed separate reporting requirements for Medicaid days. These regulations align Virginia's definition of Medicaid days with the Medicare definition and use the Medicare cost report as the source for Medicaid days.

The DSH per diem is calculated separately for Type Two hospitals excluding Children's Hospital of the King's Daughters (CHKD) and state inpatient psychiatric hospitals. State inpatient psychiatric hospitals are considered to be their own category of Type Two hospital, and are discussed below.

The regulations define a DSH allocation for Type Two hospitals excluding CHKD equal to the amount of DSH paid to these hospitals in state fiscal year 2014 increased annually by the percentage change in the federal DSH allotment, including any reductions as a result of the Affordable Care Act. The DSH per diem for these hospitals is equal to this allocation divided by eligible DSH days for these hospitals.

For CHKD, the DSH per diem equals three times the DSH per diem for Type Two hospitals excluding CHKD.

The regulations define a DSH allocation for state inpatient psychiatric hospitals equal to the amount of DSH paid to these hospitals in state fiscal year 2014 increased annually by the percentage change in the federal DSH allotment, including any reductions as a result of the Affordable Care act. The DSH per diem for these hospitals is equal to this allocation divided by eligible DSH days for these hospitals.

The DSH payment methodology for Type One hospitals equals their uncompensated care costs. This differs from the methodology authorized in the budget because the Centers for Medicare and Medicaid Services would not approve the parallel State Plan amendment. As a practical matter, however, DSH for Type One hospitals would be limited under either methodology by the annual hospital uncompensated care cost limit.

Issues: DMAS submitted to CMS, and CMS rejected, a proposal to allot Type One hospitals a DSH payment 17 times more than for Type Two hospitals. The changes in this regulatory action have been reviewed and approved by CMS.

The advantage of this regulatory action is that it will allow DSH payments to remain in place. The old system was unsustainable, and payments could not have continued under the old system.

There are no disadvantages to the public, the agency, or the Commonwealth from this action. Some individual hospital facility payments may increase or decrease under the new methodology, but that is not possible to predict in advance.

Department of Planning and Budget's Economic Impact Analysis:

Summary of the Proposed Amendments to Regulation. Pursuant to Item 301 WWW of the 2014 Appropriation Act and Item 301 WWW of the 2015 Appropriation Act, the proposed regulation replaces the disproportionate share hospital (DSH) payment methodologies in the regulation for hospitals providing care to Medicaid recipients.

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

Estimated Economic Impact. This regulation governs DSH payment methodologies for hospitals providing care to Medicaid recipients. The federal government requires the state Medicaid programs to make DSH payments to qualifying hospitals that serve a large number of Medicaid and uninsured individuals to offset their uncompensated care costs. In Virginia, there are two Type One, or commonly referred as teaching hospitals (University of Virginia and Virginia Commonwealth University), and 34 Type Two hospitals currently eligible for DSH payments. The total DSH Payments made in fiscal year (FY) 2015 are as follows: $150.5 million to two Type One hospitals, $5.4 million to two State Inpatient Psychiatric Hospitals, $9.2 million to Children's Hospital of the King's Daughters, and $24 million to the remaining 31 Type Two hospitals.

The DSH methodology in effect prior to July 1, 2014, calculated DSH payments based on operating cost reimbursement multiplied by Medicaid utilization in excess of specific utilization thresholds. As the operating costs and Medicaid utilization increased, so did the calculated DSH payments. However, the state DSH payments are subject to an annual allotment established by the federal government. Particularly, in 2010, the Affordable Care Act mandated allotment reductions for DSH payments which were short of the calculated DSH payments based on then existing methodology. The anticipated shortage of federal DSH allotment led to freezing of DSH payments or adjusting the payments on an ad hoc basis to match the available funding. Even though the allotment reductions were delayed later and have yet to be implemented, the planned reductions created the need to amend the DSH payment methodology.

In order to address the issue, Item 301 WWW of the 2014 Appropriation Act and Item 301 WWW of the 2015 Appropriation Act mandated the Department of Medical Assistance Services (DMAS) to replace the then existing DSH methodology effective July 1, 2014. DMAS obtained approval from Centers for Medicare and Medicaid Services (CMS) on June 2, 2015 and started applying the new methodology to payments made in FY 2015.

The new methodology starts with calculating DSH payments for Type Two hospitals by multiplying their eligible DSH days by the DSH per diem to calculate their DSH payment.

Eligible DSH days are any Medicaid inpatient acute, psychiatric and rehabilitation days in excess of 14% Medicaid utilization. Additional eligible DSH days for each hospital are allowed in excess of 28% Medicaid utilization. Additional eligible DSH days provide supplemental DSH reimbursement for hospitals with very high Medicaid utilization. DSH days for out-of-state enrolled hospitals is prorated by the percentage of Medicaid utilization that is for Virginia Medicaid members. In addition, eligible DSH days for out-of-state hospitals with less than 12% Virginia Medicaid utilization are reduced by 50%.

The DSH per diem is calculated by dividing the total DSH allotment for Type Two hospitals by their total DSH days. The DSH per diem is calculated for a base year and adjusted by the percentage change in the allotment available for distribution. The hospital specific DSH payment is then calculated by multiplying the hospital's eligible DSH days with the per diem. The base year is updated every year.

The DSH payment for State Inpatient Psychiatric Hospitals is also calculated using the same methodology, but it is calculated separately by dividing the allotment available for such hospitals by dividing their eligible DSH days. The per diem for Children's Hospital of the King's Daughters is defined as three times the DSH per diem for Type Two hospitals.

Unallocated DSH allotment after Type Two hospital payments are calculated is available for distribution to Type

One hospitals. The new methodology defines Type One hospital DSH payments as their uncompensated care costs. Although the 2014 and 2015 Appropriation Acts defined the Type One hospital per diem as 17 times the DSH per diem for Type Two hospitals, CMS did not approve that definition. As a practical matter, however, DSH for Type One hospitals would be limited under either methodology by the annual DSH allotment for the Commonwealth.

DMAS also notes that Medicare uses Medicaid days to calculate Medicare DSH, but Virginia's definition of Medicaid days differed from Medicare and Virginia developed separate reporting requirements for Medicaid days. In that sense, this regulation aligns Virginia's definition of Medicaid days with the Medicare definition and uses the Medicare cost report as the source for Medicaid days.

The proposed changes are budget neutral in the sense that the total DSH payments remain the same, which is the federally allowed total DSH allotment. The main effect is with respect to how the total allotment is distributed among the hospitals. Under the new methodology, some hospitals would receive more and others would receive less. However, a comparison of payments under the old and new methodologies is not available. Thus, the magnitude of hospital specific payment changes is not known at this time.

The new methodology is beneficial in several aspects. First, the DSH payments will be based on more recent utilization data. For example, FY 2014 DSH payments were based on utilization data from 2010. If 2010 utilization did not qualify a hospital for DSH payments, that hospital was disqualified receiving DSH payments in subsequent years even though they may have qualified later. Second, the methodology is formula based which brings more certainty into the distribution process. A hospital is better equipped to determine if and approximately how much DSH payments it can expect for a given year. Third, the new methodology adjusts payments automatically as a result of changes in the available allotment which eliminates the need for ad hoc adjustments. In short, the new methodology more equitably distributes the available funding and provides for annual revisions to reflect changes in the disproportionate share costs incurred by hospitals.

The proposed new methodology has been in effect since July 1, 2014. Thus, no significant economic impact is expected upon promulgation of the prosed changes other than improving the clarity of the regulation and achieving consistency between the state plan amendments approved by CMS and the language in the Virginia Administrative Code.

Businesses and Entities Affected. The proposed amendments pertain to the two Type One hospitals and 34 Type Two hospitals including Children's Hospital of the King's Daughters and two state inpatient psychiatric hospitals.

Localities Particularly Affected. The proposed changes apply statewide.

Projected Impact on Employment. Under the proposed changes some hospitals may receive more DSH payments while others receive less. A change in funding may have a negative or positive impact on a hospital's ability to hire new employees or maintain its existing employees. However, the magnitudes of the impact on hospital specific DSH payments are not known.

Effects on the Use and Value of Private Property. Similarly, a change in DSH payments received may have a negative or positive impact on a hospital's asset value. However, the magnitude of such impact is not known.

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

Small Businesses:

Definition. Pursuant to § 2.2-4007.04 of the Code of Virginia, small business is defined as "a business entity, including its affiliates, that (i) is independently owned and operated and (ii) employs fewer than 500 full-time employees or has gross annual sales of less than $6 million."

Costs and Other Effects. Affected hospitals are not small businesses.

Alternative Method that Minimizes Adverse Impact. The proposed changes do not affect small businesses.

Adverse Impacts:

Businesses. The proposed amendments would reduce DSH payments for some hospitals. The magnitudes of the reductions are not known.

Localities. The proposed amendments should not adversely affect localities.

Other Entities. The proposed amendments should not adversely affect other entities.

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

Summary:

The amendments include (i) establishing new disproportionate share payment methodologies for hospitals providing care to Medicaid members, (ii) providing for annual revisions to the methodologies to reflect changes in the disproportionate share costs incurred by hospitals, (iii) aligning the definition of Medicaid days with the Medicare definition, and (iv) using the Medicare cost report as the source for Medicaid days. Item 301 WWW of Chapter 3 of the 2014 Acts of Assembly and Item 301 WWW of Chapter 665 of the 2015 Acts of Assembly mandated the establishment of new disproportionate share hospital payment methodologies.

12VAC30-70-50. Hospital reimbursement system.

The reimbursement system for hospitals includes the following components:

A. Hospitals were grouped by classes according to number of beds and urban versus rural. (Three groupings for rural - 0 to 100 beds, 101 to 170 beds, and over 170 beds; four groupings for urban - 0 to 100, 101 to 400, 401 to 600, and over 600 beds.) Groupings are similar to those used by the ~~Health Care Financing Administration (HCFA)~~ Centers for Medicare and Medicaid Services in determining routine cost limitations.

B. Prospective reimbursement ceilings on allowable operating costs were established as of July 1, 1982, for each grouping. Hospitals with a fiscal year end after June 30, 1982, were subject to the new reimbursement ceilings.

1. The calculation of the initial group ceilings as of July 1, 1982, was based on available, allowable cost data for hospitals in calendar year 1981. Individual hospital operating costs were advanced by a reimbursement escalator from the hospital's year end to July 1, 1982. After this advancement, the operating costs were standardized using SMSA wage indices, and a median was determined for each group. These medians were readjusted by the wage index to set an actual cost ceiling for each SMSA. Therefore, each hospital grouping has a series of ceilings representing one of each SMSA area. The wage index is based on those used by HCFA in computing its Market Basket Index for routine cost limitations.

2. Effective July 1, 1986, and until June 30, 1988, providers subject to the prospective payment system of reimbursement had their prospective operating cost rate and prospective operating cost ceiling computed using a new methodology. This method uses an allowance for inflation based on the percent of change in the quarterly average of the Medical Care Index of the Chase Econometrics - Standard Forecast determined in the quarter in which the provider's new fiscal year began.

3. The prospective operating cost rate is based on the provider's allowable cost from the most recent filed cost report, plus the inflation percentage add-on.

4. The prospective operating cost ceiling is determined by using the base that was in effect for the provider's fiscal year that began between July 1, 1985, and June 1, 1986. The allowance for inflation percent of change for the quarter in which the provider's new fiscal year began is added to this base to determine the new operating cost ceiling. This new ceiling was effective for all providers on July 1, 1986. For subsequent cost reporting periods beginning on or after July 1, 1986, the last prospective operating rate ceiling determined under this new methodology will become the base for computing the next prospective year ceiling.

5. Effective on and after July 1, 1988, and until June 30, 1989, for providers subject to the prospective payment system, the allowance for inflation shall be based on the percent of change in the moving average of the Data Resources, Incorporated Health Care Cost HCFA-Type Hospital Market Basket determined in the quarter in which the provider's new fiscal year begins. Such providers shall have their prospective operating cost rate and prospective operating cost ceiling established in accordance with the methodology which became effective July 1, 1986. Rates and ceilings in effect July 1, 1988, for all such hospitals shall be adjusted to reflect this change.

6. Effective on or after July 1, 1989, for providers subject to the prospective payment system, the allowance for inflation shall be based on the percent of change in the Virginia moving average ~~of the Health Care Cost HCFA-Type Hospital Market Basket, adjusted for Virginia, as developed by Data Resources, Incorporated,~~ values as compiled and published by Global Insight (or its successor) determined in the quarter in which the provider's new fiscal year begins. Such providers shall have their prospective operating cost rate and prospective operating cost ceiling established in accordance with the methodology which became effective July 1, 1986. Rates and ceilings in effect July 1, 1989, for all such hospitals shall be adjusted to reflect this change.

7. Effective on and after July 1, 1992, for providers subject to the prospective payment system, the allowance for inflation, as described ~~above~~ in this section, which became effective on July 1, 1989, shall be converted to an escalation factor by adding two percentage points, (200 basis points) to the then current allowance for inflation. The escalation factor shall be applied in accordance with the inpatient hospital reimbursement methodology in effect on June 30, 1992. On July 1, 1992, the conversion to the new escalation factor shall be accomplished by a transition methodology which, for non-June 30 year end hospitals, applies the escalation factor to escalate their payment rates for the months between July 1, 1992, and their next fiscal year ending on or before May 31, 1993.

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

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

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

Effective July 1, 2012, through June 30, 2013, the escalation factor for inpatient hospitals, including long stay hospitals, shall be 2.6%.

Effective July 1, 2013, through June 30, ~~2014~~ 2016, the escalation factor for inpatient hospitals, including long stay hospitals, shall be 0.0%.

8. The new method will still require comparison of the prospective operating cost rate to the prospective operating ceiling. The provider is allowed the lower of the two amounts subject to the lower of cost or charges principles.

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

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

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

E. An incentive plan should be established whereby a hospital will be paid on a sliding scale, percentage for percentage, up to 10.5% of the difference between allowable operating costs and the appropriate per diem group ceiling when the operating costs are below the ceilings. The incentive should be calculated based on the annual cost report. Effective for dates of service July 1, 2010, through September 30, 2010, the incentive plan shall be eliminated.

F. Disproportionate share hospitals (DSH) defined.

~~The~~ Prior to July 1, 2014, the following criteria shall be met before a hospital is determined to be eligible for a disproportionate share ~~payment adjustment~~ pay. Effective July 1, 2014, the payment methodology for DSH is defined in 12VAC30-70-301.

1. Criteria.

a. A Medicaid inpatient utilization rate in excess of 10.5% for hospitals receiving Medicaid payments in the Commonwealth, or a low-income patient utilization rate exceeding 25% (as defined in the Omnibus Budget Reconciliation Act of 1987 and as amended by the Medicare Catastrophic Coverage Act of 1988); and

b. At least two obstetricians with staff privileges at the hospital who have agreed to provide obstetric services to individuals entitled to such services under a State Medicaid plan. In the case of a hospital located in a rural area (that is, an area outside of a Metropolitan Statistical Area, as defined by the Executive Office of Management and Budget), the term "obstetrician" includes any physician with staff privileges at the hospital to perform nonemergency obstetric procedures.

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

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

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

2. Payment adjustment.

a. Hospitals which have a disproportionately higher level of Medicaid patients shall be allowed a disproportionate share payment adjustment based on the type of hospital and on the individual hospital's Medicaid utilization. There shall be two types of hospitals: (i) Type One, consisting of state-owned teaching hospitals, and (ii) Type Two, consisting of all other hospitals. The Medicaid utilization shall be determined by dividing the number of utilization Medicaid inpatient days by the total number of inpatient days. Each hospital with a Medicaid utilization of over 10.5% shall receive a disproportionate share payment adjustment.

b. For Type One hospitals, the disproportionate share payment adjustment shall be equal to the product of (i) the hospital's Medicaid utilization in excess of 10.5% times 11, times (ii) the lower of the prospective operating cost rate or ceiling. For Type Two hospitals, the disproportionate share payment adjustment shall be equal to the product of (i) the hospital's Medicaid utilization in excess of 10.5% times (ii) the lower of the prospective operating cost rate or ceiling.

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

G. Outlier adjustments.

1. DMAS shall pay to all enrolled hospitals an outlier adjustment in payment amounts for medically necessary inpatient hospital services provided on or after July 1, 1991, involving exceptionally high costs for individuals under one year of age.

2. DMAS shall pay to disproportionate share hospitals (as defined in subsection F of this section) an outlier adjustment in payment amounts for medically necessary inpatient hospital services provided on or after July 1, 1991, involving exceptionally high costs for individuals under six years of age.

3. The outlier adjustment calculation.

a. Each eligible hospital which desires to be considered for the adjustment shall submit a log which contains the information necessary to compute the mean of its Medicaid per diem operating cost of treating individuals identified in subdivision 1 or 2 of this subsection. This log shall contain all Medicaid claims for such individuals, including, but not limited to: (i) the patient's name and Medicaid identification number; (ii) dates of service; (iii) the remittance date paid; (iv) the number of covered days; and (v) total charges for the length of stay. Each hospital shall then calculate the per diem operating cost (which excludes capital and education) of treating such patients by multiplying the charge for each patient by the Medicaid operating cost-to-charge ratio determined from its annual cost report.

b. Each eligible hospital shall calculate the mean of its Medicaid per diem operating cost of treating individuals identified in subdivision 1 or 2 of this subsection.

c. Each eligible hospital shall calculate its threshold for payment of the adjustment, at a level equal to two and one-half standard deviations above the mean or means calculated in subdivision 3 a (ii) of this subsection.

d. DMAS shall pay as an outlier adjustment to each eligible hospital all per diem operating costs which exceed the applicable threshold or thresholds for that hospital.

4. Pursuant to 12VAC30-50-100, there is no limit on length of time for medically necessary stays for individuals under six years of age. This section provides that consistent with 42 CFR 441.57, payment of medical assistance services shall be made on behalf of individuals under 21 years of age, who are Medicaid eligible, for medically necessary stays in acute care facilities in excess of 21 days per admission when such services are rendered for the purpose of diagnosis and treatment of health conditions identified through a physical examination. Medical documentation justifying admission and the continued length of stay must be attached to or written on the invoice for review by medical staff to determine medical necessity. Medically unjustified days in such admissions will be denied.

Article 2
Prospective (DRG-Based) Payment Methodology

12VAC30-70-221. General.

A. Effective July 1, 2000, the prospective (DRG-based) payment system described in this article shall apply to inpatient hospital services provided in enrolled general acute care hospitals, rehabilitation hospitals, and freestanding psychiatric facilities licensed as hospitals, unless otherwise noted.

B. The following methodologies shall apply under the prospective payment system:

1. As stipulated in 12VAC30-70-231, operating payments for DRG cases that are not transfer cases shall be determined on the basis of a hospital specific operating rate per case times relative weight of the DRG to which the case is assigned.

2. As stipulated in 12VAC30-70-241, operating payments for per diem cases shall be determined on the basis of a hospital specific operating rate per day times the covered days for the case with the exception of payments for per diem cases in freestanding psychiatric facilities. Payments for per diem cases in freestanding psychiatric facilities licensed as hospitals shall be determined on the basis of a hospital specific rate per day that represents an all-inclusive payment for operating and capital costs.

3. As stipulated in 12VAC30-70-251, operating payments for transfer cases shall be determined as follows: (i) the transferring hospital shall receive an operating per diem payment, not to exceed the DRG operating payment that would have otherwise been made and (ii) the final discharging hospital shall receive the full DRG operating payment.

4. As stipulated in 12VAC30-70-261, additional operating payments shall be made for outlier cases. These additional payments shall be added to the operating payments determined in subdivisions 1 and 3 of this subsection.

5. As stipulated in 12VAC30-70-271, payments for capital costs shall be made on an allowable cost basis.

6. As stipulated in 12VAC30-70-281, payments for direct medical education costs of nursing schools and paramedical programs shall be made on an allowable cost basis. For Type Two hospitals, payment for direct graduate medical education (GME) costs for interns and residents shall be made quarterly on a prospective basis, subject to cost settlement based on the number of full time equivalent (FTE) interns and residents as reported on the cost report. Effective April 1, 2012, payment for direct GME for interns and residents for Type One hospitals shall be 100% of allowable costs.

7. As stipulated in 12VAC30-70-291, payments for indirect medical education costs shall be made quarterly on a prospective basis.

8. As stipulated in 12VAC30-70-301, payments to hospitals that qualify as disproportionate share hospitals shall be made quarterly on a prospective basis.

C. The terms used in this article shall be defined as provided in this subsection:

"AP-DRG" means all patient diagnosis related groups.

"APR-DRG" means all patient refined diagnosis related groups.

"Base year" means the state fiscal year for which data is used to establish the DRG relative weights, the hospital case-mix indices, the base year standardized operating costs per case, and the base year standardized operating costs per day. The base year will change when the DRG payment system is rebased and recalibrated. In subsequent rebasings, the Commonwealth shall notify affected providers of the base year to be used in this calculation.

"Base year standardized costs per case" means the statewide average hospital costs per discharge for DRG cases in the base year. The standardization process removes the effects of case-mix and regional variations in wages from the claims data and places all hospitals on a comparable basis.

"Base year standardized costs per day" means the statewide average hospital costs per day for per diem cases in the base year. The standardization process removes the effects of regional variations in wages from the claims data and places all hospitals on a comparable basis. Base year standardized costs per day were calculated separately, but using the same calculation methodology, for the different types of per diem cases identified in this subsection under the definition of "per diem cases."

"Cost" means allowable cost as defined in Supplement 3 (12VAC30-70-10 through 12VAC30-70-130) and by Medicare principles of reimbursement.

"Disproportionate share hospital" means a hospital that meets the following criteria:

1. A Medicaid inpatient utilization rate in excess of 14%, or a low-income patient utilization rate exceeding 25% (as defined in the Omnibus Budget Reconciliation Act of 1987 and as amended by the Medicare Catastrophic Coverage Act of 1988); and

2. At least two obstetricians with staff privileges at the hospital who have agreed to provide obstetric services to individuals entitled to such services under a state Medicaid plan. In the case of a hospital located in a rural area (that is, an area outside of a Metropolitan Statistical Area as defined by the Executive Office of Management and Budget), the term "obstetrician" includes any physician with staff privileges at the hospital to perform nonemergency obstetric procedures.

3. Subdivision 2 of this definition does not apply to a hospital:

a. At which the inpatients are predominantly individuals under 18 years of age; or

b. Which does not offer nonemergency obstetric services as of December 21, 1987.

"DRG" means diagnosis related groups.

"DRG cases" means medical/surgical cases subject to payment on the basis of DRGs. DRG cases do not include per diem cases.

"DRG relative weight" means the average standardized costs for cases assigned to that DRG divided by the average standardized costs for cases assigned to all DRGs.

"Groupable cases" means DRG cases having coding data of sufficient quality to support DRG assignment.

"Hospital case-mix index" means the weighted average DRG relative weight for all cases occurring at that hospital.

"Medicaid utilization percentage" or "Medicaid inpatient utilization rate" is equal to the hospital's total Medicaid inpatient days divided by the hospital's total inpatient days for a given hospital fiscal year. The Medicaid utilization percentage or Medicaid inpatient utilization rate includes days associated with inpatient hospital services provided to Medicaid patients but reimbursed by capitated managed care providers. This definition includes all paid Medicaid days ~~(from DMAS MR reports for fee-for-service days and managed care organization or hospital reports for HMO days)~~ and nonpaid/denied Medicaid days to include medically unnecessary days, inappropriate level of care service days, and days that exceed any maximum day limits (with appropriate documentation). The definition of Medicaid days does not include any general assistance, Family Access to Medical Insurance Security (FAMIS), State and Local Hospitalization (SLH), charity care, low-income, indigent care, uncompensated care, bad debt, or Medicare dually eligible days. It does not include days for newborns not enrolled in Medicaid during the fiscal year even though the mother was Medicaid eligible during the birth. Effective July 1, 2014, the definition for Medicaid utilization percentage or Medicaid inpatient utilization rate is defined in 12VAC30-70-301 C.

"Medicare wage index" and the "Medicare geographic adjustment factor" are published annually in the Federal Register by the Health Care Financing Administration. The indices and factors used in this article shall be those in effect in the base year.

"Operating cost-to-charge ratio" equals the hospital's total operating costs, less any applicable operating costs for a psychiatric distinct part unit (DPU), divided by the hospital's total charges, less any applicable charges for a psychiatric DPU. The operating cost-to-charge ratio shall be calculated using data from cost reports from hospital fiscal years ending in the state fiscal year used as the base year.

"Outlier adjustment factor" means a fixed factor published annually in the Federal Register by the Health Care Financing Administration. The factor used in this article shall be the one in effect in the base year.

"Outlier cases" means those DRG cases, including transfer cases, in which the hospital's adjusted operating cost for the case exceeds the hospital's operating outlier threshold for the case.

"Outlier operating fixed loss threshold" means a fixed dollar amount applicable to all hospitals that shall be calculated in the base year so as to result in an expenditure for outliers operating payments equal to 5.1% of total operating payments for DRG cases. The threshold shall be updated in subsequent years using the same inflation values applied to hospital rates.

"Per diem cases" means cases subject to per diem payment and includes (i) covered psychiatric cases in general acute care hospitals and distinct part units (DPUs) of general acute care hospitals (hereinafter "acute care psychiatric cases"), (ii) covered psychiatric cases in freestanding psychiatric facilities licensed as hospitals (hereinafter "freestanding psychiatric cases"), and (iii) rehabilitation cases in general acute care hospitals and rehabilitation hospitals (hereinafter "rehabilitation cases").

"Psychiatric cases" means cases with a principal diagnosis that is a mental disorder as specified in the ICD, as defined in 12VAC30-95-5. Not all mental disorders are covered. For coverage information, see Amount, Duration, and Scope of Services, Supplement 1 to Attachment 3.1 A & B (12VAC30-50-95 through 12VAC30-50-310). The limit of coverage of 21 days in a 60-day period for the same or similar diagnosis shall continue to apply to adult psychiatric cases.

"Psychiatric operating cost-to-charge ratio" for the psychiatric DPU of a general acute care hospital means the

hospital's operating costs for a psychiatric DPU divided by the hospital's charges for a psychiatric DPU. In the base year, this ratio shall be calculated as described in the definition of "operating cost-to-charge ratio" in this subsection, using data from psychiatric DPUs.

"Readmissions" means when patients are readmitted to the same hospital for the same or a similar diagnosis within five days of discharge. Such cases shall be considered a continuation of the same stay and shall not be treated as new cases. Similar diagnoses shall be defined as ICD diagnosis codes possessing the same first three digits. As used here, the term "ICD" is defined in 12VAC30-95-5.

"Rehabilitation operating cost-to-charge ratio" for a rehabilitation unit or hospital means the provider's operating costs divided by the provider's charges. In the base year, this ratio shall be calculated as described in the definition of "operating cost-to-charge ratio" in this subsection, using data from rehabilitation units or hospitals.

"Statewide average labor portion of operating costs" means a fixed percentage applicable to all hospitals. The percentage shall be periodically revised using the most recent reliable data from the Virginia Health Information (VHI), or its successor.

"Transfer cases" means DRG cases involving patients (i) who are transferred from one general acute care hospital to another for related care or (ii) who are discharged from one general acute care hospital and admitted to another for the same or a similar diagnosis within five days of that discharge. Similar diagnoses shall be defined as ICD diagnosis codes possessing the same first three digits. As used here, the term "ICD" is defined in 12VAC30-95-5.

"Type One hospitals" means those hospitals that were state-owned teaching hospitals on January 1, 1996.

"Type Two hospitals" means all other hospitals.

"Uncompensated care costs" or "UCC" means unreimbursed costs incurred by hospitals from serving self-pay, charity, or Medicaid patients without regard to disproportionate share adjustment payments.

"Ungroupable cases" means cases assigned to DRG 469 (principal diagnosis invalid as discharge diagnosis) and DRG 470 (ungroupable) as determined by the AP-DRG Grouper. Effective October 1, 2014, "ungroupable cases" means cases assigned to DRG 955 (ungroupable) and DRG 956 (ungroupable) as determined by the APR-DRG grouper.

D. The All Patient Diagnosis Related Groups (AP-DRG) grouper shall be used in the DRG payment system. Effective October 1, 2014, DMAS shall replace the AP-DRG grouper with the All Patient Refined Diagnosis Related Groups (APR-DRG) grouper for hospital inpatient reimbursement. The APR-DRG Grouper will produce a DRG as well as a severity level ranging from 1 to 4. DMAS shall phase in the APR-DRG weights by blending in 50% of the full APR-DRG weights with 50% of fiscal year (FY) 2014 AP-DRG weights for each APR-DRG group and severity level in the first year. In the second year, the blend will be 75% of full APR-DRG weights and 25% of the FY 2014 AP-DRG weights. Full APR-DRG weights shall be used in the third year and succeeding years for each APR-DRG group and severity. DMAS shall notify hospitals when updating the system to later grouper versions.

E. The primary data sources used in the development of the DRG payment methodology were the department's hospital computerized claims history file and the cost report file. The claims history file captures available claims data from all enrolled, cost-reporting general acute care hospitals, including Type One hospitals. The cost report file captures audited cost and charge data from all enrolled general acute care hospitals, including Type One hospitals. The following table identifies key data elements that were used to develop the DRG payment methodology and that will be used when the system is recalibrated and rebased.

Data Elements for DRG Payment Methodology	
Data Elements	Source
Total charges for each groupable case	Claims history file
Number of groupable cases in each DRG	Claims history file
Total number of groupable cases	Claims history file
Total charges for each DRG case	Claims history file
Total number of DRG cases	Claims history file
Total charges for each acute care psychiatric case	Claims history file
Total number of acute care psychiatric days for each acute care hospital	Claims history file
Total charges for each freestanding psychiatric case	Medicare cost reports
Total number of psychiatric days for each freestanding psychiatric hospital	Medicare cost reports
Total charges for each rehabilitation case	Claims history file
Total number of rehabilitation days for each acute care and freestanding rehabilitation hospital	Claims history file
Operating cost-to-charge ratio for each hospital	Cost report file
Operating cost-to-charge ratio for each freestanding psychiatric facility licensed as a hospital	Medicare cost reports
Psychiatric operating cost-to-charge ratio for the psychiatric DPU of each general acute care hospital	Cost report file

Rehabilitation cost-to-charge ratio for each rehabilitation unit or hospital	Cost report file
Statewide average labor portion of operating costs	VHI
Medicare wage index for each hospital	Federal Register
Medicare geographic adjustment factor for each hospital	Federal Register
Outlier operating fixed loss threshold	Claims history file
Outlier adjustment factor	Federal Register

12VAC30-70-301. Payment to disproportionate share hospitals.

A. Payments to disproportionate share hospitals (DSH) shall be prospectively determined in advance of the state fiscal year to which they apply. The payments shall be made on a quarterly basis~~, shall be final, and shall not be subject to settlement except when necessary due to the limit in subsection D of this section~~ and shall be final subject to subsections E and K of this section.

B. Effective July 1, 2014, in order to qualify for DSH payments, DSH eligible hospitals shall have a total Medicaid inpatient utilization rate equal to 14% or higher in the base year using Medicaid days eligible for Medicare DSH defined in 42 USC § 1396r-4(b)(2) or a low income utilization rate defined in 42 USC § 1396r-4(b)(3) in excess of 25%. Eligibility for out-of-state cost reporting hospitals shall be based on total Medicaid utilization or on total Medicaid neonatal intensive care unit (NICU) utilization equal to 14% or higher.

C. Effective July 1, 2014, the DSH reimbursement methodology for all hospitals except Type One hospitals is the following:

1. Each hospital's DSH payment shall be equal to the DSH per diem multiplied by each hospital's eligible DSH days in a base year. Days reported in provider fiscal years in state fiscal year (FY) 2011 (available from the Medicaid cost report through the Hospital Cost Report Information System (HCRIS) as of July 30, 2013) will be the base year for FY 2015 prospective DSH payments. DSH shall be recalculated annually with an updated base year. Future base year data shall be extracted from Medicare cost report summary statistics available through HCRIS as of October 1 prior to next year's effective date.

2. Eligible DSH days are the sum of all Medicaid inpatient acute, psychiatric, and rehabilitation days above 14% for each DSH hospital subject to special rules for out-of-state cost reporting hospitals. Eligible DSH days for out-of-state cost reporting hospitals shall be the higher of the number of eligible days based on the calculation in the first sentence of this subdivision times Virginia Medicaid utilization (Virginia Medicaid days as a percent of total Medicaid days) or the Medicaid NICU days above 14% times Virginia NICU Medicaid utilization (Virginia NICU Medicaid days as a percent of total NICU Medicaid days). Eligible DSH days for out-of-state cost reporting hospitals that qualify for DSH but that have less than 12% Virginia Medicaid utilization shall be 50% of the days that would have otherwise been eligible DSH days.

3. Additional eligible DSH days are days that exceed 28% Medicaid utilization for Virginia Type Two hospitals, excluding Children's Hospital of the Kings Daughters (CHKD).

4. The DSH per diem shall be calculated in the following manner:

a. The DSH per diem for Type Two hospitals is calculated by dividing the total Type Two DSH allocation by the sum of eligible DSH days for all Type Two DSH hospitals. For purposes of DSH, Type Two hospitals do not include CHKD or any hospital whose reimbursement exceeds its federal uncompensated care cost limit. The Type Two hospital DSH allocation shall equal the amount of DSH paid to Type Two hospitals in state FY 2014 increased annually by the percent change in the federal allotment, including any reductions as a result of the Patient Protection and Affordable Care Act (Affordable Care Act), P.L. 111-148, adjusted for the state fiscal year.

b. The DSH per diem for state inpatient psychiatric hospitals is calculated by dividing the total state inpatient psychiatric hospital DSH allocation by the sum of eligible DSH days. The state inpatient psychiatric hospital DSH allocation shall equal the amount of DSH paid in state FY 2013 increased annually by the percent change in the federal allotment, including any reductions as a result of the Affordable Care Act, adjusted for the state fiscal year.

c. The DSH per diem for CHKD shall be three times the DSH per diem for Type Two hospitals.

5. Each year, the department shall determine how much Type Two DSH has been reduced as a result of the Affordable Care Act and adjust the percent of cost reimbursed for outpatient hospital reimbursement.

D. Effective July 1, 2014, the DSH reimbursement methodology for Type One hospitals shall be to pay its uncompensated care costs up to the available allotment. Interim payments shall be made based on estimates of the uncompensated care costs and allotment. Payments shall be settled at cost report settlement and at the conclusion of the DSH audit.

~~B. Hospitals~~ E. Prior to July 1, 2014, hospitals qualifying under the 14% inpatient Medicaid utilization percentage shall receive a DSH payment based on the hospital's type and the hospital's Medicaid utilization percentage.

1. Type One hospitals shall receive a DSH payment equal to:

a. The sum of (i) the hospital's Medicaid utilization percentage in excess of 10.5%, times 17, times the hospital's Medicaid operating reimbursement, times 1.4433 and (ii) the hospital's Medicaid utilization percentage in excess of 21%, times 17, times the hospital's Medicaid operating reimbursement, times 1.4433.

b. Multiplied by the Type One hospital DSH Factor. The Type One hospital DSH factor shall equal a percentage that when applied to the DSH payment calculation yields a DSH payment equal to the total calculated using the methodology outlined in subdivision 1 a of this subsection using an adjustment factor of one in the calculation of operating payments rather than the adjustment factor specified in subdivision B 1 of 12VAC30-70-331.

2. Type Two hospitals shall receive a DSH payment equal to the sum of (i) the hospital's Medicaid utilization percentage in excess of 10.5%, times the hospital's Medicaid operating reimbursement, times 1.2074 and (ii) the hospital's Medicaid utilization percentage in excess of 21%, times the hospital's Medicaid operating reimbursement, times 1.2074. Out-of-state cost reporting hospitals with Virginia utilization in the base year of less than 12% of total Medicaid days shall receive 50% of the payment described in this subsection.

~~C.~~ F. Hospitals qualifying under the 25% low-income patient utilization rate shall receive a DSH payment based on the hospital's type and the hospital's low-income utilization rate.

1. Type One hospitals shall receive a DSH payment equal to the product of the hospital's low-income utilization in excess of 25%, times 17, times the hospital's Medicaid operating reimbursement.

2. Type Two hospitals shall receive a DSH payment equal to the product of the hospital's low-income utilization in excess of 25%, times the hospital's Medicaid operating reimbursement.

3. Calculation of a hospital's low-income patient utilization percentage is defined in 42 USC § 1396r-4(b)(3).

~~D. No DSH payments shall exceed any applicable limitations upon such payments established by federal law or regulations and § 1923(g) of the Social Security Act.~~

~~E.~~ G. Each hospital's eligibility for DSH payment and the amount of the DSH payment shall be calculated at the time of each rebasing using the most recent reliable utilization data and projected operating reimbursement data available. The utilization data used to determine eligibility for DSH payment and the amount of the DSH payment shall include days for Medicaid recipients enrolled in capitated managed care programs. In years when DSH payments are not rebased in the way described ~~above~~ in this section, the previous year's amounts shall be adjusted for inflation.

For freestanding psychiatric facilities licensed as hospitals, DSH payment shall be based on the most recently settled Medicare cost report available before the beginning of the state fiscal year for which a payment is being calculated.

~~F.~~ H. Effective July 1, 2010, ~~and prior to July 1, 2013,~~ DSH payments shall be rebased for all hospitals with the final calculation reduced by a uniform percentage such that the expenditures in FY 2011 do not exceed expenditures in FY 2010 separately for Type One and Type Two hospitals. The reduction shall be calculated after determination of eligibility. Payments determined in FY 2011 shall not be adjusted for inflation in FY 2012.

~~G.~~ I. Effective July 1, 2013, DSH payments shall not be rebased for all hospitals in FY 2014 and shall be frozen at the payment levels for FY 2013 eligible providers.

J. To be eligible for DSH, a hospital shall also meet the requirements in 42 USC § 1396r-4(d). No DSH payment shall exceed any applicable limitations upon such payment established by 42 USC § 1396r 4(g).

K. If making the DSH payments prescribed in this chapter would exceed the DSH allotment, DMAS shall adjust DSH payments to Type One hospitals. Any DSH payment not made as prescribed in the State Plan as a result of the DSH allotment shall be made upon a determination that an available allotment exists.

VA.R. Doc. No. R17-4432; Filed April 17, 2017, 8:24 a.m.

TITLE 16. LABOR AND EMPLOYMENT

APPRENTICESHIP COUNCIL

Fast-Track Regulation

Title of Regulation: **16VAC20-11. Public Participation Guidelines (amending 16VAC20-11-50).**

Statutory Authority: §§ 2.2-4007.02 and 40.1-117 of the Code of Virginia.

Public Hearing Information: No public hearings are scheduled.

Public Comment Deadline: June 14, 2017.

Effective Date: June 30, 2017.

Agency Contact: Holly Raney, Regulatory Coordinator, Department of Labor and Industry, Main Street Centre, 600 East Main Street, Richmond, VA 23219, telephone (804) 371-2631, FAX (804) 371-2324, or email holly.raney@doli.virginia.gov.

Basis: Pursuant to § 40.1-117 of the Code of Virginia, the Virginia Apprenticeship Council is authorized to "formulate policies for the effective administration" of the Voluntary Apprenticeship Program.

The amendment conforms the council's regulation to Chapter 795 of the 2012 Acts of Assembly, which provides that in formulating any regulation or in evidentiary hearings on regulations, an interested party shall be entitled to be accompanied by and represented by counsel or other qualified representative.

Purpose: The purpose of this amendment is to align the Virginia Apprenticeship Council's Public Participation Guidelines to the requirements of the Administrative Process Act. Participation by the public in the regulatory process is essential to assist the council in the promulgation of regulations that will protect the health, safety, and welfare of the citizens of Virginia.

Rationale for Using Fast-Track Rulemaking Process: The amendment was recommended by the Department of Planning and Budget and is intended to conform the council's public participation guidelines to subsection B of § 2.2-4007.02 of the Code of Virginia. The rulemaking is not expected to be controversial and is therefore appropriate for the fast-track rulemaking process.

Substance: The amendment includes a requirement for the council to afford interested persons an opportunity to present their views and be accompanied by and represented by counsel or other representative in the promulgation of any actions.

Issues: Other than conformity and consistency between law and regulation, there are no primary advantages or disadvantages to the public in implementing the amended provisions since it is already in the Code of Virginia. There are no primary advantages or disadvantages for the agency or the Commonwealth. The proposed change merely conforms the council's public participation guidelines to subsection B of § 2.2-4007.02 of the Code of Virginia.

Department of Planning and Budget's Economic Impact Analysis:

Summary of the Proposed Amendments to Regulation. Pursuant to Chapter 795 of the 2012 Acts of Assembly,[1] the Virginia Apprenticeship Council (Council) proposes to specify in this regulation that interested persons shall be afforded an opportunity to be accompanied by and represented by counsel or other representative when submitting data, views, and arguments, either orally or in writing, to the agency.

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

Estimated Economic Impact. The current Public Participation Guidelines state that: "In considering any nonemergency, nonexempt regulatory action, the agency shall afford interested persons an opportunity to submit data, views, and arguments, either orally or in writing, to the agency." The Council proposes to append "and (ii) be accompanied by and represented by counsel or other representative."

Chapter 795 of the 2012 Acts of Assembly added to § 2.2-4007.02 of the Code of Virginia "that interested persons also be afforded an opportunity to be accompanied by and represented by counsel or other representative." Since the Code of Virginia already specifies that interested persons shall be afforded an opportunity to be accompanied by and represented by counsel or other representative, The Council's proposal to add this language to the regulation will not change the law in effect, but will be beneficial in that it will inform interested parties who read this regulation but not the statute of their legal rights concerning representation.

Businesses and Entities Affected. The proposed amendment potentially affects all individuals who comment on pending regulatory changes.

Localities Particularly Affected. The proposed amendment does not disproportionately affect particular localities.

Projected Impact on Employment. The proposed amendment does not significantly affect employment.

Effects on the Use and Value of Private Property. The proposed amendment does not affect the use and value of private property.

Real Estate Development Costs. The proposed amendment does not affect real estate development costs.

Small Businesses:

Definition. Pursuant to § 2.2-4007.04 of the Code of Virginia, small business is defined as "a business entity, including its affiliates, that (i) is independently owned and operated and (ii) employs fewer than 500 full-time employees or has gross annual sales of less than $6 million."

Costs and Other Effects. The proposed amendment does not affect costs for small businesses.

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

Adverse Impacts:

Businesses. The proposed amendment does not adversely affect businesses.

Localities. The proposed amendment does not adversely affect localities.

Other Entities. The proposed amendment does not adversely affect other entities.

[1] See http://leg1.state.va.us/cgi-bin/legp504.exe?121+ful+CHAP0795+hil

Agency's Response to Economic Impact Analysis: The Department of Labor and Industry has no additional comment in response to the economic impact analysis.

Summary:

Pursuant to § 2.2-4007.02 of the Code of Virginia, the amendment provides that interested persons submitting data, views, and arguments on a regulatory action may be

accompanied by and represented by counsel or other representative.

Part III
Public Participation Procedures

16VAC20-11-50. Public comment.

A. In considering any nonemergency, nonexempt regulatory action, the agency shall afford interested persons an opportunity to (i) submit data, views, and arguments, either orally or in writing, to the agency; and (ii) be accompanied by and represented by counsel or other representative. Such opportunity to comment shall include an online public comment forum on the Town Hall.

1. To any requesting person, the agency shall provide copies of the statement of basis, purpose, substance, and issues; the economic impact analysis of the proposed or fast-track regulatory action; and the agency's response to public comments received.

2. The agency may begin crafting a regulatory action prior to or during any opportunities it provides to the public to submit comments.

B. The agency shall accept public comments in writing after the publication of a regulatory action in the Virginia Register as follows:

1. For a minimum of 30 calendar days following the publication of the notice of intended regulatory action (NOIRA).

2. For a minimum of 60 calendar days following the publication of a proposed regulation.

3. For a minimum of 30 calendar days following the publication of a reproposed regulation.

4. For a minimum of 30 calendar days following the publication of a final adopted regulation.

5. For a minimum of 30 calendar days following the publication of a fast-track regulation.

6. For a minimum of 21 calendar days following the publication of a notice of periodic review.

7. Not later than 21 calendar days following the publication of a petition for rulemaking.

C. The agency may determine if any of the comment periods listed in subsection B of this section shall be extended.

D. If the Governor finds that one or more changes with substantial impact have been made to a proposed regulation, he may require the agency to provide an additional 30 calendar days to solicit additional public comment on the changes in accordance with § 2.2-4013 C of the Code of Virginia.

E. The agency shall send a draft of the agency's summary description of public comment to all public commenters on the proposed regulation at least five days before final adoption of the regulation pursuant to § 2.2-4012 E of the Code of Virginia.

VA.R. Doc. No. R17-5080; Filed April 24, 2017, 8:29 a.m.

TITLE 18. PROFESSIONAL AND OCCUPATIONAL LICENSING

VIRGINIA BOARD FOR ASBESTOS, LEAD, AND HOME INSPECTORS

Final Regulation

REGISTRAR'S NOTICE: The Board for Asbestos, Lead, and Home Inspectors is claiming an exemption from the Administrative Process Act in accordance with the fourth enactment of Chapters 161 and 436 of the 2016 Acts of Assembly, which exempts the board's initial adoption of regulations necessary to implement the provisions of the acts; however, the board is required to provide an opportunity for public comment on the regulations prior to adoption.

Title of Regulation: **18VAC15-40. Virginia Certified Home Inspectors Regulations (amending 18VAC15-40-10, 18VAC15-40-20, 18VAC15-40-30, 18VAC15-40-45, 18VAC15-40-60, 18VAC15-40-72, 18VAC15-40-80, 18VAC15-40-90, 18VAC15-40-105, 18VAC15-40-120, 18VAC15-40-130, 18VAC15-40-140, 18VAC15-40-150, 18VAC15-40-160, 18VAC15-40-180, 18VAC15-40-240; adding 18VAC15-40-25, 18VAC15-40-32, 18VAC15-40-33, 18VAC15-40-34, 18VAC15-40-35, 18VAC15-40-75, 18VAC15-40-76, 18VAC15-40-78, 18VAC15-40-107, 18VAC15-40-108, 18VAC15-40-145, 18VAC15-40-152, 18VAC15-40-155; repealing 18VAC15-40-40, 18VAC15-40-85, 18VAC15-40-170, 18VAC15-40-190).**

Statutory Authority: §§ 54.1-201 and 54.1-501 of the Code of Virginia.

Effective Date: July 1, 2017.

Agency Contact: Trisha L. Henshaw, Executive Director, Virginia Board for Asbestos, Lead, and Home Inspectors, 9960 Mayland Drive, Suite 400, Richmond, VA 23233, telephone (804) 367-8595, FAX (804) 350-5354, or email alhi@dpor.virginia.gov.

Summary:

To conform to the requirements of Chapters 161 and 436 of the 2016 Acts of Assembly, this regulatory action replaces the current voluntary certification program for home inspectors with a mandatory licensure program. The amendments include (i) establishing licensure requirements, equivalency standards for individuals licensed in other jurisdictions, and qualifications for the new residential structure (NRS) specialty; (ii) requiring home inspections on new residential structures be conducted by a home inspector with a NRS specialty; (iii) establishing renewal and reinstatement requirements; (iv) requiring continuing professional education (CPE) and maintenance of records of CPE; (v) establishing minimum standards for conducting home inspections, including requirements for home inspection contracts and reports; (vi) establishing standards of conduct and practice; (vii)

updating definitions; and (viii) making technical and minor changes.

CHAPTER 40
~~VIRGINIA CERTIFIED~~ HOME ~~INSPECTORS~~
INSPECTOR LICENSING REGULATIONS

Part I
General

18VAC15-40-10. Definitions.

A. Section 54.1-500 of the Code of Virginia provides definitions of the following terms and phrases as used in this chapter:

"Board"

"Home inspection"

"Home inspector"

"Person"

"Residential building"

~~A.~~ B. The following words and terms when used in this chapter shall have the following meanings unless a different meaning is provided or is plainly required by the context:

"Address of record" means the mailing address designated by the licensee to receive notices and correspondence from the board.

"Adjacent" means ~~structures, grading, drainage, or vegetation~~ adjoining or within three feet of the residential building and that may affect the residential building.

"Applicant" means an individual who has submitted an application for licensure.

"Application" means a completed, board-prescribed form submitted with the appropriate fee and other required documentation.

~~"Board" means the Virginia Board for Asbestos, Lead, and Home Inspectors.~~

~~"Certificate holder" means any person holding a valid certificate as a certified home inspector issued by the board.~~

~~"Certification" means an authorization issued to an individual by the board to perform certified home inspections by meeting the entry requirements established in these regulations.~~

"Client" means a person who engages ~~or seeks to engage~~ the services of a ~~certified~~ home inspector for ~~the purpose of obtaining an~~ a home inspection ~~of and a written report upon the condition of a residential building~~.

"Compensation" means the receipt of monetary payment or other valuable consideration for services rendered.

"Component" means a part of a system.

"Contact hour" means 50 minutes of participation in a structured training activity.

"CPE" means continuing professional education.

"Department" means the Department of Professional and Occupational Regulation.

"Financial interest" means financial benefit accruing to an individual or to a member of his immediate family. Such interest shall exist by reason of (i) ownership in a business if the ownership exceeds 3.0% of the total equity of the business; (ii) annual gross income that exceeds or may be reasonably anticipated to exceed $1,000 from ownership in real or personal property or a business; (iii) salary, other compensation, fringe benefits, forgiveness of debt, or benefits from the use of property, or any combination of it, paid or provided by a business that exceeds or may be reasonably expected to exceed $1,000 annually; ~~or~~ (iv) ownership of real or personal property if the interest exceeds $1,000 in value and excluding ownership in business, income, salary, other compensation, fringe benefits, or benefits from the use of property; (v) personal liability incurred or assumed on behalf of a business if the liability exceeds 3.0% of the asset value of the business; or (vi) an option for ownership of a business, real property, or personal property if the ownership interest will consist of clause (i) or (iv) of this definition.

"Fireplace" means an interior fire-resistant masonry permanent or prefabricated fixture that can be used to burn fuel and is either vented or unvented.

"Foundation" means the ~~base upon which the structure or a wall rests, usually masonry, concrete, or stone, and generally partially underground~~ element of a structure that connects to the ground and transfers loads from the structure to the ground. Foundations may be shallow or deep.

~~"New residential structure" or "NRS" means a residential structure for which the first conveyance of record title to a purchaser has not occurred or the purchaser has not taken possession, whichever occurs later.~~

~~"Prelicense education course" means an instruction program approved by the board and is one of the requirements for licensure effective July 1, 2017.~~

~~"Inspect" or "inspection" means to visually examine readily accessible systems and components of a building established in this chapter.~~

"Licensee" means a home inspector as defined in Chapter 5 (§ 54.1-500 et seq.) of Title 54.1 of the Code of Virginia.

"Licensure" means a method of regulation whereby the Commonwealth, through the issuance of a license, authorizes a person possessing the character and minimum skills to engage in the practice of a profession or occupation that is unlawful to practice without such license.

"New residential structure" or "NRS" means a residential structure for which the first conveyance of record title to a purchaser has not occurred or the purchaser has not taken possession, whichever occurs later.

"NRS specialty" means a designation granted by the board to a home inspector that authorizes such individual to conduct home inspections on any new residential structure.

"Outbuilding" means any ~~building~~ structure on the property that is more than three feet from the residential building ~~that~~

~~might burn or collapse~~ and that may affect the residential building.

"Prelicense education course" means an instruction program approved by the board and is one of the requirements for licensure effective July 1, 2017.

"Readily accessible" means available for ~~visual inspection~~ access without requiring moving ~~of personal property, dismantling, destructive measures, or any action that will likely involve risk to persons or property~~ or removing of any obstacles.

"Reinstatement" means ~~having a certificate restored to effectiveness after the expiration date has passed~~ the process and requirements through which an expired license can be made valid without the licensee having to apply as a new applicant.

"Renewal" means ~~continuing the effectiveness of a certificate for another period of time~~ the process and requirements for periodically approving the continuance of a license.

"Residential ~~building"~~ structure" means~~, for the purposes of home inspection,~~ a structure consisting of ~~one to four~~ no more than two dwelling units ~~used or occupied, or intended to be used or occupied, for residential purposes~~ or a townhouse.

"Solid fuel burning appliances" means a hearth and fire chamber or similarly prepared place in which a fire may be built and that is built in conjunction with a chimney, or a listed assembly of a fire chamber, its chimney and related factory-made parts designed for unit assembly without requiring field construction.

"System" means a combination of interacting or interdependent components, assembled to carry out one or more functions.

"Virginia Residential Code" means the provisions of the Virginia Construction Code (Part I (13VAC5-63-10 et seq.) of 13VAC5-63) applicable to R-5 residential structures and that includes provisions of the International Residential Code as amended by the Board of Housing and Community Development.

~~B. Terms not defined in this chapter have the same definitions as those set forth in § 54.1-500 of the Code of Virginia.~~

~~Part II~~
~~Entry Requirements~~

18VAC15-40-20. Necessity for ~~certification~~ licensure.

~~Any person who holds himself out as or uses the title of "certified home inspector" or conducts or offers to provide a "certified home inspection" shall have a current and valid certificate issued by the board. Nothing in this chapter shall be construed to preclude noncertified individuals from performing home inspections for hire provided their conduct is in compliance with § 54.1-517.1 of the Code of Virginia.~~ A. It shall be unlawful for any individual who does not possess a license as a home inspector issued by the board to perform a home inspection for compensation on a residential building.

B. A home inspection on a new residential structure shall only be conducted by a home inspector with the NRS specialty and who has completed a training module on the Virginia Residential Code.

Part II
Entry

18VAC15-40-25. Application procedures.

A. All applicants seeking licensure shall submit an application with the appropriate fee specified in 18VAC15-40-50. Application shall be made on forms provided by the board or its agent.

1. By submitting the application to the department, the applicant certifies that the applicant has read and understands the applicable statutes and the board's regulations.

2. The receipt of an application and the deposit of fees by the board do not indicate approval of the application by the board.

B. The board may make further inquiries and investigations with respect to the applicant's qualifications to confirm or amplify information supplied. All applications shall be completed in accordance with the instructions contained in this section and on the application. Applications will not be considered complete until all required documents are received by the board.

C. The applicant will be notified within 30 days of the board's receipt of an initial application if the application is incomplete. An individual who fails to complete the application process within 12 months of receipt of the application in the board's office must submit a new application.

D. The applicant shall immediately report all changes in information supplied with the application, if applicable, prior to issuance of the license or expiration of the application.

18VAC15-40-30. ~~Qualifications~~ General requirements for ~~certification~~ licensure.

~~Every~~ A. In addition to the provisions of 18VAC15-40-32, every applicant for ~~an individual~~ a home inspector ~~certificate~~ license shall ~~have the following qualifications:~~ meet the requirements provided in this section.

~~1.~~ B. The applicant shall be at least 18 years old.

~~2. The applicant shall meet the following educational and experience requirements:~~

~~a. High school diploma or equivalent; and~~

~~b. One of the following:~~

~~(1) Completed 35 contact hours of instruction courses, of which no more than half of the required hours may be completed using distance or online education technology,~~

~~and have completed a minimum of 100 home inspections;~~

~~(2) Completed 35 contact hours of instruction courses, of which no more than half of the required hours may be completed using distance or online education technology, and have completed a minimum of 50 certified home inspections in compliance with this chapter under the direct supervision of a certified home inspector, who shall certify the applicant's completion of each inspection and shall be responsible for each inspection;~~

~~(3) Completed 70 contact hours of instruction courses, of which no more than half of the required hours may be completed using distance or online education technology, and have completed a minimum of 50 home inspections; or~~

~~(4) Completed 70 contact hours of instruction courses, of which no more than half of the required hours may be completed using distance or online education technology, and have completed a minimum of 25 certified home inspections in compliance with this chapter under the direct supervision of a certified home inspector, who shall certify the applicant's completion of each inspection and shall be responsible for each inspection.~~

~~Instruction courses shall cover the content areas of the board-approved examinations.~~

~~An applicant who cannot fulfill the instruction course requirement as outlined in this subsection may provide documentation of a minimum of 10 years of experience as a home inspector with a minimum of 250 home inspections completed in substantial compliance with this chapter to satisfy this requirement. The documentation is subject to board review and approval.~~

~~3. The applicant shall have passed a written competency examination approved by the board.~~

~~4. The board may accept proof of membership in good standing, in a national or state professional home inspectors association approved by the board, as satisfaction of subdivisions 1, 2, and 3 of this section, provided that the requirements for the applicant's class of membership in such association are equal to or exceed the requirements established by the board for all applicants.~~

~~5. The applicant shall have a good reputation for honesty, truthfulness, and fair dealing, and be competent to transact the business of a home inspector in such a manner as to safeguard the interests of the public.~~

~~6. The applicant shall disclose whether a certificate or license as a home inspector from any jurisdiction where certified or licensed has ever been suspended, revoked or surrendered in connection with a disciplinary action or which has been the subject of discipline in any jurisdiction prior to applying for certification in Virginia. The board may deny certification to any applicant so disciplined after examining the totality of the circumstances.~~

~~7. The applicant shall disclose any conviction or finding of guilt, regardless of adjudication, in any jurisdiction of the United States of any misdemeanor involving violence, repeat offenses, multiple offenses, or crimes that endangered public health or safety, or of any felony, there being no appeal pending therefrom or the time for appeal having elapsed. Subject to the provisions of § 54.1-204 of the Code of Virginia, the board shall have the authority to determine, based upon all the information available, including the applicant's record of prior convictions, if the applicant is unfit or unsuited to engage in the profession of residential home inspections. The board will decide each case by taking into account the totality of the circumstances. Any plea of nolo contendere shall be considered a conviction for purposes of this subdivision. A certified copy of a final order, decree, or case decision by a court with the lawful authority to issue such order, decree or case decision shall be admissible as prima facie evidence of such conviction or guilt.~~

~~8. Procedures and appropriate conduct established by either the board or any testing service administering an examination approved by the board or both shall be followed by the applicant. Such procedures shall include any written instructions communicated prior to the examination date and any instructions communicated at the site, either written or oral, on the date of the examination. Failure to comply with all procedures established by the board or the testing service with regard to conduct at the examination shall be grounds for denial of the application.~~

~~9. Applicants shall show evidence of having obtained general liability insurance with minimum limits of $250,000.~~

C. The applicant shall provide a mailing address, which shall serve as the address of record. A post office box is only acceptable as the address of record when a physical address is also provided.

D. In accordance with § 54.1-204 of the Code of Virginia, each applicant shall disclose the following information:

1. All misdemeanor convictions involving moral turpitude, sexual offense, drug distribution, or physical injury within five years of the date of the application; and

2. All felony convictions during his lifetime.

Any plea of nolo contendere shall be considered a conviction for the purposes of this section. The record of conviction received from a court shall be accepted as prima facie evidence of a conviction or finding of guilt. The board, in its discretion, may deny licensure to any applicant in accordance with § 54.1-204 of the Code of Virginia.

E. The applicant for licensure shall be in compliance with the standards of conduct and practice set forth in Part V (18VAC15-40-140 et seq.) of this chapter at the time of application, while the application is under review by the board, and at all times when the license is in effect.

F. The applicant shall report any suspension, revocation, or surrender of a license, certification, or registration in connection with a disciplinary action or a license, certification, or registration that has been the subject of discipline in any jurisdiction prior to applying for licensure. The board, in its discretion, may deny licensure to any applicant based on prior suspensions, revocations, or surrender of licenses based on disciplinary action by any jurisdiction. The applicant has the right to request further review of any such action by the board under the Administrative Process Act (§ 2.2-4000 et seq. of the Code of Virginia).

G. The applicant for licensure shall submit evidence of having obtained general liability insurance with minimum limits of $250,000 per occurrence. A business liability insurance policy or a commercial general liability insurance policy with minimum limits of $250,000 may be considered to meet such requirement, so long as the applicant is listed as an additional insured. If for any reason the board cannot reasonably ensure that the applicant is sufficiently covered in accordance with this subsection, the board may require that requisite coverage be obtained in the name of the applicant. Proof of such insurance policy must be submitted in order to obtain the license.

18VAC15-40-32. Qualifications for licensure.

A. An applicant for licensure as a home inspector shall furnish documentation acceptable to the board that one of the qualifications for licensure in Table 1 has been met.

TABLE 1

	Board-approved prelicense education course contact hours	Experience	Passed the board-approved examination
1.	35	Completion of 100 home inspections prior to July 1, 2017	Yes
2.	35	Completion of 50 home inspections under the direct supervision of a home inspector	Yes
3.	70	Completion of 50 home inspections prior to July 1, 2017	Yes
4.	70	Completion of 25 home inspections under the direct supervision of a home inspector	Yes
5.	None	Verification of 10 years' experience as a home inspector prior to July 1, 2017, with a minimum of 250 home inspections completed during such time period	Yes

B. Prelicense education courses must be approved by the board pursuant to Part VI (18VAC15-40-120 et seq.) of this chapter. No more than half of the required hours may be completed using distance or online education technology.

C. Verification of home inspections completed under the direct supervision of a home inspector must be provided by an individual who was properly licensed or certified by the board during the applicable time period.

D. The National Home Inspector Examination provided by the Examination Board of Professional Home Inspectors is the board-approved examination pursuant to § 54.1-517.2 A 2 c of the Code of Virginia.

18VAC15-40-33. Examination conduct.

Procedures and appropriate conduct established by the board or examination organization administering the examination approved by the board, or both, shall be followed by the applicant. Such procedures shall include written instructions communicated prior to the examination date and instructions communicated at the site, either written or oral, on the date of the examination. Failure to comply with all procedures established by the board or the examination organization with regard to conduct at the examination shall be grounds for denial of the application.

18VAC15-40-34. Individuals certified or licensed in another jurisdiction; equivalency to Virginia home inspector requirements.

A. The board may waive the requirements of 18VAC15-40-32 for an applicant who holds an active, current license or certificate as a home inspector in another state, the District of Columbia, or any other territory or possession of the United States provided the requirements and standards under which the license or certificate was issued are substantially equivalent to those established in this chapter.

B. In considering qualifications pursuant to 18VAC15-40-32, the board may consider experience gained under a licensed (however denominated) home inspector in another state provided the requirements and standards under which the home inspector was licensed are substantially equivalent to those established in this chapter.

18VAC15-40-35. Qualifications for the new residential structure specialty.

To obtain the NRS specialty, the applicant shall submit the appropriate application form and fee pursuant to 18VAC15-40-50 and meet the following qualifications:

1. Hold a current and valid home inspector license. An applicant who does not hold a current and valid home inspector license shall apply for such licensure and meet the requirements contained in 18VAC15-40-30 and 18VAC15-40-32.

2. Submit proof of successful completion of an NRS training module approved by the board pursuant to Part VI (18VAC15-40-120 et seq.) of this chapter and completed no more than two years prior to the date of application.

18VAC15-40-40. ~~Waiver of the requirements of this chapter.~~ (Repealed.)

~~Except as required by law, the board may, in its reasonable discretion, waive any of the requirements of this chapter when in its judgment it finds that the waiver in no way lessens the protection provided by this chapter and Title 54.1 of the Code of Virginia to the public health, safety and welfare. The burden of proof that demonstrates continued public protection rests with the individual requesting the waiver. Documents referenced are in effect as they existed as of the date the act or action has occurred.~~

18VAC15-40-45. Application denial.

The board may refuse initial ~~certification~~ licensure due to an applicant's failure to comply with entry requirements or for any of the reasons it may discipline a ~~regulant~~ licensee. The applicant has the right to request further review of any such action by the board under the Administrative Process Act (§ 2.2.-4000 et seq. of the Code of Virginia).

Part III

Renewal and Reinstatement of ~~Certificate~~ License

18VAC15-40-60. Renewal required.

~~Certificates~~ Licenses issued under this chapter shall expire two years from the last day of the month in which they were issued~~, as indicated on the certificate~~.

18VAC15-40-72. Continuing professional education ~~(CPE)~~ required for home inspector licensure.

A. Each ~~certificate holder~~ licensee shall have completed 16 contact hours of continuing professional education (CPE) during each ~~certificate~~ license renewal cycle~~, beginning with the certificate renewal cycle that ends April 30, 2013~~. CPE can be met through classroom instruction, distance learning, or online education technology.

B. ~~The~~ Notwithstanding the provisions of 18VAC15-40-75, the subject matter addressed during CPE contact hours shall be limited to the content areas covered by the board's approved examination.

~~C. The following shall be maintained by the certificate holder to document completion of the hours of CPE specified in subsection A of this section:~~

~~1. Evidence of completion that shall contain the name, address, and telephone number of the training sponsor;~~

~~2. The dates the applicant participated in the training;~~

~~3. Descriptive material of the subject matter presented documenting that it covers the content areas covered by the board's examination; and~~

~~4. A statement from the sponsor verifying the number of CPE contact hours completed.~~

~~D. Each certificate holder shall maintain evidence of the satisfactory completion of CPE for at least three years following the end of the certificate renewal cycle for which the CPE was taken. Such documentation shall be in the form required by subsection C of this section and shall be provided to the board or its duly authorized agents upon request.~~

~~E.~~ C. The ~~certificate holder~~ licensee shall not receive CPE credit for the same training course more than once during a single ~~certificate~~ license renewal cycle.

~~F. Distance learning courses that comply with subsection B of this section and provide the documentation required by subsection C of this section shall comply with the CPE requirement.~~

~~G. The certificate holder may request additional time to meet the CPE requirement; however, CPE hours earned during a certificate renewal cycle to satisfy the CPE requirement of the preceding certificate renewal cycle shall be valid only for that preceding certificate renewal cycle.~~

D. A licensee who completes the initial training module required by 18VAC15-40-35 to obtain an NRS specialty may count completion of the module towards the required 16 hours of CPE credit for that renewal cycle.

18VAC15-40-75. Board-approved new residential structure update continuing professional education course required to maintain new residential structure specialty.

In addition to the CPE requirements of 18VAC15-40-72, to maintain the NRS specialty, the licensee shall submit proof of completion of a four-hour, board-approved NRS CPE course, which can be applied toward the 16 contact hours of CPE required for the license renewal.

18VAC15-40-76. Continuing professional education for instructors.

A licensee may receive CPE credit for teaching a course that otherwise meets the requirements of this chapter; however, additional credit shall not be given for subsequent offerings of a course or activity with the same content within the same licensing cycle. In addition, a licensee may receive two hours of CPE no more than once during a single licensing cycle for the initial development or substantial updating of a CPE course.

18VAC15-40-78. Maintenance of continuing professional education records.

A. Each licensee shall maintain evidence of the satisfactory completion of CPE for at least three years following the end of the license renewal cycle for which the CPE was taken. Such documentation shall be provided to the board or its duly authorized agents upon request. The following shall be maintained by the licensee to document completion of the hours of CPE specified in 18VAC15-40-72:

1. Evidence of completion that shall contain the name, address, and telephone number of the training provider;

2. The dates the applicant participated in the training;

3. Descriptive material of the subject matter presented documenting that it covers the content areas covered by the board's examination; and

4. A statement from the provider verifying the number of CPE contact hours completed.

B. The board may conduct an audit of its licensees to ensure compliance with the applicable CPE requirements. Licensees who are selected for audit shall provide the necessary documentation stipulated in this section.

C. The licensee may request additional time to meet the CPE requirement; however, CPE hours earned during a license renewal cycle to satisfy the CPE requirement of the preceding license renewal cycle shall be valid only for that preceding license renewal cycle.

18VAC15-40-80. Procedures for renewal.

A. ~~The~~ Prior to the expiration date shown on the license, the board shall mail a renewal ~~application form~~ notice to the ~~certificate holder at the last known home~~ licensee's address of record. ~~These notices shall outline the procedures for renewal. Failure of the board to mail or of the certificate holder to receive these notices does not relieve the certificate holder of the obligation to renew.~~

B. Prior to the expiration date shown on the ~~certificate~~ license, ~~regulants~~ the licensee desiring to renew ~~their certificate~~ his license shall return to the board the renewal ~~application form to the board together with~~ notice, proof of insurance required by 18VAC15-40-30, and the appropriate fee specified in ~~18VAC15-40-52~~ 18VAC15-40-50. ~~If the regulant fails to receive the renewal notice, a copy of the certificate may be submitted with the required fee as an application for renewal. The date on which the fee is received by the department or its agent will determine whether the fee is on time.~~

C. Prior to the expiration date shown on the license, a licensee with the NRS specialty must submit proof of completion of four hours of board-approved NRS CPE, in accordance with 18VAC15-40-75, along with the renewal notice and the appropriate fee specified in 18VAC15-40-50.

D. Failure to receive the renewal notice does not relieve the licensee of the obligation to renew. If the licensee fails to receive the renewal notice, a copy of the license may be submitted with the required fee and any other required documentation as an application for renewal. The date on which the renewal application is received by the department or its agent will determine whether the renewal application was received on time.

~~C.~~ E. By ~~causing a~~ submitting the renewal application ~~to be sent to the board or its authorized agent~~, the ~~regulant~~ licensee is affirming that the ~~insurance required by 18VAC15-40-30 continues to be in effect, that the~~ CPE requirements of 18VAC15-40-72 have been met, and ~~that~~ he is in continued compliance with this chapter.

18VAC15-40-85. ~~Late renewal.~~ (Repealed.)

~~If the renewal requirements of 18VAC15-40-80 are met more than 30 days but less than six months after the expiration date on the certificate, a late renewal fee shall be required as established in 18VAC15-40-52. The date on which the renewal application and the required fees are actually received by the board or its agent shall determine whether the certificate holder must pay the renewal fee only or whether the late renewal fee must be paid.~~

18VAC15-40-90. Reinstatement.

A. If the requirements for renewal of a ~~certificate~~ license, ~~including receipt of the fee by the board,~~ as provided in 18VAC15-40-80, are not completed by the ~~certificate holder~~ licensee within ~~six months~~ 30 days after the expiration date ~~noted~~ on the ~~certificate~~ license, ~~a~~ reinstatement ~~fee~~ of the license shall be required.

B. All applicants for reinstatement shall meet all requirements set forth in 18VAC15-40-30, 18VAC15-40-72, and ~~18VAC15-40-80~~ 18VAC15-40-75, as applicable.

C. A ~~certificate~~ license may be reinstated for up to two years following the expiration date ~~with~~ upon submittal of the reinstatement application consisting of (i) payment of the reinstatement fee, (ii) proof of insurance required by 18VAC15-40-30, (iii) proof of CPE in accordance with 18VAC15-40-72, and (iv) proof of CPE to maintain the NRS specialty, if applicable. After two years, the ~~certificate~~ license shall not be reinstated under any circumstances, and the ~~applicant~~ individual shall apply as a new applicant and meet entry requirements current at the time of submittal of the new application.

D. By submitting the reinstatement application, the individual is affirming that he is in continued compliance with this chapter.

18VAC15-40-105. Status of ~~certificate holder~~ licensee during the period prior to reinstatement.

A. A ~~certificate holder~~ licensee who reinstates his ~~certificate~~ license shall be regarded as having been continuously ~~certified~~ licensed without interruption and shall remain under the disciplinary authority of the board during this entire period and shall be held accountable for his activities during this period.

B. Any regulated activity conducted subsequent to the license expiration date may constitute unlicensed activity and be subject to prosecution under Chapter 1 (§ 54.1-100 et seq.) of Title 54.1 of the Code of Virginia.

18VAC15-40-107. Board discretion to deny renewal or reinstatement.

The board may deny renewal or reinstatement of a license for the same reasons as the board may refuse initial licensure or discipline a licensee. The licensee has the right to request further review of any such action by the board under the Administrative Process Act (§ 2.2-4000 et seq. of the Code of Virginia).

18VAC15-40-108. License renewal or reinstatement after July 1, 2017.

A license eligible for renewal or reinstatement on or after July 1, 2017, shall be required to meet the requirements of this part as amended effective July 1, 2017, upon submittal of the renewal or reinstatement application, as applicable.

Part IV
Minimum Standards for Conducting ~~Certified~~ Home Inspections

18VAC15-40-120. ~~Certified home~~ Home inspection contract.

A. For the protection of both the client and the ~~certificate holder~~ licensee, both parties shall sign a legible, written contract clearly specifying the terms, conditions, and limitations and exclusions of the work to be performed.

B. At a minimum, the written contract shall include:

1. Name, business name (if applicable), business address, and telephone number of the ~~certified~~ home inspector.

2. ~~Certificate~~ License number ~~and expiration date~~ of the ~~certified~~ home inspector, and notation of NRS specialty, if applicable.

3. Name of the clients.

4. Physical address of the residential ~~properties~~ property to be inspected.

5. Cost ~~and method of payment~~ of the ~~certified~~ home inspection.

6. A listing of all areas and systems to be inspected, including those inspections that are either partial or limited in scope.

7. A statement in the contract that the home inspection does not include a review for compliance with regulatory requirements (Virginia Uniform Statewide Building Code or other codes, regulations, laws, ordinances, etc.).

~~7.~~ 8. To the extent that any of the following categories are not covered by the home inspection, they shall be noted as exclusions in the inspection contract:

a. The condition of systems or components that are not readily accessible.

b. The remaining life of any system or component.

c. The strength, adequacy, effectiveness, or efficiency of any system or component.

d. The causes of any condition or deficiency.

e. The methods, materials, or costs of corrections.

f. Future conditions including~~, but not limited to,~~ failure of systems and components.

g. The suitability of the property for any specialized use.

~~h. Compliance with regulatory requirements (codes, including the Virginia Uniform Statewide Building Code, regulations, laws, ordinances, etc.).~~

~~i.~~ h. The market value of the property or its marketability.

~~j.~~ i. The advisability of the purchase of the property.

~~k.~~ j. The presence of diseases harmful to humans or potentially hazardous plants or animals including~~, but not limited to,~~ wood destroying organisms and mold.

~~l.~~ k. The presence of any environmental hazards including~~, but not limited to,~~ toxins, carcinogens, noise, asbestos, lead-based paint, mold, radon, and contaminates in soil, water, and air.

~~m.~~ l. The effectiveness of any system installed or methods utilized to control or remove suspected hazardous substances.

~~n.~~ m. The operating costs of systems or components.

~~o.~~ n. The acoustical properties of any system or component.

~~p.~~ o. The presence of components involved in manufacturer's recalls.

~~q.~~ p. The inspection of outbuildings.

To the extent any other items are not specifically included in the home inspection by agreement of the parties, they shall also be noted as exclusions in the home inspection contract.

~~8. Expected~~ 9. Estimated delivery date to the client of the ~~certified~~ home inspection report.

~~9.~~ 10. Dated signatures of both the ~~certified~~ home inspector and the client or the client's authorized representative.

C. The ~~certified~~ home inspection contract shall make written disclosure that the ~~certified~~ home inspection report is based upon visual observation of existing conditions of the inspected property at the time of the inspection and is not intended to be, or to be construed as, a guarantee, warranty, or any form of insurance. This provision does not prevent a home inspector from offering a separate guarantee, warranty, or any form of insurance if he so chooses.

D. If the ~~certified~~ home inspector recommends a person to the client for repairs or modifications to the inspected property, the ~~certified~~ home inspector shall disclose to the client all financial interests that the ~~certified~~ home inspector has with the recommended person. The disclosure shall be written within the ~~certified~~ home inspection contract.

18VAC15-40-130. ~~Certified home~~ Home inspection report.

A. ~~Certified home~~ Home inspection reports shall contain:

1. ~~The name, business address and telephone number of the certificate holder as well as his certificate number and expiration date;~~ Information pertaining to the licensee, including:

a. Licensee's name;

b. Business address;

c. Telephone number; and

d. License number and expiration date, to be followed by "NRS" if so designated and performing a home inspection on a new residential structure.

2. The name, address, and telephone number of the client or the client's authorized representative, if available at the time of the inspection;

3. The physical address of the residential ~~properties~~ property inspected; and

4. The date, time (to include both start and finish times of the home inspection), and weather conditions at the time of the ~~certified~~ home inspection.

B. In conducting a ~~certified~~ home inspection and reporting its findings, the ~~certified~~ home inspector, at a minimum, shall inspect the condition of and shall describe in writing the composition~~/~~ or characteristics of the following readily accessible components and readily observable defects, except as may be limited in the ~~certified~~ home inspection contract agreement:

1. Structural system.

a. Foundation.

b. Framing.

c. Stairs.

d. Crawl space, the method of inspecting the crawl space shall be noted and explained in the home inspection report. If the crawl space cannot be inspected, the ~~certificate holder~~ licensee shall explain in the home inspection report why this component was not inspected.

e. Crawl space ventilation and vapor barriers.

f. Slab floor, when present.

g. Floors, ceilings, and walls.

2. Roof structure, attic, and insulation.

a. Roof covering. The method of inspecting the roof covering shall be noted and explained in the home inspection report. If the roof covering cannot be inspected, the ~~certificate holder~~ licensee shall explain in the home inspection report why this component was not inspected.

b. Roof ventilation.

c. Roof drainage system, to include gutters and downspouts.

d. Roof flashings, if readily visible.

e. Skylights, chimneys, and roof penetrations, but not antennae or other roof attachments.

f. Roof framing and sheathing.

g. Attic, unless area is not readily accessible.

h. Attic insulation.

3. Exterior of ~~dwelling~~ residential building or NRS.

a. Wall covering, flashing, and trim.

b. Readily accessible doors and windows, but not the operation of associated security locks, devices, or systems.

c. ~~Attached, or adjacent and on the same property, decks~~ Decks, balconies, stoops, steps, porches, attached garages, carports, and any associated railings~~,~~ that are adjacent to the residential building or NRS and on the same property but not associated screening, shutters, awnings, storm windows, detached garages, or storm doors.

d. Eaves, ~~soffitts~~ soffits, and fascias where readily accessible from ground level.

e. Walkways, grade steps, patios, and driveways, but not fences or privacy walls.

f. Vegetation, trees, grading, drainage, and any retaining walls ~~in contact with or~~ adjacent to the ~~dwelling that may affect the dwelling~~ residential building or NRS.

g. Visible exterior portions of chimneys.

4. Interior of ~~dwelling~~ residential building or NRS.

a. ~~Readily accessible interior~~ Interior walls, ceilings, and floors of ~~dwelling~~ residential building or NRS and any ~~attached or~~ adjacent garage.

b. Steps, stairways, railings, and balconies and associated railings.

c. Countertops and installed cabinets, including hardware.

d. ~~Readily accessible doors~~ Doors and windows, but not the operation of associated security locks, devices, or systems.

e. Garage doors and permanently mounted and installed garage door operators. The automatic safety reverse function of garage door openers shall be tested, either by physical obstruction as specified by the manufacturer, or by breaking the beam of the electronic photo eye but only when the test can be safely performed and will not risk damage to the door, the opener, any nearby structure, or any stored items.

f. Fireplaces, ~~including flues,~~ venting systems, hearths, dampers, and fireboxes, but not mantles, fire screens and doors, seals and gaskets.

g. Solid fuel burning appliances, if applicable.

5. Plumbing system.

a. Interior water supply and distribution systems, including water supply lines and all fixtures and faucets, but not water conditioning systems or fire sprinkler systems.

b. Water drainage, waste, and vent systems, including all fixtures.

c. Drainage sumps, sump pumps, and related piping.

d. Water heating equipment, including energy source and related vent systems, flues, and chimneys, but not solar water heating systems.

e. Fuel storage and distribution systems for visible leaks.

6. Electrical system.

a. Service drop.

b. Service entrance conductors, cables, and raceways.

c. Service equipment and main disconnects.

d. Service grounding.

e. Interior components of service panels and sub panels, including feeders.

f. Conductors.

g. Overcurrent protection devices.

h. Readily accessible installed lighting fixtures, switches, and receptacles.

i. Ground fault circuit interrupters.

j. Presence or absence of smoke detectors.

k. Presence of solid conductor aluminum branch circuit wiring.

l. Arc fault interrupters shall be noted if installed but not tested if equipment is attached to them.

7. Heating system.

a. Heating equipment, including operating controls, but not heat exchangers, gas logs, built-in gas burning appliances, grills, stoves, space heaters, solar heating devices, or heating system accessories such as humidifiers, air purifiers, motorized dampers, and heat reclaimers.

b. Energy source.

c. Heating distribution system.

d. Vent systems, flues, and chimneys, including dampers.

8. Air conditioning system.

a. Central and installed wall air conditioning equipment.

b. Operating controls, access panels, and covers.

c. Energy source.

d. Cooling distribution system.

C. Systems in the home that are turned off, winterized, or otherwise secured so that they do not respond to normal activation using standard operating controls need not be put into operating condition. The ~~certified~~ home inspector shall state, in writing, the reason these systems or components were not ~~tested~~ inspected.

Part V
Standards of Conduct and Practice

18VAC15-40-140. Conflict of interest.

A. The ~~certificate holder~~ licensee shall not:

1. Design or perform repairs or modifications to a residential building or NRS on which he has performed a ~~certified~~ home inspection as a result of the findings of the ~~certified~~ home inspection within 12 months after the date he performed the ~~certified~~ home inspection, except in cases where the home inspector purchased the residence after he performed the home inspection;

2. Perform a ~~certified~~ home inspection of a residential building or NRS upon which he has designed or performed repairs or modifications within the preceding 12 months without disclosing to the client in the ~~certified~~ home inspection contract the specifics of the repairs or modifications he designed or performed;

3. Refer his client to another person to make repairs or modifications to a residential building or NRS on which he has performed a ~~certified~~ home inspection unless, in accordance with 18VAC15-40-120 D, he provides written documentation to his client that clearly discloses all financial interests that the ~~certificate holder~~ licensee has or reasonably expects to have with the person who is recommended for the repairs or modifications;

4. Represent the financial interests, either personally or through his employment, of any of the parties to the transfer or sale of a residential building on which he has performed a ~~certified~~ home inspection; or

5. Perform a ~~certified~~ home inspection of a residential building or NRS under a contingent agreement whereby any compensation or future referrals are dependent on the reported findings or on the sale of the property.

B. The ~~certificate holder~~ licensee shall not disclose any information concerning the results of the ~~certified~~ home inspection without the approval of the client for whom the ~~certified~~ home inspection was performed. However, the ~~certificate holder~~ licensee may disclose information in situations where there is an imminent endangerment to life or health.

C. The ~~certificate holder will~~ licensee shall not accept compensation~~, financial or otherwise,~~ from more than one interested party for the same service on the same property without the consent of all interested parties.

D. The ~~certificate holder~~ licensee shall not accept nor offer commissions or allowances, directly or indirectly, from other parties dealing with the client in connection with work for which the ~~certificate holder~~ licensee is responsible. Additionally, the ~~certificate holder~~ licensee shall not enter into any financial relationship with any party that may

compromise the ~~certificate holder's~~ licensee's commitment to the best interest of his client.

E. The ~~certified~~ home inspection shall not be used as a pretext by the ~~certificate holder~~ licensee to solicit or obtain work in another field, except for additional diagnostic inspections or testing.

18VAC15-40-145. Competency for assignments.

A. The licensee shall undertake to perform professional assignments only when qualified by education or experience, or both.

B. A licensee shall not misrepresent to a prospective or existing client or employer his qualifications and the scope of his responsibility in connection with a home inspection.

18VAC15-40-150. Grounds for disciplinary action.

The board has the power to ~~fine any certificate holder and to suspend or revoke any certificate issued under the provisions of Chapter 5 (§ 54.1-500 et seq.) of Title 54.1 of the Code of Virginia, and this chapter, where the certificate holder~~ place a licensee on probation, impose a monetary penalty in accordance with § 54.1-202 A of the Code of Virginia, or revoke, suspend, or refuse to renew a license when the licensee has been found to have violated or cooperated with others in violating any provision of Chapter 1, 2, 3, or 5 of Title 54.1 of the Code of Virginia or this chapter.

18VAC15-40-152. Notice of adverse action.

A. A licensee shall notify the board of the following actions against the licensee:

1. Any disciplinary action taken by any jurisdiction, board, or administrative body of competent jurisdiction, including any (i) reprimand; (ii) license or certificate revocation, suspension, or denial; (iii) monetary penalty; (iv) requirement for remedial education; or (v) other corrective action.

2. Any voluntary surrendering of a related license, certificate, or registration done in connection with a disciplinary action in another jurisdiction.

3. Any conviction, finding of guilt, or plea of guilty, regardless of adjudication or deferred adjudication, in any jurisdiction of the United States of any (i) misdemeanor involving moral turpitude, sexual offense, drug distribution, or physical injury or relating to performing a home inspection or (ii) felony, there being no appeal pending therefrom or the time for appeal having lapsed. Review of convictions shall be subject to the requirements of § 54.1-204 of the Code of Virginia. Any plea of nolo contendere shall be considered a conviction for the purpose of this section.

B. The notice must be made to the board in writing within 30 days of the action. A copy of the order or other supporting documentation must accompany the notice. The record of conviction, finding, or case decision shall be considered prima facie evidence of a conviction or finding of guilt.

18VAC15-40-155. Prohibited acts.

The following acts are prohibited and any violation may result in disciplinary action by the board:

1. Obtaining or attempting to obtain a license by false or fraudulent representation.

2. Performing improvements or repairs to a residential building as a result of the findings of the home inspection within 12 months before or after performing a home inspection on it, except in cases where the home inspector purchased the residential building after he performed the home inspection.

3. Violating or inducing another person to violate any of the provisions of Chapter 1, 2, 3, or 5 of Title 54.1 of the Code of Virginia or this chapter.

4. A licensee having been convicted, found guilty, or disciplined in any jurisdiction of any offense or violation enumerated in 18VAC15-40-152. Review of convictions shall be subject to the requirements of § 54.1-204 of the Code of Virginia.

5. Failing to inform the board in writing within 30 days that the licensee was convicted, found guilty, or disciplined in any jurisdiction of any offense or violation enumerated in 18VAC15-40-152.

6. Failing to act as a licensee in such a manner as to safeguard the interests of the public.

7. Engaging in improper, fraudulent, or dishonest conduct in conducting a home inspection.

8. Having performed a home inspection when not qualified by training or experience to competently perform any part of the home inspection.

9. Failing to maintain, through training, the proficiency to perform Virginia home inspections.

10. Conducting a home inspection on any new residential structure without the NRS specialty issued by the board.

11. Failing to maintain the insurance policy required pursuant to 18VAC15-40-30 G.

12. Failing to report a change pursuant to 18VAC15-40-160.

13. Having cited, stated, or represented that there exists a violation of the Virginia Uniform Statewide Building Code (13VAC5-63) in a home inspection report or other document prepared relative to a home inspection.

18VAC15-40-160. Maintenance of ~~certificates~~ licenses, reports, and documentation.

A. ~~A certificate holder~~ The licensee shall at all times keep the board informed of his current address of record, to include the ~~home~~ physical address, as applicable. Changes of address shall be reported to the board in writing within 30 calendar days after such change. ~~A physical address is required; a post office box is not acceptable.~~ A post office box is acceptable as the address of record only when a physical address is also

provided. The board shall not be responsible for the ~~certificate holder's~~ licensee's failure to receive notices, communications and correspondence caused by the ~~certificate holder's~~ licensee's failure to promptly notify the board of any change of address.

B. ~~A certificate holder~~ The licensee shall notify the board in writing of a name change within 30 calendar days of any change in the ~~certificate holder's~~ licensee's legal name. Such notification shall be accompanied by a copy of a marriage ~~certificate~~ license, divorce decree, court order, or other documentation that verifies the name change.

C. ~~A certificate holder~~ The licensee shall retain all records pertaining to ~~certified~~ home inspections performed to include~~, but not limited to,~~ written reports and supporting documentation for a period of three years from the date of the related ~~certified~~ home inspection.

D. The licensee shall report the cancellation, amendment, expiration, or any other change of the insurance policy submitted in accordance with 18VAC15-40-30 G within 30 days of the change.

18VAC15-40-170. ~~Provision of records to the board.~~ (Repealed.)

~~A certificate holder shall, upon demand, produce to the board or any of its agents any written reports and supporting documentation concerning any certified home inspection in which the certificate holder was involved, or for which the certificate holder is required to maintain records for inspection and copying by the board or its agents.~~

18VAC15-40-180. Response to inquiry of the board.

~~A certificate holder shall respond to an inquiry from the board or any of its agents within 15 business days.~~

A. A licensee must respond within 10 days to a request by the board or any of its agents regarding any complaint filed with the department.

B. Unless otherwise specified by the board, a licensee of the board shall produce to the board or any of its agents within 10 days of the request any document, book, or record concerning any transaction pertaining to a complaint filed in which the licensee was involved, or for which the licensee is required to maintain records. The board may extend such timeframe upon a showing of extenuating circumstances prohibiting delivery within such 10-day period.

C. A licensee shall not provide a false, misleading, or incomplete response to the board or any of its agents seeking information in the investigation of a complaint filed with the board.

D. With the exception of the requirements of subsections A and B of this section, a licensee must respond to an inquiry by the board or its agent within 21 days.

18VAC15-40-190. ~~Unworthiness and incompetence.~~ (Repealed.)

~~The following shall constitute unworthy and incompetent conduct and may result in disciplinary action by the board:~~

~~1. Obtaining a certificate by false or fraudulent representation.~~

~~2. Performing improvements or repairs to a residential building as a result of the findings of the certified home inspection within 12 months before or after performing a certified home inspection on it, except in cases where the home inspector purchased the residential building after he performed the inspection.~~

~~3. Violating or inducing another person to violate any of the provisions of Chapter 1, 2, 3, or 5 of Title 54.1 of the Code of Virginia or this chapter.~~

~~4. Subject to the provisions of § 54.1-204 of the Code of Virginia, having been convicted or found guilty, regardless of adjudication in any jurisdiction of the United States, of any misdemeanor involving violence, repeat offenses, multiple offenses, or crimes that endangered public health or safety, or of any felony, there being no appeal pending therefrom or the time for appeal having elapsed. Any plea of nolo contendere shall be considered a conviction for the purposes of this subdivision. A certified copy of a final order, decree, or case decision by a court with the lawful authority to issue such order, decree or case decision shall be admissible as prima facie evidence of such conviction or guilt.~~

~~5. Failing to inform the board in writing within 30 days of pleading guilty or nolo contendere or being convicted or found guilty, regardless of adjudication in any jurisdiction of the United States of any misdemeanor involving violence, repeat offenses, multiple offenses, or crimes that endangered public health or safety, or of any felony, there being no appeal pending therefrom or the time for appeal having elapsed.~~

~~6. Failing to act as a certificate holder in such a manner as to safeguard the interests of the public.~~

~~7. Engaging in improper, fraudulent, or dishonest conduct in conducting a certified home inspection.~~

~~8. Having been found guilty by the board, an administrative body, or by any court of any misrepresentation in the course of performing home inspections.~~

~~9. Having performed a certified home inspection when not qualified by training or experience to competently perform any part of the certified home inspection.~~

~~10. Failing to maintain, through training, the proficiency to perform Virginia certified home inspections.~~

18VAC15-40-240. New residential structures training module requirements.

A. In order to qualify as an NRS training module ~~pursuant to this chapter~~ under 18VAC15-40-35, the training module must include a minimum of eight contact hours, and the syllabus shall encompass all of the subject areas set forth in subsection B of this section.

B. The following subject areas as they relate to the Virginia Residential Code shall be included in all NRS training modules. The time allocated to each subject area must be sufficient to ensure adequate coverage of the subject as determined by the board.

1. Origin of the Virginia Residential Code.

a. Overview of Title 36 of the Code of Virginia.

b. Roles and responsibilities of the Board of Housing and Community Development and the Department of Housing and Community Development.

c. Virginia Uniform Statewide Building Code, Part I (13VAC5-63-10 ~~et seq.~~) through 13VAC5-63-390) of 13VAC5-63.

2. Scope of the Virginia Residential Code.

a. Purpose of the Virginia Residential Code.

b. Exemptions from the Virginia Residential Code.

c. Compliance alternatives.

d. Code official discretion in administration and enforcement of the Virginia Residential Code.

e. Process for amending the Virginia Residential Code.

f. Code violations and enforcement.

(1) Statute of limitations.

(2) Effect of violations.

g. Examples of code and non-code violations.

3. Roles of the building code official and the home inspector, including an overview of § 36-105 of the Code of Virginia.

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

FORMS (18VAC15-40)

~~Home Inspector Association Membership Form, A506-3380AMF-v4 (rev. 8/2015)~~

~~Home Inspector Certification Application Instructions, A506-3380INS-v2 (eff. 8/2015)~~

~~Home Inspector Certification Application, A506-3380CERT-v3 (eff. 8/2015)~~

~~Home Inspector Experience Verification Form, A506-3380EXP-v4 (rev. 8/2015)~~

Home Inspector License/NRS Specialty Designation Application, A506-3380LIC-v1 (eff. 7/2017)

Home Inspector Experience Verification Form, A506-3380EXP-v5 (eff. 7/2017)

Home Inspector Reinstatement Application, A506-3380REI-v1 (eff. 7/2017)

Home Inspector - Course Approval Application, Prelicense Education Course/NRS Training Module/NRS CPE, A506-3331HICRS-v1 (eff. 4/2017)

VA.R. Doc. No. R17-4780; Filed April 21, 2017, 4:42 p.m.

BOARD FOR CONTRACTORS

Final Regulation

REGISTRAR'S NOTICE: The Board for Contractors is claiming an exemption from Article 2 of the Administrative Process Act in accordance with § 2.2-4006 A 6 of the Code of Virginia, which excludes regulations of the regulatory boards served by the Department of Professional and Occupational Regulation pursuant to Title 54.1 of the Code of Virginia that are limited to reducing fees charged to regulants and applicants. The Board for Contractors will receive, consider, and respond to petitions by any interested person at any time with respect to reconsideration or revision.

Title of Regulation: **18VAC50-22. Board for Contractors Regulations (amending 18VAC50-22-140, 18VAC50-22-170).**

Statutory Authority: §§ 54.1-201, 54.1-1102, and 54.1-1146 of the Code of Virginia.

Effective Date: July 1, 2017.

Agency Contact: Eric L. Olson, Executive Director, Board for Contractors, 9960 Mayland Drive, Suite 400, Richmond, VA 23233, telephone (804) 367-2785, FAX (866) 430-1033, or email contractors@dpor.virginia.gov.

Summary:

The amendment extends the temporary reduction in fees for contractor license renewal and reinstatement applications received on or before August 31, 2019, in order to reduce an accumulated budget surplus and remain in compliance with the Callahan Act (§ 54.1-113 of the Code of Virginia).

18VAC50-22-140. Renewal fees.

Each check or money order should be made payable to the Treasurer of Virginia. All fees required by the board are nonrefundable.

In the event that a check, money draft, or similar instrument for payment of a fee required by statute or regulation is not honored by the bank or financial institution named, the applicant or regulant shall be required to remit fees sufficient to cover the original fee, plus an additional processing charge set by the department:

Fee Type	When Due	Amount Due
Class C renewal	with renewal application	$195
Class B renewal	with renewal application	$225
Class A renewal	with renewal application	$240
Residential Building Energy Analyst Firm renewal	with renewal application	$195

The date on which the renewal fee is received by the Department of Professional and Occupational Regulation or its agent shall determine whether the licensee is eligible for renewal or must apply for reinstatement.

For renewal fees received on or before August 31, ~~2017~~ 2019, the fees shall be $100 for a Class C renewal, $125 for a Class B renewal, and $150 for a Class A renewal.

18VAC50-22-170. Reinstatement fees.

Each check or money order should be made payable to the Treasurer of Virginia. All fees required by the board are nonrefundable. In the event that a check, money draft, or similar instrument for payment of a fee required by statute or regulation is not honored by the bank or financial institution named, the applicant or regulant shall be required to remit fees sufficient to cover the original fee, plus an additional processing charge set by the department:

Fee Type	When Due	Amount Due
Class C reinstatement	with reinstatement application	$405*
Class B reinstatement	with reinstatement application	$460*
Class A reinstatement	with reinstatement application	$490*
Residential Building Energy Analyst Firm reinstatement	with reinstatement application	$405*

*Includes renewal fee listed in 18VAC50-22-140.

The date on which the reinstatement fee is received by the Department of Professional and Occupational Regulation or its agent shall determine whether the licensee is eligible for reinstatement or must apply for a new license and meet the entry requirements in place at the time of that application. In order to ensure that licensees are qualified to practice as contractors, no reinstatement will be permitted once two years from the expiration date of the license have passed.

For reinstatement fees received on or before August 31, ~~2017~~ 2019, the fees shall be $200 for Class C reinstatement, $250 for Class B reinstatement, and $300 for Class A reinstatement. These fees include the renewal fee listed in 18VAC50-22-140.

VA.R. Doc. No. R17-5097; Filed April 20, 2017, 9:23 a.m.

Final Regulation

REGISTRAR'S NOTICE: The Board for Contractors is claiming an exemption from Article 2 of the Administrative Process Act in accordance with § 2.2-4006 A 6 of the Code of Virginia, which excludes regulations of the regulatory boards served by the Department of Professional and Occupational Regulation pursuant to Title 54.1 of the Code of Virginia that are limited to reducing fees charged to regulants and applicants. The Board for Contractors will receive, consider, and respond to petitions by any interested person at any time with respect to reconsideration or revision.

Title of Regulation: **18VAC50-30. Individual License and Certification Regulations (amending 18VAC50-30-120, 18VAC50-30-130).**

Statutory Authority: §§ 54.1-201, 54.1-1102, and 54.1-1146 of the Code of Virginia.

Effective Date: July 1, 2017.

Agency Contact: Eric L. Olson, Executive Director, Board for Contractors, 9960 Mayland Drive, Suite 400, Richmond, VA 23233, telephone (804) 367-2785, FAX (866) 430-1033, or email contractors@dpor.virginia.gov.

Summary:

The amendment extends the temporary reduction in fees for individual license and certification renewal and reinstatement applications received on or before August 31, 2019, in order to reduce an accumulated budget surplus and remain in compliance with the Callahan Act (§ 54.1-113 of the Code of Virginia).

18VAC50-30-120. Renewal.

A. Licenses and certification cards issued under this chapter shall expire two years from the last day of the month in which they were issued as indicated on the license or certification card.

B. Effective with all licenses issued or renewed after December 31, 2007, as a condition of renewal or reinstatement and pursuant to § 54.1-1133 of the Code of Virginia, all individuals holding tradesman licenses with the trade designations of plumbing, electrical and heating ventilation and cooling shall be required to satisfactorily complete three hours of continuing education for each designation and individuals holding licenses as liquefied petroleum gas fitters and natural gas fitter providers, one hour of continuing education, relating to the applicable building code, from a provider approved by the board in accordance

with the provisions of this chapter. An inactive tradesman is not required to meet the continuing education requirements as a condition of renewal.

C. Certified elevator mechanics and certified accessibility mechanics, as a condition of renewal or reinstatement and pursuant to § 54.1-1143 of the Code of Virginia, shall be required to satisfactorily complete eight hours of continuing education relating to the provisions of the Virginia Uniform Statewide Building Code pertaining to elevators, escalators, and related conveyances. This continuing education will be from a provider approved by the board in accordance with the provisions of this chapter.

D. Certified water well systems providers, as a condition of renewal or reinstatement and pursuant to § 54.1-1129.1 B of the Code of Virginia, shall be required to satisfactorily complete eight hours of continuing education in the specialty of technical aspects of water well construction, applicable statutory and regulatory provisions, and business practices related to water well construction from a provider approved by the board in accordance with the provisions of this chapter.

E. Renewal fees are as follows:

Tradesman license	$90
Liquefied petroleum gas fitter license	$90
Natural gas fitter provider license	$90
Backflow prevention device worker certification	$90
Elevator mechanic certification	$90
Certified accessibility mechanic	$90
Water well systems provider certification	$90
Residential building energy analyst license	$90

All fees are nonrefundable and shall not be prorated.

For renewal fees received on or before August 31, ~~2017~~ 2019, the fee shall be $60.

F. The board will mail a renewal notice to the regulant outlining procedures for renewal. Failure to receive this notice, however, shall not relieve the regulant of the obligation to renew. If the regulant fails to receive the renewal notice, a photocopy of the tradesman license or backflow prevention device worker certification card may be submitted with the required fee as an application for renewal within 30 days of the expiration date.

G. The date on which the renewal fee is received by the department or its agent will determine whether the regulant is eligible for renewal or required to apply for reinstatement.

H. The board may deny renewal of a tradesman license or a backflow prevention device worker certification card for the same reasons as it may refuse initial issuance or ~~to~~ discipline a regulant. The regulant has a right to appeal any such action by the board under the Virginia Administrative Process Act (§ 2.2-4000 et seq. of the Code of Virginia).

I. Failure to timely pay any monetary penalty, reimbursement of cost, or other fee assessed by consent order or final order shall result in delaying or withholding services provided by the department such as, but not limited to, renewal, reinstatement, processing of a new application, or exam administration.

J. Residential building energy analysts, as a condition of renewal or reinstatement, shall provide documentation of continued membership, in good standing, of a certifying organization approved by the board and proof of insurance as required in 18VAC50-30-40 I 4.

18VAC50-30-130. Reinstatement.

A. Should the Department of Professional and Occupational Regulation fail to receive the renewal application or fees within 30 days of the expiration date, the regulant will be required to apply for reinstatement of the license or certification card.

B. Reinstatement fees are as follows:

Tradesman license	$140*
Liquefied petroleum gas fitter license	$140*
Natural gas fitter provider license	$140*
Backflow prevention device worker certification	$140*
Elevator mechanic certification	$140*
Certified accessibility mechanic	$140*
Water well systems provider certification	$140*
Residential building energy analyst license	$140*

*Includes renewal fee listed in 18VAC50-30-120.

All fees required by the board are nonrefundable and shall not be prorated.

For reinstatement fees received on or before August 31, ~~2017~~ 2019, the fee shall be $100. This fee includes the renewal fee listed in 18VAC50-30-120.

C. Applicants for reinstatement shall meet the requirements of 18VAC50-30-30.

D. The date on which the reinstatement fee is received by the department or its agent will determine whether the license or certification card is reinstated or a new application is required.

E. In order to ensure that license or certification card holders are qualified to practice as tradesmen, liquefied petroleum gas fitters, natural gas fitter providers, backflow prevention device workers, elevator mechanics, water well systems providers, or residential building energy analysts, no

reinstatement will be permitted once two years from the expiration date has passed. After that date the applicant must apply for a new license or certification card and meet the then current entry requirements.

F. Any tradesman, liquefied petroleum gas fitter, or natural gas fitter provider activity conducted subsequent to the expiration of the license may constitute unlicensed activity and may be subject to prosecution under Title 54.1 of the Code of Virginia. Further, any person who holds himself out as a certified backflow prevention device worker, as defined in § 54.1-1128 of the Code of Virginia, or as a certified elevator mechanic or certified accessibility mechanic, as defined in § 54.1-1140 of the Code of Virginia, or as a water well systems provider as defined in § 54.1-1129.1 of the Code of Virginia, without the appropriate certification, may be subject to prosecution under Title 54.1 of the Code of Virginia. Any activity related to the operating integrity of an elevator, escalator, or related conveyance, conducted subsequent to the expiration of an elevator mechanic certification may constitute illegal activity and may be subject to prosecution under Title 54.1 of the Code of Virginia. Any individual who completes a residential building energy analysis, as defined in § 54.1-1144 of the Code of Virginia, subsequent to the expiration of a residential building energy analyst license may have engaged in illegal activity and may be subject to prosecution under Title 54.1 of the Code of Virginia.

G. The board may deny reinstatement of a license or certification card for the same reasons as it may refuse initial issuance or to discipline a regulant. The regulant has a right to appeal any such action by the board under the Virginia Administrative Process Act (§ 2.2-4000 et seq. of the Code of Virginia).

H. Failure to timely pay any monetary penalty, reimbursement of cost, or other fee assessed by consent order or final order shall result in delaying or withholding services provided by the department, such as, but not limited to, renewal, reinstatement, processing of a new application, or exam administration.

VA.R. Doc. No. R17-4675; Filed April 20, 2017, 9:24 a.m.

BOARD OF DENTISTRY

Final Regulation

Title of Regulation: **18VAC60-21. Regulations Governing the Practice of Dentistry (amending 18VAC60-21-291, 18VAC60-21-301).**

Statutory Authority: §§ 54.1-2400 and 54.1-2709.5 of the Code of Virginia.

Effective Date: June 14, 2017.

Agency Contact: Sandra Reen, Executive Director, Board of Dentistry, 9960 Mayland Drive, Suite 300, Richmond, VA 23233, telephone (804) 367-4437, FAX (804) 527-4428, or email sandra.reen@dhp.virginia.gov.

Summary:

The amendments require that a dentist who administers conscious/moderate sedation, deep sedation, or general anesthesia (i) maintain an end-tidal carbon dioxide monitor (capnograph) in working order and immediately available to areas where patients will be sedated and recover from sedation and (ii) monitor end-tidal carbon dioxide in a patient during administration of conscious/moderate sedation or deep sedation or general anesthesia.

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.

18VAC60-21-291. Requirements for administration of conscious/moderate sedation.

A. Delegation of administration.

1. A dentist who does not hold a permit to administer conscious/moderate sedation shall only use the services of a qualified dentist or an anesthesiologist to administer such sedation in a dental office. In a licensed outpatient surgery center, a dentist who does not hold a permit to administer conscious/moderate sedation shall use ~~either~~ a qualified dentist, an anesthesiologist, or a certified registered nurse anesthetist to administer such sedation.

2. A dentist who holds a permit may administer or use the services of the following personnel to administer conscious/moderate sedation:

a. A dentist with the training required by 18VAC60-21-290 D 2 to administer by an enteral method;

b. A dentist with the training required by 18VAC60-21-290 D 1 to administer by any method;

c. An anesthesiologist;

d. A certified registered nurse anesthetist under the medical direction and indirect supervision of a dentist who meets the training requirements of 18VAC60-21-290 D 1; or

e. A registered nurse upon his direct instruction and under the immediate supervision of a dentist who meets the training requirements of 18VAC60-21-290 D 1.

3. If minimal sedation is self-administered by or to a patient 13 years of age or older before arrival at the dental office, the dentist may only use the personnel listed in subdivision 2 of this subsection to administer local anesthesia. No sedating medication shall be prescribed for or administered to a patient 12 years of age or younger prior to his arrival at the dentist office or treatment facility.

4. Preceding the administration of conscious/moderate sedation, a permitted dentist may use the services of the following personnel under indirect supervision to administer local anesthesia to anesthetize the injection or treatment site:

a. A dental hygienist with the training required by 18VAC60-25-100 C to parenterally administer Schedule VI local anesthesia to persons 18 years of age or older; or

b. A dental hygienist, dental assistant, registered nurse, or licensed practical nurse to administer Schedule VI topical oral anesthetics.

5. A dentist who delegates administration of conscious/moderate sedation shall ensure that:

a. All equipment required in subsection B of this section is present, in good working order, and immediately available to the areas where patients will be sedated and treated and will recover; and

b. Qualified staff is on site to monitor patients in accordance with requirements of subsection D of this section.

B. Equipment requirements. A dentist who administers conscious/moderate sedation shall have available the following equipment in sizes for adults or children as appropriate for the patient being treated and shall maintain it in working order and immediately available to the areas where patients will be sedated and treated and will recover:

1. Full face mask or masks;

2. Oral and nasopharyngeal airway management adjuncts;

3. Endotracheal tubes with appropriate connectors or other appropriate airway management adjunct such as a laryngeal mask airway;

4. A laryngoscope with reserve batteries and bulbs and appropriately sized laryngoscope blades;

5. Pulse oximetry;

6. Blood pressure monitoring equipment;

7. Pharmacologic antagonist agents;

8. Source of delivery of oxygen under controlled positive pressure;

9. Mechanical (hand) respiratory bag;

10. Appropriate emergency drugs for patient resuscitation;

11. Electrocardiographic monitor if a patient is receiving parenteral administration of sedation or if the dentist is using titration;

12. Defibrillator;

13. Suction apparatus;

14. Temperature measuring device;

15. Throat pack; ~~and~~

16. Precordial or pretracheal stethoscope; and

17. A end-tidal carbon dioxide monitor (capnograph).

C. Required staffing. At a minimum, there shall be a two-person treatment team for conscious/moderate sedation. The team shall include the operating dentist and a second person to monitor the patient as provided in 18VAC60-21-260 K and assist the operating dentist as provided in 18VAC60-21-260 J, both of whom shall be in the operatory with the patient throughout the dental procedure. If the second person is a dentist, an anesthesiologist, or a certified registered nurse anesthetist who administers the drugs as permitted in 18VAC60-21-291 A, such person may monitor the patient.

D. Monitoring requirements.

1. Baseline vital signs shall be taken and recorded prior to administration of any controlled drug at the facility and prior to discharge.

2. Blood pressure, oxygen saturation, [end-tidal carbon dioxide,] and pulse shall be monitored continually during the administration and recorded every five minutes.

3. Monitoring of the patient under conscious/moderate sedation is to begin prior to administration of sedation or, if pre-medication is self-administered by the patient, immediately upon the patient's arrival at the dental facility and shall take place continuously during the dental procedure and recovery from sedation. The person who administers the sedation or another licensed practitioner qualified to administer the same level of sedation must remain on the premises of the dental facility until the patient is evaluated and is discharged.

E. Discharge requirements.

1. The patient shall not be discharged until the responsible licensed practitioner determines that the patient's level of consciousness, oxygenation, ventilation, and circulation are satisfactory for discharge and vital signs have been taken and recorded.

2. Post-operative instructions shall be given verbally and in writing. The written instructions shall include a 24-hour emergency telephone number.

3. The patient shall be discharged with a responsible individual who has been instructed with regard to the patient's care.

F. Emergency management. The dentist shall be proficient in handling emergencies and complications related to pain control procedures, including the maintenance of respiration and circulation, immediate establishment of an airway, and cardiopulmonary resuscitation.

18VAC60-21-301. Requirements for administration of deep sedation or general anesthesia.

A. Preoperative requirements. Prior to the appointment for treatment under deep sedation or general anesthesia the patient shall:

1. Be informed about the personnel and procedures used to deliver the sedative or anesthetic drugs to assure informed consent as required by 18VAC60-21-260 F.

2. Have a physical evaluation as required by 18VAC60-21-260 C.

3. Be given preoperative verbal and written instructions including any dietary or medication restrictions.

B. Delegation of administration.

1. A dentist who does not meet the requirements of 18VAC60-21-300 shall only use the services of a dentist who does meet those requirements or an anesthesiologist to administer deep sedation or general anesthesia in a dental office. In a licensed outpatient surgery center, a dentist shall use either a dentist who meets the requirements of ~~18VAC60-20-300~~ 18VAC60-21-300, an anesthesiologist, or a certified registered nurse anesthetist to administer deep sedation or general anesthesia.

2. A dentist who meets the requirements of ~~18VAC60-20-300~~ 18VAC60-21-300 may administer or use the services of the following personnel to administer deep sedation or general anesthesia:

a. A dentist with the training required by 18VAC60-21-300 C;

b. An anesthesiologist; or

c. A certified registered nurse anesthetist under the medical direction and indirect supervision of a dentist who meets the training requirements of 18VAC60-21-300 C.

3. Preceding the administration of deep sedation or general anesthesia, a dentist who meets the requirements of ~~18VAC60-20-300~~ 18VAC60-21-300 may use the services of the following personnel under indirect supervision to administer local anesthesia to anesthetize the injection or treatment site:

a. A dental hygienist with the training required by 18VAC60-25-100 C to parenterally administer Schedule VI local anesthesia to persons 18 years of age or older; or

b. A dental hygienist, dental assistant, registered nurse, or licensed practical nurse to administer Schedule VI topical oral anesthetics.

C. Equipment requirements. A dentist who administers deep sedation or general anesthesia shall have available the following equipment in sizes appropriate for the patient being treated and shall maintain it in working order and immediately available to the areas where patients will be sedated and treated and will recover:

1. Full face mask or masks;

2. Oral and nasopharyngeal airway management adjuncts;

3. Endotracheal tubes with appropriate connectors or other appropriate airway management adjunct such as a laryngeal mask airway;

4. A laryngoscope with reserve batteries and bulbs and appropriately sized laryngoscope blades;

5. Source of delivery of oxygen under controlled positive pressure;

6. Mechanical (hand) respiratory bag;

7. Pulse oximetry and blood pressure monitoring equipment available and used in the treatment room;

8. Appropriate emergency drugs for patient resuscitation;

9. EKG monitoring equipment;

10. Temperature measuring devices;

11. Pharmacologic antagonist agents;

12. External defibrillator (manual or automatic);

13. ~~For intubated patients, an End-Tidal CO^2 monitor~~ An end-tidal carbon dioxide monitor (capnograph);

14. Suction apparatus;

15. Throat pack; and

16. Precordial or pretracheal stethoscope.

D. Required staffing. At a minimum, there shall be a three-person treatment team for deep sedation or general anesthesia. The team shall include the operating dentist, a second person to monitor the patient as provided in 18VAC60-21-260 K, and a third person to assist the operating dentist as provided in 18VAC60-21-260 J, all of whom shall be in the operatory with the patient during the dental procedure. If a second dentist, an anesthesiologist, or a certified registered nurse anesthetist administers the drugs as permitted in [~~18VAC60-21-301~~ subsection] B [of this section], such person may serve as the second person to monitor the patient.

E. Monitoring requirements.

1. Baseline vital signs shall be taken and recorded prior to administration of any controlled drug at the facility to include: temperature, blood pressure, pulse, oxygen saturation, and respiration.

2. The patient's vital signs [, end-tidal carbon dioxide,] and EKG readings shall be monitored, recorded every five minutes, and reported to the treating dentist throughout the administration of controlled drugs ~~and recovery~~. When depolarizing medications are administered, temperature shall be monitored constantly.

3. Monitoring of the patient undergoing deep sedation or general anesthesia is to begin prior to the administration of any drugs and shall take place continuously during administration, the dental procedure, and recovery from anesthesia. The person who administers the anesthesia or another licensed practitioner qualified to administer the same level of anesthesia must remain on the premises of the dental facility until the patient has regained consciousness and is discharged.

F. Emergency management.

1. A secured intravenous line must be established and maintained throughout the procedure.

2. The dentist shall be proficient in handling emergencies and complications related to pain control procedures, including the maintenance of respiration and circulation, immediate establishment of an airway, and cardiopulmonary resuscitation.

G. Discharge requirements.

1. The patient shall not be discharged until the responsible licensed practitioner determines that the patient's level of consciousness, oxygenation, ventilation, and circulation are satisfactory for discharge and vital signs have been taken and recorded.

2. Post-operative instructions shall be given verbally and in writing. The written instructions shall include a 24-hour emergency telephone number for the dental practice.

3. The patient shall be discharged with a responsible individual who has been instructed with regard to the patient's care.

VA.R. Doc. No. R16-4438; Filed April 17, 2017, 7:53 a.m.

Emergency Regulation

Title of Regulation: **18VAC60-21. Regulations Governing the Practice of Dentistry (adding 18VAC60-21-101 through 18VAC60-21-106).**

Statutory Authority: §§ 54.1-2400 and 54.1-2708.4 of the Code of Virginia.

Effective Dates: April 24, 2017, through October 23, 2018.

Agency Contact: Sandra Reen, Executive Director, Board of Dentistry, 9960 Mayland Drive, Suite 300, Richmond, VA 23233, telephone (804) 367-4437, FAX (804) 527-4428, or email sandra.reen@dhp.virginia.gov.

Preamble:

Regulations for dentists prescribing medications containing opioids are being promulgated as emergency regulations to address the opioid abuse crisis in Virginia. On November 16, 2016, State Health Commissioner Marissa Levine declared the opioid addiction crisis to be a public health emergency in Virginia. In a news conference about the opioid crisis, Governor McAuliffe noted that the declaration would "provide a framework for further actions to fight it, and to save Virginians' lives." One of those "further actions" is adoption of emergency regulations by the Board of Dentistry setting out rules for prescribing opioids.

Section 2.2-4011 of the Code of Virginia authorizes an agency to adopt emergency regulations necessitated by an emergency situation upon consultation with the Attorney General, and the necessity for the action is at the sole discretion of the Governor. The declaration by Commissioner Levine is indeed evidence that such an emergency situation exists in the Commonwealth. In addition, the board is required to adopt regulations by Chapter 291 of the 2017 Acts of Assembly, effective March 3, 2017.

The emergency regulations for the management of acute pain include requirements for the evaluation of the patient, limitations on quantity and dosage, and recordkeeping. A dentist who manages a patient with chronic pain must either refer the patient to a pain management specialist or adhere to the regulations of the Board of Medicine. A dentist who prescribes Schedules II through IV controlled substances is required to complete two hours of continuing education in pain management during the license renewal cycle following the effective date of the emergency regulations.

Part III
Prescribing for Pain Management

18VAC60-21-101. Definitions.

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

"Acute pain" means pain that occurs within the normal course of a disease or condition or as the result of surgery for which controlled substances may be prescribed for no more than three months.

"Chronic pain" means nonmalignant pain that goes beyond the normal course of a disease or condition for which controlled substances may be prescribed for a period greater than three months.

"Controlled substance" means drugs listed in The Drug Control Act (§ 54.1-3400 et seq. of the Code of Virginia) in Schedules II through IV.

"MME" means morphine milligram equivalent.

"Prescription Monitoring Program" means the electronic system within the Department of Health Professions that monitors the dispensing of certain controlled substances.

18VAC60-21-102. Evaluation of the patient in prescribing for acute pain.

A. Nonpharmacologic and non-opioid treatment for pain shall be given consideration prior to treatment with opioids. If an opioid is considered necessary for the treatment of acute pain, the dentist shall follow the regulations for prescribing and treating with opioids in 18VAC60-21-103 and 18VAC60-21-104.

B. Prior to initiating treatment with a controlled substance containing an opioid for a complaint of acute pain, the dentist shall perform a health history and physical examination appropriate to the complaint, query the Prescription Monitoring Program as set forth in § 54.1-2522.1 of the Code of Virginia, and conduct an assessment of the patient's history and risk of substance abuse.

18VAC60-21-103. Treatment of acute pain with opioids.

A. Initiation of opioid treatment for all patients with acute pain shall include the following:

1. A prescription for an opioid shall be a short-acting opioid in the lowest effective dose for the fewest number of days, not to exceed seven days as determined by the manufacturer's directions for use, unless extenuating circumstances are clearly documented in the patient record.

2. The dentist shall carefully consider and document in the patient record the reasons to exceed 50 MME/day.

3. Prior to exceeding 120 MME/day, the dentist shall refer the patient to or consult with a pain management specialist and document in the patient record the reasonable justification for such dosage.

4. Naloxone shall be prescribed for any patient when any risk factor of prior overdose, substance abuse, doses in excess of 120 MME/day, or concomitant use of benzodiazepine is present.

B. If another prescription for an opioid is to be written beyond seven days, the dentist shall:

1. Reevaluate the patient and document in the patient record the continued need for an opioid prescription; and

2. Check the patient's prescription history in the Prescription Monitoring Program.

C. Due to a higher risk of fatal overdose when opioids are prescribed with benzodiazepines, sedative hypnotics, carisoprodol, and tramadol, the dentist shall only co-prescribe these substances when there are extenuating circumstances and shall document in the patient record a tapering plan to achieve the lowest possible effective doses if these medications are prescribed.

18VAC60-21-104. Patient recordkeeping requirement in prescribing for acute pain.

The patient record shall include a description of the pain, a presumptive diagnosis for the origin of the pain, an examination appropriate to the complaint, a treatment plan, and the medication prescribed (including date, type, dosage, strength, and quantity prescribed).

18VAC60-21-105. Prescribing of opioids for chronic pain.

If a dentist treats a patient for whom an opioid prescription is necessary for chronic pain, he shall either:

1. Refer the patient to a medical doctor who is a pain management specialist; or

2. Comply with regulations of the Board of Medicine, 18VAC85-21-60 through 18VAC85-21-120 (see 33:16 VA.R. 1930-1931 April 3, 2017), if he chooses to manage the chronic pain with an opioid prescription.

18VAC60-21-106. Continuing education required for prescribers.

A dentist who prescribes Schedules II through IV controlled substances during one license renewal cycle shall obtain two hours of continuing education on pain management during the next renewal cycle following April 24, 2017. Continuing education hours required for prescribing of controlled substances may be included in the 15 hours required for renewal of licensure.

VA.R. Doc. No. R17-5064; Filed April 17, 2017, 9:25 a.m.

BOARD OF MEDICINE

Fast-Track Regulation

Title of Regulation: **18VAC85-50. Regulations Governing the Practice of Physician Assistants (amending 18VAC85-50-110).**

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

Public Hearing Information: No public hearings are scheduled.

Public Comment Deadline: June 14, 2017.

Effective Date: June 29, 2017.

Agency Contact: William L. Harp, M.D., Executive Director, Board of Medicine, 9960 Mayland Drive, Suite 300, Richmond, VA 23233, telephone (804) 367-4558, FAX (804) 527-4429, or email william.harp@dhp.virginia.gov.

Basis: Section 54.-2400 of the Code of Virginia authorizes the Board of Medicine to promulgate regulations that are reasonable and necessary to administer effectively the regulatory system. The specific Code of Virginia sections relating to licensure and practice of physician assistants are § 54.1-2952 (Supervision of assistants by licensed physician, or podiatrist; services that may be performed by assistants; responsibility of licensee; employment of assistants), § 54.1-2952.1 (Prescription of certain controlled substances and devices by licensed physician assistant), § 54.1-2952.2 (When physician assistant signature accepted), and § 54.1-2953 (Renewal, revocation, suspension and refusal).

Purpose: Chapter 450 of the 2016 Acts of Assembly deletes the requirement for physician assistants (PAs) and their supervising doctors to submit a practice agreement for Board of Medicine approval and the requirement for the practice agreement to include periodic site visits for physician assistants who provide services at a location other than where the physician regularly practices. Given that the practice agreement will no longer be submitted and approved by the board, it is reasonable to delete or modify requirements for submission of other documents relating to the oversight of PAs by physicians. Elimination of documents relating to invasive procedures will make the supervision and practice of PAs somewhat less burdensome. Maintenance of a requirement for a physician to attest to the competency of a PA to perform specific invasive procedures will continue to protect the public health and safety.

Rationale for Using Fast-Track Rulemaking Process: The amendments were unanimously approved by members of the Physician Assistant Advisory Board and the Board of Medicine. The Virginia Academy of Physician Assistants commented on the Notice of Intended Regulatory Action in full support of the amendments. Therefore, the board determined to move forward with adoption of a fast-track rulemaking action.

Substance: 18VAC85-50-110 is amended to eliminate the requirements that a physician provide certification for board

approval for the PA to perform certain invasive procedures. Physicians would still be required to directly supervise the performance of a specific procedure at least three times and then attest on the practice agreement that the PA is competent to do the procedure under general supervision; that attestation would become part of the PA's practice agreement and would not need to be submitted and approved by the board.

Issues: There are no advantages or disadvantages to the public. The public continues to be protected by maintaining the requirement for physician oversight and certification of the PA's competency to perform invasive procedures. There are no advantages or disadvantages to the agency or the Commonwealth.

Department of Planning and Budget's Economic Impact Analysis:

Summary of the Proposed Amendments to Regulation. The Board of Medicine (Board) proposes to eliminate current requirements for submission to the Board and Board approval of a physician's certification that his/her physician assistant (PA) is competent to perform specific invasive procedures[1] without direct supervision.

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

Estimated Economic Impact. The proposed regulation would continue to require that the supervising physician attest to the competency of a PA to perform the specific invasive procedures without direct supervision, but would no longer require that the certification be submitted to and approved by the Board. The certification would be in the practice agreement between the supervising physician and the PA. Eliminating the requirements for submission to the Board and Board approval of the physician's certification would save time and effort and potentially would enable a PA to start work sooner. Given that the supervising physician must still attest to the competency of the PA to perform the specific invasive procedures without direct supervision, the proposed amendment should not affect public health and safety. Thus it should produce a net benefit.

Businesses and Entities Affected. The proposed amendments affect current and future physician assistants in the Commonwealth, and their supervising physicians. There are 3,444 persons who hold a current Virginia license as a physician assistant,[2] each of whom may have multiple supervising physicians.

Localities Particularly Affected. The proposed amendments do not disproportionately affect particular localities.

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

Effects on the Use and Value of Private Property. The proposed amendments are unlikely to significantly affect the use and value of private property.

Real Estate Development Costs. The proposed amendments do not affect real estate development costs.

Small Businesses:

Definition. Pursuant to § 2.2-4007.04 of the Code of Virginia, small business is defined as "a business entity, including its affiliates, that (i) is independently owned and operated and (ii) employs fewer than 500 full-time employees or has gross annual sales of less than $6 million."

Costs and Other Effects. The proposed amendments would save staff time and potentially enable PAs to start work sooner at small medical practices and other small firms that employ PAs.

Alternative Method that Minimizes Adverse Impact. The proposed amendments do not adversely affect small businesses.

Adverse Impacts:

Businesses. The proposed amendments do not adversely affect businesses.

Localities. The proposed amendments do not adversely affect localities.

Other Entities. The proposed amendments do not adversely affect other entities.

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[1]The applicable invasive procedures are all invasive procedures other than insertion of a nasogastric tube, bladder catheter, needle, or peripheral intravenous catheter, but not a flow-directed catheter, and minor suturing, venipuncture, and subcutaneous intramuscular or intravenous injection. These named procedures may already be performed by a PA under general supervision.

[2]Data source: Department of Health Professions.

Agency's Response to Economic Impact Analysis: The Board of Medicine concurs with the economic impact analysis.

Summary:

The amendments require that a supervising physician attest on the practice agreement to the competence of the physician assistant to perform certain invasive procedures without direct supervision and eliminate the requirement that written certification of competence be submitted to the Board of Medicine for approval.

18VAC85-50-110. Responsibilities of the supervisor.

The supervising physician shall:

1. Review the clinical course and treatment plan for any patient who presents for the same acute complaint twice in a single episode of care and has failed to improve as expected. The supervising physician shall be involved with any patient with a continuing illness as noted in the written or electronic practice agreement for the evaluation process.

2. Be responsible for all invasive procedures.

a. Under general supervision, a physician assistant may insert a nasogastric tube, bladder catheter, needle, or peripheral intravenous catheter, but not a flow-directed catheter, and may perform minor suturing, venipuncture, and subcutaneous intramuscular or intravenous injection.

b. All other invasive procedures not listed in subdivision 2 a of this section must be performed under direct supervision unless, after directly supervising the performance of a specific invasive procedure three times or more, the supervising physician attests on the practice agreement to the competence of the physician assistant to perform the specific procedure without direct supervision ~~by certifying to the board in writing the number of times the specific procedure has been performed and that the physician assistant is competent to perform the specific procedure. After such certification has been accepted and approved by the board, the physician assistant may perform the procedure under general supervision~~.

3. Be responsible for all prescriptions issued by the assistant and attest to the competence of the assistant to prescribe drugs and devices.

VA.R. Doc. No. R17-4861; Filed April 17, 2017, 3:04 p.m.

Final Regulation

Title of Regulation: **18VAC85-170. Regulations Governing the Practice of Genetic Counselors (adding 18VAC85-170-10 through 18VAC85-170-190).**

Statutory Authority: §§ 54.1-2400 and 54.1-2957.19 of the Code of Virginia.

Effective Date: June 14, 2017.

Agency Contact: William L. Harp, M.D., Executive Director, Board of Medicine, 9960 Mayland Drive, Suite 300, Richmond, VA 23233, telephone (804) 367-4558, FAX (804) 527-4429, or email william.harp@dhp.virginia.gov.

Summary:

As mandated by Chapters 10 and 266 of the 2014 Acts of Assembly, the Board of Medicine is promulgating Regulations Governing the Practice of Genetic Counselors (18VAC85-170) to establish licensure for genetic counselors. Qualifications for licensure are specified in the Code of Virginia, so regulations set identical requirements. Other provisions, including fees charged to applicants and licensees, biennial renewal schedule, and responsibilities of licensees, are identical to other allied health professions regulated under the board. Continuing education requirements of 50 hours per biennium are consistent with the recertification requirement for maintenance of professional certification. Standards of professional conduct, including requirements for confidentiality, recordkeeping, communication with patients, and prohibition on sexual contact, are also identical to other professional regulations under the Board of Medicine. The provision for exercise of the conscience clause is unique to genetic counseling and is mandated by § 54.1-2957.21 of the Code of Virginia.

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

CHAPTER 170
REGULATIONS GOVERNING THE PRACTICE OF GENETIC COUNSELORS

Part I
General Provisions

18VAC85-170-10. Definitions.

A. The following words and terms when used in this chapter shall have the meanings ascribed to them in § 54.1-2900 of the Code of Virginia:

"Board"

"Genetic counselor"

"Practice of genetic counseling"

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

"ABGC" means the American Board of Genetic Counseling.

"ABMG" means the American Board of Medical Genetics.

"Active practice" means a minimum of 160 hours of professional practice as a genetic counselor within the 24-month period immediately preceding application for reinstatement or reactivation of licensure. The active practice of genetic counseling may include supervisory, administrative, educational, or consultative activities or responsibilities for the delivery of such services.

"Conscience clause" means the provision of § 54.1-2957.21 of the Code of Virginia.

"NSGC" means the National Society of Genetic Counselors.

18VAC85-170-20. Public participation.

A separate board regulation, Public Participation Guidelines (18VAC85-11), provides for involvement of the public in the development of all regulations of the Virginia Board of Medicine.

18VAC85-170-30. Current name and address.

Each licensee shall furnish the board his current name and address of record. All notices required by law or by this chapter to be given by the board to any such licensee shall be validly given when mailed to the latest address of record provided or served to the licensee. Any change of name or change in the address of record or public address, if different from the address of record, shall be furnished to the board within 30 days of such change.

18VAC85-170-40. Fees.

The following fees are required:

1. The application fee for licensure, payable at the time the application is filed, shall be $130.

2. The application fee for a temporary license, payable at the time the application is filed, shall be $50.

[~~2.~~ 3.] The biennial fee for renewal of active licensure shall be $135 and for renewal of inactive licensure shall be

$70, payable in each odd-numbered year in the license holder's birth month.

[~~3.~~ 4.] The additional fee for late renewal of licensure within one renewal cycle shall be $50.

[~~4.~~ 5.] The fee for reinstatement of a license that has lapsed for a period of two years or more shall be $180 and shall be submitted with an application for licensure reinstatement.

[~~5.~~ 6.] The fee for reinstatement of a license pursuant to § 54.1-2408.2 of the Code of Virginia shall be $2,000.

[~~6.~~ 7.] The fee for a duplicate license shall be $5, and the fee for a duplicate wall certificate shall be $15.

[~~7.~~ 8.] The fee for a returned check shall be $35.

[~~8.~~ 9.] The fee for a letter of good standing or letter of verification to another jurisdiction shall be $10.

Part II
Requirements for Licensure as a Genetic Counselor

18VAC85-170-50. Application requirements.

An applicant for licensure shall submit the following on forms provided by the board:

1. A completed application and a fee as prescribed in 18VAC85-170-40.

2. Verification of a professional credential in genetic counseling as required in 18VAC85-170-60.

3. Verification of practice as required on the application form.

4. If licensed or certified in any other jurisdiction, documentation of any disciplinary action taken or pending in that jurisdiction.

18VAC85-170-60. Licensure requirements.

A. An applicant for a license to practice as a genetic counselor shall provide documentation of (i) a master's degree from a genetic counseling training program that is accredited by the Accreditation Council of Genetic Counseling and (ii) a current, valid certificate issued by the ABGC or ABMG to practice genetic counseling.

B. Pursuant to § 54.1-2957.19 D of the Code of Virginia, applicants for licensure who do not meet the requirements of subsection A of this section may be issued a license provided they (i) apply for licensure before July 1, 2016; (ii) comply with the board's regulations relating to the NSGC Code of Ethics; (iii) have at least 20 years of documented work experience practicing genetic counseling; (iv) submit two letters of recommendation, one from a genetic counselor and another from a physician; and (v) have completed, within the last five years, 25 hours of continuing education approved by the NSGC or the ABGC. For the purpose of this subsection, the board deems the provisions of Part IV (18VAC85-170-110 et seq.) of this chapter to be consistent with the NSGC Code of Ethics.

C. An applicant for a temporary license shall provide documentation of having been granted the active candidate status by the ABGC. Such license shall expire 12 months from issuance or upon expiration of active candidate status, whichever comes first.

Part III
Renewal and Reinstatement

18VAC85-170-70. Renewal of license.

A. Every licensed genetic counselor who intends to maintain an active license shall biennially renew his license each odd-numbered year during his birth month and shall:

1. Submit the prescribed renewal fee; and

2. Attest to having met the continuing education requirements of 18VAC85-170-100.

B. The license of a genetic counselor that has not been renewed by the first day of the month following the month in which renewal is required is lapsed. Practice with a lapsed license may be grounds for disciplinary action. A license that is lapsed for two years or less may be renewed by payment of the renewal fee, a late fee as prescribed in 18VAC85-170-40, and attestation of compliance with continuing education requirements.

18VAC85-170-80. Inactive license.

A licensed genetic counselor who holds a current, unrestricted license in Virginia shall, upon a request at the time of renewal and submission of the required fee, be issued an inactive license. The holder of an inactive license shall not be entitled to perform any act requiring a license to practice genetic counseling in Virginia.

18VAC85-170-90. Reactivation or reinstatement.

A. To reactivate an inactive license or to reinstate a license that has been lapsed for more than two years, a genetic counselor shall submit evidence of competency to return to active practice to include one of the following:

1. Information on continued active practice in another jurisdiction during the period in which the license has been inactive or lapsed;

2. Attestation of meeting requirements for continuing education as specified in 18VAC85-170-100 for each biennium in which the license has been inactive or lapsed, not to exceed four years; or

3. Current certification by ABGC or ABMG.

B. To reactivate an inactive license, a genetic counselor shall pay a fee equal to the difference between the current renewal fee for inactive licensure and the renewal fee for active licensure.

C. To reinstate a license that has been lapsed for more than two years a genetic counselor shall file an application for reinstatement and pay the fee for reinstatement of his licensure as prescribed in 18VAC85-170-40. The board may specify additional requirements for reinstatement of a license so lapsed to include education, experience, or reexamination.

D. A genetic counselor whose licensure has been revoked by the board and who wishes to be reinstated shall make a new application to the board, fulfill additional requirements as specified in the order from the board, and make payment of the fee for reinstatement of his licensure as prescribed in 18VAC85-170-40 pursuant to § 54.1-2408.2 of the Code of Virginia.

E. The board reserves the right to deny a request for reactivation or reinstatement to any licensee who has been determined to have committed an act in violation of § 54.1-2915 of the Code of Virginia or any provisions of this chapter.

18VAC85-170-100. Continuing education requirements.

A. In order to renew an active license biennially, a licensee shall complete the Continued Competency Activity and Assessment Form that is provided by the board indicating completion of at least 50 contact hours of continuing learning activities as follows:

1. A minimum of 30 of the 50 hours shall be in Category 1 activities approved by the ABGC, the ABMG, or the NSGC and may include in-service training, self-study courses, continuing education courses, or professional workshops.

2. No more than 20 of the 50 hours may be Category 2 activities or professional activity credits, which may include consultation with another counselor or a physician, independent reading or research, authorship, clinical supervision, volunteer leadership in the profession, preparation for a presentation, or other such experiences that promote continued learning.

B. A licensee shall be exempt from the continuing education requirements for the first biennial renewal following the date of initial licensure in Virginia.

C. The licensee shall retain in his records the completed form with all supporting documentation for a period of four years following the renewal of an active license.

D. The board shall periodically conduct a random audit of its active licensees to determine compliance. The licensees selected for the audit shall provide all supporting documentation within 30 days of receiving notification of the audit.

E. Failure to comply with these requirements may subject the licensee to disciplinary action by the board.

F. The board may grant an extension of the deadline for continuing competency requirements, for up to one year, for good cause shown upon a written request from the licensee prior to the renewal date.

G. The board may grant an exemption for all or part of the requirements for circumstances beyond the control of the licensee, such as temporary disability, mandatory military service, or officially declared disasters.

Part IV

Scope of Practice

18VAC85-170-110. General responsibility.

A genetic counselor shall engage in the practice of genetic counseling, as defined in § 54.1-2900 of the Code of Virginia. The practice of genetic counseling may include supervisory, administrative, educational, or consultative activities or responsibilities for the delivery of such services.

18VAC85-170-120. Supervisory responsibilities.

A. A genetic counselor shall be responsible for supervision of unlicensed personnel who work under his direction and ultimately responsible and accountable for patient care and outcomes under his clinical supervision.

B. Delegation to unlicensed personnel shall:

1. Not include delegation of the discretionary aspects of the initial assessment, evaluation, or development of recommendations for a patient, or any task requiring a clinical decision or the knowledge, skills, and judgment of a licensed genetic counselor;

2. Only be made if, in the judgment of the genetic counselor, the task or procedures do not require the exercise of professional judgment and can be properly and safely performed by appropriately trained unlicensed personnel, and the delegation does not jeopardize the health or safety of the patient; and

3. Be communicated on a patient-specific basis with clear, specific instructions for performance of activities, potential complications, and expected results.

18VAC85-170-125. Responsibilities of a temporary licensee.

A. A person holding a temporary license as a genetic counselor shall practice under the clinical supervision of a genetic counselor or a physician licensed in the Commonwealth.

B. Clinical supervision shall require that:

1. The supervisor and temporary licensee routinely meet to review and evaluate patient care and treatment; and

2. The supervisor reviews notes on patient care entered by the temporary licensee prior to reporting study results and making recommendations to a patient. Such review shall be documented by some method in a patient record.

Part V

Standards of Professional Conduct

18VAC85-170-130. Confidentiality.

A practitioner shall not willfully or negligently breach the confidentiality between a practitioner and a patient. A breach of confidentiality that is required or permitted by applicable law or beyond the control of the practitioner shall not be considered negligent or willful.

18VAC85-170-140. Patient records.

A. Practitioners shall comply with the provisions of § 32.1-127.1:03 of the Code of Virginia related to the confidentiality and disclosure of patient records.

B. Practitioners shall provide patient records to another practitioner or to the patient or his personal representative in a timely manner in accordance with provisions of § 32.1-127.1:03 of the Code of Virginia.

C. Practitioners shall properly manage and keep timely, accurate, legible, and complete patient records.

D. Practitioners who are employed by a health care institution or other entity in which the individual practitioner does not own or maintain his own records shall maintain patient records in accordance with the policies and procedures of the employing entity.

E. Practitioners who are self-employed or employed by an entity in which the individual practitioner owns and is responsible for patient records shall:

1. Maintain a patient record for a minimum of six years following the last patient encounter with the following exceptions:

a. Records of a minor child shall be maintained until the child reaches the age of 18 years or becomes emancipated, with a minimum time for record retention of six years from the last patient encounter regardless of the age of the child;

b. Records that have previously been transferred to another practitioner or health care provider or provided to the patient or his personal representative; or

c. Records that are required by contractual obligation or federal law may need to be maintained for a longer period of time.

2. Post information or in some manner inform all patients concerning the timeframe for record retention and destruction. Patient records shall only be destroyed in a manner that protects patient confidentiality, such as by incineration or shredding.

3. When closing, selling, or relocating his practice, meet the requirements of § 54.1-2405 of the Code of Virginia for giving notice that copies of records can be sent to any like-regulated provider of the patient's choice or provided to the patient.

18VAC85-170-150. Practitioner-patient communication; conscience clause; termination of relationship.

A. Communication with patients.

1. Except as provided in § 32.1-127.1:03 F of the Code of Virginia, a practitioner shall accurately present information to a patient or his legally authorized representative in understandable terms and encourage participation in decisions regarding the patient's care.

2. A practitioner shall not deliberately withhold pertinent findings or information or make a false or misleading statement regarding the practitioner's skill or the efficacy or value of a medication, treatment, or procedure provided or directed by the practitioner in the treatment of any disease or condition.

3. When a genetic procedure is recommended, informed consent shall be obtained from the patient in accordance with the policies of the health care entity. Practitioners shall inform patients of the risks, benefits, and alternatives of the recommended procedure that a reasonably prudent practitioner practicing genetic counseling in Virginia would tell a patient.

a. In the instance of a minor or a patient who is incapable of making an informed decision on his own behalf or is incapable of communicating such a decision due to a physical or mental disorder, the legally authorized person available to give consent shall be informed and the consent documented.

b. An exception to the requirement for consent prior to performance of a genetic procedure may be made in an emergency situation when a delay in obtaining consent would likely result in imminent harm to the patient.

c. For the purposes of this provision, "genetic procedure" means any diagnostic or therapeutic procedure performed on a patient that is not part of routine, general care and for which the usual practice within the health care entity is to document specific informed consent from the patient or surrogate decisionmaker prior to proceeding.

4. Practitioners shall adhere to requirements of § 32.1-162.18 of the Code of Virginia for obtaining informed consent from patients prior to involving them as subjects in human research with the exception of retrospective chart reviews.

B. Exercise of the conscience clause.

1. Notwithstanding provisions of subsection A of this section, a practitioner may exercise the conscience clause pursuant to requirements of § 54.1-2957.21 of the Code of Virginia. If a genetic counselor has deeply held moral or religious beliefs that may prevent him from participating in genetic counseling, he shall immediately inform a prospective patient with specificity about any associated limitations on counseling resulting therefrom, prior to the initiation of the patient-practitioner relationship and shall:

a. Offer to refer the patient to another licensed health care practitioner with a relevant scope of practice and direct the patient to the online directory of licensed genetic counselors maintained by the board;

b. Immediately notify any referring practitioner, if known, of this refusal to participate in genetic counseling for the patient; and

c. Alert the patient and the referring practitioner if the referral is time sensitive.

2. If, during the course of patient care, the genetic counselor encounters a situation in which his deeply held

moral or religious beliefs would prevent him from participating in counseling, he shall immediately inform the patient with specificity about any associated limitations on counseling and shall:

a. Document the communication of such information in the patient record;

b. Offer to refer the patient to another licensed health care practitioner with a relevant scope of practice and direct the patient to the online directory of licensed genetic counselors;

c. Immediately notify any referring practitioner, if known, of such refusal and referral of the patient; and

d. Alert the patient and the referring practitioner if the referral is time sensitive.

C. Termination of the practitioner-patient relationship.

1. The practitioner or the patient may terminate the relationship. In either case, the practitioner shall make the patient record available, except in situations where denial of access is allowed by law.

2. A practitioner shall not terminate the relationship or make his services unavailable without documented notice to the patient that allows for a reasonable time to obtain the services of another practitioner.

18VAC85-170-160. Practitioner responsibility.

A. A practitioner shall not:

1. Perform procedures or techniques that are outside the scope of his practice or for which he is not trained and individually competent;

2. Knowingly allow subordinates to jeopardize patient safety or provide patient care outside of the subordinate's scope of practice or area of responsibility. Practitioners shall delegate patient care only to subordinates who are properly trained and supervised;

3. Engage in an egregious pattern of disruptive behavior or interaction in a health care setting that interferes with patient care or could reasonably be expected to adversely impact the quality of care rendered to a patient; or

4. Exploit the practitioner-patient relationship for personal gain.

B. Advocating for patient safety or improvement in patient care within a health care entity shall not constitute disruptive behavior provided the practitioner does not engage in behavior prohibited in subdivision A 3 of this section.

18VAC85-170-170. Solicitation or remuneration in exchange for referral.

A practitioner shall not knowingly and willfully solicit or receive any remuneration, directly or indirectly, in return for referring an individual to a facility as defined in § 37.2-100 of the Code of Virginia or hospital as defined in § 32.1-123 of the Code of Virginia.

"Remuneration" means compensation, received in cash or in kind, but shall not include any payments, business arrangements, or payment practices allowed by 42 USC § 1320a-7b(b), as amended, or any regulations promulgated thereto.

18VAC85-170-180. Sexual contact.

A. For purposes of § 54.1-2915 A 12 and A 19 of the Code of Virginia and this section, sexual contact includes sexual behavior or verbal or physical behavior that:

1. May reasonably be interpreted as intended for the sexual arousal or gratification of the practitioner, the patient, or both; or

2. May reasonably be interpreted as romantic involvement with a patient regardless of whether such involvement occurs in the professional setting or outside of it.

B. Sexual contact with a patient.

1. The determination of when a person is a patient for purposes of § 54.1-2915 A 19 of the Code of Virginia is made on a case-by-case basis with consideration given to the nature, extent, and context of the professional relationship between the practitioner and the person. The fact that a person is not actively receiving treatment or professional services from a practitioner is not determinative of this issue. A person is presumed to remain a patient until the practitioner-patient relationship is terminated.

2. The consent to, initiation of, or participation in sexual behavior or involvement with a practitioner by a patient neither changes the nature of the conduct nor negates the statutory prohibition.

C. Sexual contact between a practitioner and a former patient after termination of the practitioner-patient relationship may still constitute unprofessional conduct if the sexual contact is a result of the exploitation of trust, knowledge, or influence of emotions derived from the professional relationship.

D. Sexual contact between a practitioner and a key third party shall constitute unprofessional conduct if the sexual contact is a result of the exploitation of trust, knowledge, or influence derived from the professional relationship or if the contact has had or is likely to have an adverse effect on patient care. For purposes of this section, key third party of a patient means spouse or partner, parent or child, guardian, or legal representative of the patient.

E. Sexual contact between a supervisor and a trainee shall constitute unprofessional conduct if the sexual contact is a result of the exploitation of trust, knowledge, or influence derived from the professional relationship or if the contact has had or is likely to have an adverse effect on patient care.

18VAC85-170-190. Refusal to provide information.

A practitioner shall not willfully refuse to provide information or records as requested or required by the board

or its representative pursuant to an investigation or to the enforcement of a statute or regulation.

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

FORMS (18VAC85-170)

[~~Continued Competency Activity and Assessment Form (undated)~~

Genetic Counselor Application (https://www.license.dhp.virginia.gov/apply/)

Instructions for Completing an Application to Practice Genetic Counseling in Virginia (eff. 4/2017)

Instructions for Completing an Application for a Temporary License to Practice Genetic Counseling in Virginia (eff. 4/2017)

Form B, Employment History (rev. 3/2017)

Continued Competency Activity and Assessment Form (eff. 6/2017)]

VA.R. Doc. No. R15-4172; Filed April 17, 2017, 8:07 a.m.

BOARD OF PHARMACY

Final Regulation

REGISTRAR'S NOTICE: The Board of Pharmacy is claiming an exemption from Article 2 of the Administrative Process Act in accordance with § 2.2-4006 A 13 of the Code of Virginia, which exempts amendments to regulations of the board to schedule a substance in Schedule I or II pursuant to subsection D of § 54.1-3443 of the Code of Virginia. The board will receive, consider, and respond to petitions by any interested person at any time with respect to reconsideration or revision.

Title of Regulation: **18VAC110-20. Regulations Governing the Practice of Pharmacy (amending 18VAC110-20-322).**

Statutory Authority: §§ 54.1-2400 and 54.1-3443 of the Code of Virginia.

Effective Date: June 14, 2017.

Agency Contact: Caroline Juran, RPh, Executive Director, Board of Pharmacy, 9960 Mayland Drive, Suite 300, Richmond, VA 23233-1463, telephone (804) 367-4416, FAX (804) 527-4472, or email caroline.juran@dhp.virginia.gov.

Summary:

The amendments add eight compounds into Schedule I of the Drug Control Act as recommended by the Virginia Department of Forensic Science pursuant to § 54.1-3443 of the Code of Virginia. The compounds added by this regulatory action will remain in effect for 18 months or until the compounds are placed in Schedule I by legislative action of the General Assembly.

18VAC110-20-322. Placement of chemicals in Schedule I.

A. Pursuant to subsection D of § 54.1-3443 of the Code of Virginia, the Board of Pharmacy places the following in Schedule I of the Drug Control Act:

1. N-phenyl-N-[1-(2-phenylethyl)-4-piperidinyl]-butanamide (other name: butyryl fentanyl).

2. Flubromazolam.

3. 5-methoxy-N,N-methylisopropyltryptamine (Other name: 5-MeO-MIPT).

4. Cannabimimetic agents:

a. N-(1-Amino-3,3-dimethyl-1-oxobutan-2-yl)-1-[(4-fluorophenyl)methyl]-1H-indazole-3-carboxamide (other name: ADB-FUBINACA);

b. Methyl 2-[1-[(4-fluorophenyl)methyl]-1H-indazole-3-carboxamido]-3,3-dimethylbutanoate (other name: MDMB-FUBINACA); and

c. Methyl 2-[1-(5-fluoropentyl)-1H-indazole-3-carboxamido]-3,3-dimethylbutanoate (other names: 5-fluoro-ADB, 5-Fluoro-MDMB-PINACA).

The placement of drugs listed in this subsection shall remain in effect until December 14, 2017, unless enacted into law in the Drug Control Act.

B. Pursuant to subsection D of § 54.1-3443 of the Code of Virginia, the Board of Pharmacy places the following in Schedule I of the Drug Control Act:

1. Beta-keto-N,N-dimethylbenzodioxolylbutanamine (other names: Dibutylone, bk-DMBDB);

2. 1-(1,3-benzodioxol-5-yl)-2-(ethylamino)-1-pentanone (other name: N-ethylpentylone);

3. 1-[1-(3-methoxyphenyl)cyclohexyl]piperidine (other name: 3-methoxy PCP);

4. 1-[1-(4-methoxyphenyl)cyclohexyl]piperidine (other name: 4-methoxy PCP);

5. 4-Chloroethcathinone (other name: 4-CEC);

6. 3-Methoxy-2-(methylamino)-1-(4-methylphenyl)-1-propanone (other name: Mexedrone);

7. 3,4-dichloro-N-[2-(dimethylamino)cyclohexyl]-N-methyl-benzamide (other name: U-47700);

8. 3,4-dichloro-N-{[1-(dimethylamino)cyclohexyl] methyl}benzamide (other name: AH-7921);

9. N-phenyl-N-[1-(2-phenylethyl)-4-piperidinyl]-pentanamide (other name: Pentanoyl fentanyl);

10. N-phenyl-N-[1-(2-phenylethyl)-4-piperidinyl]-2-furancarboxamide (other name: Furanyl fentanyl);

11. N-(3-fluorophenyl)-N-[1-(2-phenethyl)-4-piperidinyl]-propanamide (other name: 3-fluorofentanyl);

12. Clonazolam; and

13. Cannabimimetic agents:

a. Methyl 2-({1-[(4-fluorophenyl)methyl]-1H-indazole-3-carbonyl}amino)-3-methylbutanoate (other names: AMB-FUBINACA, FUB-AMB);

b. N-(adamantan-1-yl)-1-(4-fluorobenzyl)-1H-indazole-3-carboxamide (other name: FUB-AKB48);

c. N-(adamantan-1-yl)-1-(5-fluoropentyl)-1H-indazole-3-carboxamide (other name: 5F-AKB48);

d. Naphthalen-1-yl 1-pentyl-1H-indazole-3-carboxylate (other name: SDB-005); and

e. N-(1-amino-3-methyl-1-oxobutan-2-yl)-1-(cyclohexylmethyl)indole-3-carboxamide (other name: AB-CHMICA).

The placement of drugs listed in this subsection shall remain in effect until March 7, 2018, unless enacted into law in the Drug Control Act.

C. Pursuant to subsection D of § 54.1-3443 of the Code of Virginia, the Board of Pharmacy places the following in Schedule I of the Drug Control Act:

1. 1-propionyl lysergic acid diethylamide (other name: 1P-LSD);

2. (2-Methylaminopropyl)benzofuran (other name: MAPB);

3. Ethyl phenyl(piperidin-2-yl)acetate (other name: Ethylphenidate);

4. 2-(3-fluorophenyl)-3-methylmorpholine (other name: 3-fluorophenmetrazine); and

5. N-(4-fluorophenyl)-N-[1-(2-phenylethyl)-4-piperidinyl]-butanamide (other name: para-fluorobutyrylfentanyl), its optical, positional, and geometric isomers, salts, and salts of isomers.

The placement of drugs listed in this subsection shall remain in effect until May 10, 2018, unless enacted into law in the Drug Control Act.

D. Pursuant to subsection D of § 54.1-3443 of the Code of Virginia, the Board of Pharmacy places the following in Schedule I of the Drug Control Act:

1. 1-(1,3-benzodioxol-5-yl)-2-(dimethylamino)-1-pentanone (other names: N,N-Dimethylpentylone, Dipentylone);

2. 4-chloro-alpha-Pyrrolidinovalerophenone (other name: 4-chloro-alpha-PVP);

3. 4-methyl-alpha-Pyrrolidinohexiophenone (other name: MPHP);

4. 4-fluoro-alpha-Pyrrolidinoheptiophenone (other name: 4-fluoro-PV8);

5. 1-(4-methoxyphenyl)-2-(pyrrolidin-1-yl)octan-1-one (other name: 4-methoxy-PV9);

6. 4-allyloxy-3,5-dimethoxyphenethylamine (other name: Allylescaline);

7. 4-methyl-alpha-ethylaminopentiophenone; and

8. N-(4-fluorophenyl)-2-methyl-N-[1-(2-phenylethyl)-4-piperidinyl]-propanamide (other name: para-fluoroisobutyryl fentanyl).

The placement of drugs listed in this subsection shall remain in effect until August 22, 2018, unless enacted into law in the Drug Control Act.

E. Pursuant to subsection D of § 54.1-3443 of the Code of Virginia, the Board of Pharmacy places the following in Schedule I of the Drug Control Act:

1. 6-ethyl-6-nor-lysergic acid diethylamide (other name: ETH-LAD), its optical, position, and geometric isomers, salts, and salts of isomers, whenever the existence of such salts, isomers, and salts of isomers is possible within the specific chemical designation;

2. 6-allyl-6-nor-lysergic acid diethylamide (other name: AL-LAD), its optical, position, and geometric isomers, salts, and salts of isomers, whenever the existence of such salts, isomers, and salts of isomers is possible within the specific chemical designation;

3. Synthetic opioids:

a. N-[1-[2-hydroxy-2-(2-thienyl)ethyl]-4-piperidinyl]-N-phenylpropanamide (other name: beta-hydroxythiofentanyl), its isomers, esters, ethers, salts, and salts of isomers, esters, and ethers, unless specifically excepted, whenever the existence of these isomers, esters, ethers, and salts is possible within the specific chemical designation;

b. N-(2-fluorophenyl)-N-[1-(2-phenylethyl)-4-piperidinyl]-propanamide (other names: 2-fluorofentanyl, ortho-fluorofentanyl), its isomers, esters, ethers, salts, and salts of isomers, esters, and ethers, unless specifically excepted, whenever the existence of these isomers, esters, ethers, and salts is possible within the specific chemical designation; and

c. N-phenyl-N-[1-(2-phenylethyl)-4-piperidinyl]-2-propenamide (other name: Acryl fentanyl), its isomers, esters, ethers, salts, and salts of isomers, esters, and ethers, unless specifically excepted, whenever the existence of these isomers, esters, ethers, and salts is possible within the specific chemical designation;

4. Cannabimimetic agents:

a. 1-pentyl-N-(phenylmethyl)-1H-indole-3-carboxamide (other name: SDB-006), its salts, isomers, and salts of isomers whenever the existence of such salts, isomers, and salts of isomers is possible within the specific chemical designation; and

b. Quinolin-8-yl 1-(4-fluorobenzyl)-1H-indole-3-carboxylate (other name: FUB-PB-22), its salts, isomers, and salts of isomers whenever the existence of such salts, isomers, and salts of isomers is possible within the specific chemical designation; and

5. Benzodiazepine: flubromazepam, its salts, isomers, and salts of isomers whenever the existence of such salts, isomers, and salts of isomers is possible within the specific chemical designation.

The placement of drugs listed in this subsection shall remain in effect until December 13, 2018, unless enacted into law in the Drug Control Act.

VA.R. Doc. No. R17-5057; Filed April 12, 2017, 2:18 p.m.

Fast-Track Regulation

Title of Regulation: **18VAC110-50. Regulations Governing Wholesale Distributors, Manufacturers, and Warehousers (amending 18VAC110-50-10 through 18VAC110-50-40, 18VAC110-50-60, 18VAC110-50-70, 18VAC110-50-80, 18VAC110-50-100 through 18VAC110-50-150; repealing 18VAC110-50-160 through 18VAC110-50-190).**

Statutory Authority: §§ 54.1-2400 and 54.1-3307 of the Code of Virginia.

Public Hearing Information: No public hearings are scheduled.

Public Comment Deadline: June 14, 2017.

Effective Date: June 29, 2017.

Agency Contact: Caroline Juran, RPh, Executive Director, Board of Pharmacy, 9960 Mayland Drive, Suite 300, Richmond, VA 23233-1463, telephone (804) 367-4416, FAX (804) 527-4472, or email caroline.juran@dhp.virginia.gov.

Basis: Section 54.1-2400 of the Code of Virginia provides the Board of Pharmacy the authority to promulgate regulations to administer the regulatory system, and § 54.1-3307 of the Code of Virginia requires the board to regulate the practice of pharmacy and the manufacturing, dispensing, selling, distributing, processing, compounding, or disposal of drugs and devices; control the character and standard of all drugs, cosmetics, and devices within the Commonwealth; investigate all complaints as to the quality and strength of all drugs, cosmetics, and devices; and take such action as may be necessary to prevent the manufacturing, dispensing, selling, distributing, processing, compounding and disposal of such drugs, cosmetics and devices that do not conform to the requirements of law. Chapter 221 of the 2016 Acts of Assembly requires the board to promulgate regulations for third-party logistics providers and nonresident manufacturers.

Purpose: The Drug Quality and Security Act (DQSA) became effective November 27, 2013. Title II of DQSA, Drug Supply Chain Security Act (DSCSA), outlines steps to build an electronic, interoperable system to identify and trace certain prescription drugs as they are distributed in the United States. The law intends to enhance the U.S. Food and Drug Administration's ability to help protect consumers from exposure to drugs that may be counterfeit, stolen, contaminated, or otherwise harmful. The DSCSA preempts states from (i) imposing pedigree (track and trace) requirements that do not comply with federal track and trace requirements for drug distribution and (ii) issuing a wholesale distributor license or nonresident wholesale distributor registration to third-party logistics providers and nonresident manufacturers. Therefore, it was necessary to amend certain state laws, including § 54.1-3307 of the Code of Virginia, and regulations to provide the board with legal ability to fulfill its duties in regulating the manufacturing, compounding, and distribution of drugs while not violating federal law.

Previously, state law authorized the board to license third-party logistics providers (entities that provide or coordinate warehousing, or other logistics services of a drug or device in interstate commerce on behalf of a manufacturer, wholesale distributor, or dispenser of a drug or device, but does not take ownership of the product or have responsibility to direct the sale or disposition of the product) as wholesale distributors and nonresident wholesale distributors. The DSCSA preempts states from issuing out-of-state manufacturers and in-state and out-of-state third-party logistics providers a wholesale distributor license. Since state law does not authorize an entity to ship controlled substances within or into the Commonwealth without holding a license with the board, it is necessary to create new licensing categories for these entities in order to ensure the continued ability of third-party logistics providers and nonresident manufacturers to provide services in Virginia and for the board to continue regulatory oversight of such entities to protect the integrity of the drug supply and the health and safety of citizens of the Commonwealth.

Rationale for Using Fast-Track Rulemaking Process: The board has adopted regulations that conform to the statutory provisions of the Code of Virginia as amended by the General Assembly. There is no fiscal impact on entities that were previously permitted as wholesale distributors since the fees are identical. Therefore, there should be no opposition to using the fast-track rulemaking process.

Substance: The amendments eliminate definitions that are no longer applicable or are set out in the Code of Virginia, provide for permits for third-party logistics providers and for registration of nonresident manufacturers with fees and schedules for renewal of such permits or registrations, include third-party logistics providers in all sections currently applicable to wholesale distributors, include nonresident manufacturers in requirements for manufacturers, and eliminate Part IV (18VAC110-50-160 et seq.) on pedigree requirements and replace those regulations with reference to the federal requirements for an electronic, interoperable system to identify, trace, and verify prescription drugs as they are distributed.

Issues: The primary advantage to the public is continuation of services currently provided by nonresident manufacturers and third-party logistics providers. There are no disadvantages to the public or the businesses that have previously held permits as wholesale distributors. There are no advantages or disadvantages to the agency.

Department of Planning and Budget's Economic Impact Analysis:

Summary of the Proposed Amendments to Regulation. Pursuant to Chapter 221 of the 2016 Acts of Assembly[1] and to conform to requirements in the federal Drug Quality and Security Act (DQSA – 2013),[2] the Board of Pharmacy (Board) proposes to amend its regulation that governs wholesale distributers, manufacturers and warehousers of drugs. Specifically, the Board proposes to 1) remove definitions from the regulation that have been made obsolete by, or are duplicative of, definitions in Chapter 221, 2) provide for some individuals currently licensed as nonresident wholesale distributers and resident wholesale distributers to be permitted as third-party logistics providers or registered as nonresident manufacturers, 3) amend language to clarify that the newly categorized nonresident manufacturers follow the same rules as resident manufacturers, and 4) eliminate the susceptible drugs and pedigree requirements and authentications sections in this regulation and replace them with a reference to federal requirements for an electronic, interoperable system to identify trace and verify prescription drugs as they are distributed.

Result of Analysis. Benefits outweigh costs for all proposed changes.

Estimated Economic Impact. Current regulation licenses all third-party logistics providers[3] as wholesale distributers or nonresident wholesale distributers. In 2013, the United States Congress passed the DQSA and it was signed into law. The DQSA preempts states from licensing out-of-state manufacturers and in-state and out-of-state third-party logistics providers as wholesale distributers and nonresident wholesale distributers. In 2016, the General Assembly passed Chapter 221 to conform state law to the DQSA. In order to implement Chapter 221 and conform this regulation to the DQSA, the Board now proposes to 1) remove definitions that are obsolete or duplicative of those in state legislation, 2) create two new categories of licensure to cover third-party logistics providers and nonresident manufacturers, 3) amend language to clarify that the newly categorized nonresident manufacturers follow the same rules as resident manufacturers, and 4) eliminate the susceptible drugs and pedigree requirements and authentications sections in this regulation and replace them with a reference to federal requirements for an electronic, interoperable system to identify trace and verify prescription drugs as they are distributed.

No entities are likely to incur additional costs on account of these proposed changes as they strictly clarify and conform regulation to state and federal law. Specifically, third-party logistics providers and nonresident manufacturers will not incur additional costs because their fees for permits and registration will be that same as the fees they paid to be licensed as wholesale distributers and nonresident wholesale distributers and their renewal cycle will not change. All affected entities will benefit from this regulatory action as it will eliminate confusion about the rules for drug wholesale distributers, manufacturers, and warehousers.

Businesses and Entities Affected. Board staff reports that there are 759 nonresident wholesale distributers and 120 resident wholesale distributers that are governed by this regulation and that some of these distributers will change to a new category of licensure on account of this proposed regulation. Affected entities will pay the same fees and follow the same rules as they do currently. Only the name of their license will change.

Localities Particularly Affected. No locality is likely to be particularly affected by these proposed regulatory changes.

Projected Impact on Employment. These proposed regulatory changes are unlikely to affect employment in the Commonwealth.

Effects on the Use and Value of Private Property. These proposed regulatory changes are unlikely to affect the use or value of private property in the Commonwealth.

Real Estate Development Costs. These proposed regulatory changes are unlikely to affect real estate development costs in the Commonwealth.

Small Businesses:

Definition. Pursuant to § 2.2-4007.04 of the Code of Virginia, small business is defined as "a business entity, including its affiliates, that (i) is independently owned and operated and (ii) employs fewer than 500 full-time employees or has gross annual sales of less than $6 million."

Costs and Other Effects. No small businesses will be adversely affected by these proposed regulatory changes.

Alternative Method that Minimizes Adverse Impact. No small businesses will be adversely affected by these proposed regulatory changes.

Adverse Impacts:

Businesses. No businesses will be adversely affected by these proposed regulatory changes.

Localities. Localities in the Commonwealth are unlikely to see any adverse impacts on account of these proposed regulatory changes.

Other Entities. No other entities are likely to be adversely affected by these proposed changes.

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[1] http://leg1.state.va.us/cgi-bin/legp504.exe?161+ful+CHAP0221

[2] https://www.gpo.gov/fdsys/pkg/PLAW-113publ54/pdf/PLAW-113publ54.pdf

[3] Third party logistics providers are entities licensed by the Board as wholesale distributors or registered as nonresident wholesale distributors that contract with a manufacturer to provide or coordinate warehousing, distribution, or other services on behalf of a manufacturer for a prescription drug, but do not take title to the prescription drug and only sell, distribute, or otherwise dispose of the prescription drug at the direction of the manufacturer.

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

Summary:

Pursuant to Chapter 221 of the 2016 Acts of Assembly, the amendments (i) eliminate definitions that are no longer applicable or are set out in the Code of Virginia; (ii) provide for permits for third-party logistics providers and for registration of nonresident manufacturers with fees and schedules for renewal of such permits or registrations; (iii) include third-party logistics providers in all sections currently applicable to wholesale distributors; (iv) include nonresident manufacturers in requirements for manufacturers; and (v) repeal Part IV (18VAC110-50-160 et seq.) on pedigree requirements and replace those provisions with reference to the federal requirements for an electronic, interoperable system to identify, trace, and verify prescription drugs as they are distributed.

Part I
General Provisions

18VAC110-50-10. Definitions.

In addition to words and terms defined in §§ 54.1-3300 and 54.1-3401 of the Code of Virginia, the following words and terms when used in this chapter shall have the following meanings unless the context clearly indicates otherwise:

"Authorized collector" means a registered manufacturer, wholesale distributor, or reverse distributor that is authorized by the U.S. Drug Enforcement Administration to receive drugs from an ultimate user, a person lawfully entitled to dispose of an ultimate user decedent's property, or a long-term care facility on behalf of an ultimate user who resides or has resided at that facility for the purpose of destruction.

"Authorized distributor of record" means a wholesale distributor with whom a manufacturer has entered into a written agreement under which such wholesale distributor is either authorized to distribute all of that manufacturer's prescription drug products, or only those products listed in the agreement, for such a period of time or number of shipments as specified in the agreement.

"Control number" means the unique identifying customer number assigned by the Virginia Department of Motor Vehicles to an individual when issuing a driver's license, learner's permit, or official identification card. This number is displayed on the driver's license or ID card in lieu of the social security number.

"DEA" means the U.S. Drug Enforcement Administration.

"Drop shipment" means the sale and distribution of a prescription drug in which a manufacturer~~,~~ or a third-party logistics provider~~, or the manufacturer's exclusive distributor~~ directly ships the prescription drug to a pharmacy, chain drug warehouse, or other person authorized to dispense or administer the prescription drug, and the pharmacy, chain drug warehouse or other authorized person is invoiced by a wholesale distributor that took title to the prescription drug during the shipping, but did not take physical possession of the prescription drug.

"Expiration date" means that date placed on a drug package by the manufacturer or repacker beyond which the product may not be dispensed or used.

"FDA" means the U.S. Food and Drug Administration.

~~"Manufacturer's exclusive distributor" means a distributor licensed by the board as a wholesale distributor or registered as a nonresident wholesale distributor who contracts with a manufacturer to provide or coordinate warehousing, distribution or other services on behalf of a manufacturer for a prescription drug and who takes title to that manufacturer's prescription drug, but who does not have general responsibility to direct the sale or disposition of the prescription drug.~~

~~"Third party logistics provider" means an entity licensed by the board as a wholesale distributor or registered as a nonresident wholesale distributor that contracts with a manufacturer to provide or coordinate warehousing, distribution, or other services on behalf of a manufacturer for a prescription drug, but does not take title to the prescription drug and that only sells, distributes, or otherwise disposes of the prescription drug at the direction of the manufacturer.~~

"Ultimate user" means a person who has lawfully obtained, and who possesses, a controlled substance for his own use or for the use of a member of his household or for an animal owned by him or a member of his household.

"USP-NF" means the United States Pharmacopeia-National Formulary.

18VAC110-50-20. Fees.

A. Unless otherwise provided, fees listed in this section shall not be refundable.

B. Initial application fees.

1. Nonrestricted manufacturer permit	$270
2. Restricted manufacturer permit	$180
3. Wholesale distributor license	$270
4. Warehouser permit	$270
5. Nonresident wholesale distributor registration	$270
6. Controlled substances registration	$90
7. Third-party logistics provider permit	$270
8. Nonresident manufacturer registration	$270

C. Annual renewal fees shall be due on February 28 of each year.

1. Nonrestricted manufacturer permit	$270
2. Restricted manufacturer permit	$180

3. Wholesale distributor license	$270
4. Warehouser permit	$270
5. Nonresident wholesale distributor registration	$270
6. Controlled substances registration	$90
7. Third-party logistics provider permit	$270
8. Nonresident manufacturer registration	$270

D. Late fees. The following late fees shall be paid in addition to the current renewal fee to renew an expired license within one year of the expiration date. In addition, engaging in activities requiring a license, permit, or registration after the expiration date of such license, permit, or registration shall be grounds for disciplinary action by the board.

1. Nonrestricted manufacturer permit	$90
2. Restricted manufacturer permit	$60
3. Wholesale distributor license	$90
4. Warehouser permit	$90
5. Nonresident wholesale distributor registration	$90
6. Controlled substances registration	$30
7. Third-party logistics provider permit	$90
8. Nonresident manufacturer registration	$90

E. Reinstatement fees.

1. Any entity attempting to renew a license, permit, or registration more than one year after the expiration date shall submit an application for reinstatement with any required fees. Reinstatement is at the discretion of the board and, except for reinstatement following license revocation or suspension, may be granted by the executive director of the board upon completion of an application and payment of any required fees.

2. Engaging in activities requiring a license, permit, or registration after the expiration date of such license, permit, or registration shall be grounds for disciplinary action by the board. Facilities or entities that cease operation and wish to resume shall not be eligible for reinstatement, but shall apply for a new permit or registration.

3. Facilities or entities that failed to renew and continued to operate for more than one renewal cycle shall pay the current and all back renewal fees for the years in which they were operating plus the following reinstatement fees:

a. Nonrestricted manufacturer permit	$240
b. Restricted manufacturer permit	$210
c. Wholesale distributor license	$240
d. Warehouser permit	$240
e. Nonresident wholesale distributor registration	$240
f. Controlled substances registration	$180
g. Third-party logistics provider permit	$240
h. Nonresident manufacturer registration	$240

F. Application for change or inspection fees.

1. Reinspection fee	$150
2. Inspection fee for change of location, structural changes, or security system changes	$150
3. Change of ownership fee	$50
4. Change of responsible party	$50

G. The fee for a returned check shall be $35.

H. The fee for verification of license ~~or,~~ permit, or registration shall be $25.

18VAC110-50-30. Application; location of business; inspection required.

A. Any person or entity desiring to obtain a license as a wholesale distributor, registration as a nonresident wholesale distributor or nonresident manufacturer, or permit as a manufacturer, ~~or~~ warehouser, or third-party logistics provider shall file an application with the board on a form approved by the board. An application shall be filed for a new license, registration, or permit, or for acquisition of an existing wholesale distributor, manufacturer, ~~or~~ warehouser, nonresident wholesale distributor, nonresident manufacturer, or third-party logistics provider.

B. A licensee or permit holder proposing to change the location of an existing license or permit, or make structural or security system changes to an existing location, shall file an application for approval of the changes following an inspection conducted by an authorized agent of the board.

C. A license ~~or,~~ permit, or registration shall not be issued to any wholesale distributor, manufacturer ~~or,~~ warehouser, nonresident wholesale distributor, nonresident manufacturer, or third-party logistics provider to operate from a private dwelling or residence or to operate without meeting the applicable facility requirements for proper storage and distribution of drugs or devices. Before any license ~~or,~~ permit, or registration is issued, the applicant shall demonstrate compliance with all federal, state and local laws and ordinances.

D. If a wholesale distributor, manufacturer ~~or,~~ warehouser, or third-party logistics provider engages in receiving, possessing, storing, using, manufacturing, distributing, or otherwise disposing of any ~~Schedule II-V~~ Schedules II

through V controlled substances, it shall also obtain a controlled substances registration from the board in accordance with § 54.1-3422 of the Code of Virginia, and shall also be duly registered with DEA and in compliance with all applicable laws and rules for the storage, distribution, shipping, handling, and transporting of controlled substances.

E. The proposed location, structural changes, or security system changes shall be inspected by an authorized agent of the board prior to issuance of a license or permit.

1. Applications that indicate a requested inspection date, or requests that are received after the application is filed, shall be honored provided a 14-day notice is allowed prior to the requested inspection date.

2. Requested inspection dates that do not allow a 14-day notice to the board may be adjusted by the board to provide 14 days for the scheduling of the inspection.

3. At the time of the inspection, the proposed prescription drug storage area shall comply with 18VAC110-50-40 and 18VAC110-50-50, and wholesale distributors shall meet the requirements of 18VAC110-50-90.

4. If an applicant substantially fails to meet the requirements for issuance of a permit or license and a reinspection is required, or if the applicant is not ready for the inspection on the established date and fails to notify the inspector or the board at least 24 hours prior to the inspection, the applicant shall pay a reinspection fee as specified in 18VAC110-50-20 prior to a reinspection being conducted.

F. Prescription drugs shall not be stocked within the proposed location or moved to a new location until approval is granted by the inspector or board staff.

18VAC110-50-40. Safeguards against diversion of drugs.

A. The holder of the license as a wholesale distributor or permit as a manufacturer ~~or,~~ warehouser, or third-party logistics provider, or registration as a nonresident wholesale distributor or nonresident manufacturer shall restrict all areas in which prescription drugs are stored or kept for sale to only those persons specifically designated as necessary for the manufacture, receipt, storage, distribution, or quality control of the controlled substance inventory~~,~~ and shall provide reasonable security measures to include appropriate locking devices on all access doors to these areas and adequate lighting both inside and outside the facility to deter unauthorized entry and diversion.

B. The holder of the license ~~or,~~ permit, or registration, except for those distributors of only medical gases other than nitrous oxide, shall install a device for the detection of breaking subject to the following conditions:

1. The device shall be a sound, microwave, photoelectric, ultrasonic, or any other generally accepted and suitable device.

2. The installation shall be hardwired and both the installation and device shall be based on accepted burglar alarm industry standards.

3. The device shall be maintained in operating order and shall have an auxiliary source of power.

4. The device shall fully protect all areas where prescription drugs are stored and shall be capable of detecting breaking by any means when activated.

5. Access to the alarm system shall be restricted to the person named on the application as the responsible party or to persons specifically designated in writing in a policy and procedure manual.

6. The system shall be activated whenever the drug storage areas are closed for business.

C. Distribution or delivery of prescription drugs shall be accomplished in a manner to prevent diversion or possession of drugs by unauthorized persons.

1. The holder of the license ~~or,~~ permit, or registration shall only deliver prescription drugs to a person authorized to possess such drugs at a location where the person is authorized to possess such drugs, and only at a time when someone authorized to possess such drugs is in attendance.

2. The holder of the license ~~or,~~ permit, or registration shall affirmatively verify that the person to whom prescription drugs are delivered is authorized by law to receive such drugs.

3. Prescription drugs may be transferred to an authorized agent of a person who may lawfully possess prescription drugs, provided the transfer occurs on the premises of the wholesale distributor, manufacturer ~~or,~~ warehouser, third-party logistics provider, nonresident wholesale distributor, or nonresident manufacturer and provided the identity and authorization of the agent is verified, and such transfer is only used to meet the immediate needs of a patient or patients.

Part II

Wholesale Distributors and Third-Party Logistics Providers

18VAC110-50-60. Special or limited-use licenses.

The board may issue a limited-use wholesale distributor license, limited-use nonresident wholesale distributor registration, or limited-use third-party logistics provider permit to entities that do not engage in the wholesale distribution of prescription drugs or in the acts of a third-party logistics provider except medical gases and may waive certain requirements of regulation based on the limited nature of such distribution.

18VAC110-50-70. Minimum required information.

A. The application form for a new license ~~or for,~~ registration as a nonresident wholesale distributor, or permit as a third-party logistics provider or any change of ownership shall include at least the following information:

1. The name, full business address, and telephone number of the applicant or licensee, registrant, or permit holder and name and telephone number of a designated contact person;

2. All trade or business names used by the applicant or licensee, registrant, or permit holder;

3. The federal employer identification number of the applicant or licensee, registrant, or permit holder;

4. The type of ownership and ~~name(s)~~ name of the owner of the entity, including:

a. If an individual, the name, address, and social security number or control number;

b. If a partnership, the name, address, and social security number or control number of each partner who is specifically responsible for the operations of the facility, and the name of the partnership and federal employer identification number;

c. If a corporation:

(1) The name and address of the corporation, federal employer identification number, state of incorporation, and the name and address of the resident agent of the corporation;

(2) The name, address, social security number or control number, and title of each corporate officer and director who is specifically responsible for the operations of the facility;

(3) For nonpublicly held corporations, the name and address of each shareholder that owns 10% or more of the outstanding stock of the corporation;

(4) The name, federal employer identification number, and state of incorporation of the parent company.

d. If a sole proprietorship, the full name, address, and social security number or control number of the sole proprietor and the name and federal employer identification number of the business entity;

e. If a limited liability company, the name and address of each member, the name and address of each manager, the name of the limited liability company and federal employer identification number, the name and address of the resident agent of the limited liability company, and the name of the state in which the limited liability company was organized;

5. Name, business address and telephone number, and social security number or control number, and documentation of required qualifications as stated in 18VAC110-50-80 of the person who will serve as the responsible party;

6. A list of all states in which the entity is licensed, registered, or permitted to purchase, possess and distribute prescription drugs, and into which it ships prescription drugs;

7. A list of all disciplinary actions imposed against the entity by state or federal regulatory bodies, including any such actions against the responsible party, principals, owners, directors, or officers over the last seven years;

8. A full description, for nonresident wholesale distributors, including the address, square footage, security and alarm system description, temperature and humidity control, and other relevant information of the facility or warehouse space used for prescription drug storage and distribution; and

9. An attestation providing a complete disclosure of any past criminal convictions and violations of the state and federal laws regarding drugs or devices or an affirmation and attestation that the applicant has not been involved in, or convicted of, any criminal or prohibited acts. Such attestation shall include the responsible party, principals, owners, directors, or officers.

B. An applicant or licensee, registrant, or permit holder shall notify the board of any changes to the information required in this section within 30 days of such change.

18VAC110-50-80. Minimum qualifications, eligibility, and responsible party.

A. The board shall use the following factors in determining the eligibility for licensure of wholesale distributors, registration of nonresident wholesale distributors, and permitting of third-party logistics providers:

1. The existence of grounds to deny an application as set forth in § 54.1-3435.1 of the Code of Virginia;

2. The applicant's past experience in the manufacture or distribution of drugs or devices;

3. Compliance with the recordkeeping requirements;

4. Prior disciplinary action by a regulatory authority, prior criminal convictions, or ongoing investigations related to the manufacturing, distribution, prescribing, or dispensing of drugs by the responsible party or immediate family members of the responsible party, and owners, directors, or officers; and

5. The responsible party's credentials as set forth in subsection B of this section.

B. Requirements for the person named as the responsible party.

1. The responsible party shall be the primary contact person for the board as designated by the wholesale distributor, nonresident wholesale distributor, or third-party logistics provider, who shall be responsible for managing the wholesale distribution operations at that location;

2. The responsible party shall have a minimum of two years of verifiable experience in a pharmacy or wholesale distributor or third-party logistics provider licensed, registered, or permitted in Virginia or another state where the person's responsibilities included, but were not limited

to, managing or supervising the recordkeeping, storage, and shipment for drugs or devices;

3. A person may only serve as the responsible party for one wholesale distributor license, nonresident wholesale distributor registration, or third-party logistics provider permit at any one time;

4. The responsible party shall be employed full time in a managerial position and actively engaged in daily operations of the wholesale distributor, nonresident wholesale distributor, or third-party logistics provider;

5. The responsible party shall be present on a full-time basis at the location of the wholesale distributor, nonresident wholesale distributor, or third-party logistics provider during normal business hours, except for time periods when absent due to illness, family illness or death, vacation, or other authorized absence; and

6. The responsible party shall be aware of, and knowledgeable about, all policies and procedures pertaining to the operations of the wholesale distributor, nonresident wholesale distributor, or third-party logistics provider and all applicable state and federal laws related to wholesale distribution of prescription drugs or the legal acts of a third-party logistics provider.

C. The person named as the responsible party on the application shall submit the following with the application:

1. A passport size and quality photograph taken within 30 days of submission of the application;

2. A resume listing employment, occupations, or offices held for the past seven years including names, addresses, and telephone numbers of the places listed;

3. An attestation disclosing whether the person has a criminal conviction or is the subject of any pending criminal charges within or outside the Commonwealth;

4. A criminal history record check through the Central Criminal Records Exchange; and

5. A description of any involvement by the person with any business, including any investments, other than the ownership of stock in publicly traded company or mutual fund, during the past seven years, which manufactured, administered, prescribed, distributed, or stored drugs and devices and any lawsuits, regulatory actions, or criminal convictions related to drug laws or laws concerning third-party logistics providers or wholesale distribution of prescription drugs in which such businesses were named as a party.

D. Responsibilities of the responsible party.

1. Ensuring that any employee engaged in operations is adequately trained in the requirements for the lawful and appropriate wholesale distribution of prescription drugs or the legal acts of a third-party logistics provider;

2. Requiring any employee who has access to prescription drugs to attest that he has not been convicted of any federal or state drug law or any law relating to third-party logistics providers or to the manufacture, distribution, or dispensing of prescription drugs;

3. Maintaining current working knowledge of requirements for wholesale distributors or third-party logistics providers and assuring continued training for employees;

4. Maintaining proper security, storage and shipping conditions for all prescription drugs;

5. Maintaining all required records.

E. Each nonresident wholesale distributor shall designate a registered agent in Virginia for service of any notice or other legal document. Any nonresident wholesale distributor that does not so designate a registered agent shall be deemed to have designated the Secretary of the Commonwealth to be its true and lawful agent, upon who may be served all legal process in any action or proceeding against such nonresident wholesale distributor. A copy of any such service of legal documents shall be mailed to the nonresident wholesale distributor by the board by certified mail at the address of record.

18VAC110-50-100. Examination of drug shipments and accompanying documents.

A. Upon receipt, each shipping container shall be visually examined for identity to determine if it may contain contaminated, contraband, counterfeit, suspected of being counterfeit, or damaged drugs, or drugs or devices that are otherwise unfit for distribution. This examination shall be adequate to reveal container damage that would suggest possible contamination, adulteration, misbranding, counterfeiting, suspected counterfeiting, or other damage to the contents.

B. Upon receipt of drugs, a wholesale distributor, nonresident wholesale distributor, or third-party logistics provider must review records for accuracy, completeness, and the integrity of the drugs considering the total facts and circumstances surrounding the transactions and the wholesale distributors, nonresident wholesale distributor, or third-party logistics provider involved.

C. Each outgoing shipment shall be carefully inspected for identity of the drugs and to ensure that there is no delivery of drugs that have been damaged in storage or held under improper conditions.

18VAC110-50-110. Returned, damaged and counterfeit drugs; investigations.

A. Any drug or device returned to a manufacturer ~~or,~~ another wholesale distributor, or a third-party logistics provider shall be kept under the proper conditions and documentation showing that proper conditions were maintained shall be provided to the manufacturer ~~or,~~ wholesale distributor, or third-party logistics provider to which the drugs are returned.

B. Any drug or device that, or any drug whose immediate or sealed outer or secondary container or labeling, is outdated,

damaged, deteriorated, misbranded, adulterated, counterfeited, suspected of being counterfeited or adulterated, or otherwise deemed unfit for human consumption shall be quarantined and physically separated from other drugs and devices until its appropriate disposition.

C. When a drug or device is adulterated, misbranded, counterfeited or suspected of being counterfeit, or when the immediate or sealed outer or secondary container or labeling of any drug or device is adulterated, misbranded other than misbranding identified by the manufacturer through a recall or withdrawal, counterfeited, or suspected of being counterfeit, the wholesale distributor, nonresident wholesale distributor, or third-party logistics provider shall:

1. Provide notice to the board and the manufacturer ~~or,~~ wholesale distributor, or third-party logistics provider from which such drug or device was acquired within three business days of that determination.

2. Maintain any such drug or device, its containers and labeling, and its accompanying documentation or any evidence of criminal activity until its disposition by the appropriate state and federal government authorities.

D. The wholesale distributor, nonresident wholesale distributor, or third-party logistics provider shall fully cooperate with authorities conducting any investigation of counterfeiting or suspected counterfeiting to include the provision of any records related to receipt or distribution of the suspect drug or device.

18VAC110-50-120. Policies and procedures.

All wholesale distributors, nonresident wholesale distributors, or third-party logistics providers shall establish, maintain, and adhere to written policies and procedures for the proper receipt, security, storage, inventory, and distribution of prescription drugs. Wholesale distributors, nonresident wholesale distributors, or third-party logistics providers shall include in their policies and procedures at least the following:

1. A procedure for reporting thefts or losses of prescription drugs to the board and other appropriate authorities;

2. A procedure whereby the oldest approved stock of a prescription drug is distributed first. The procedure may permit deviation from this process provided the deviation is temporary and appropriate for the distribution;

3. A procedure for handling recalls and withdrawals of prescription drugs and devices;

4. Procedures for preparing for, protecting against, and handling emergency situations that affect the security and integrity of drugs or the operations of the wholesale distributor, nonresident wholesale distributor, or third-party logistics provider;

5. A procedure to ensure that outdated drugs are segregated from other drugs to include the disposition of such drugs;

6. A procedure to ensure initial and ongoing training of all employees;

7. A procedure for ensuring, both initially and on an ongoing basis, that persons with access to prescription drugs have not been convicted of a drug law or any law related to wholesale distribution of prescription drugs or that of a third-party logistics provider; and

8. A procedure for reporting counterfeit or suspected counterfeit prescription drugs or counterfeiting or suspected counterfeiting activities to the board and other appropriate law enforcement or regulatory agencies.

18VAC110-50-130. Recordkeeping.

A. All records and documentation required in this subsection shall be maintained and made available for inspection and photocopying upon request by an authorized agent of the board for a period of three years following the date the record was created or received by the wholesale distributor, nonresident wholesale distributor, or third-party logistics provider. If records are not maintained on premises at the address of record, they shall be made available within 48 hours of such request. A wholesale distributor, nonresident wholesale distributor, or third-party logistics provider shall establish and maintain the following:

1. ~~Inventories~~ Unless otherwise indicated in federal law, inventories and records of all transactions ~~regarding the receipt and distribution, or other disposition of all prescription drugs~~, including the dates of receipt and distribution or other disposition or provision, and records related to the federal requirements for an electronic, interoperable system to identify, trace, and verify prescription drugs as they are distributed;

2. Records documenting monitoring of environmental conditions to ensure compliance with the storage requirements as required in 18VAC110-50-50;

3. Documentation of visual inspection of drugs and accompanying documents required in 18VAC110-50-100, including the date of such inspection and the identity of the person conducting the inspection;

4. Documentation of quarantine of any product and steps taken for the proper reporting and disposition of the product shall be maintained, including the handling and disposition of all outdated, damaged, deteriorated, misbranded, or adulterated drugs;

5. An ongoing list of persons or entities from whom it receives prescription drugs and persons or entities to whom it distributes prescription drugs or provides prescription drugs as a third-party logistics provider; and

6. Copies of the mandated report of thefts or unusual losses of ~~Schedule II - V~~ Schedules II through V controlled substances in compliance with the requirements of § 54.1-3404 of the Code of Virginia.

B. Records shall either (i) be kept at the inspection site or immediately retrievable by computer or other electronic

means and made readily available at the time of inspection or (ii) if kept at a central location and not electronically retrievable at the inspection site, be made available for inspection within 48 hours of a request by an authorized agent of the board.

C. All facilities shall have adequate backup systems to protect against the inadvertent loss or deliberate destruction of data.

18VAC110-50-140. Due diligence.

A. Prior to the initial purchase of prescription drugs from another wholesale distributor or third-party logistics provider not residing and licensed in Virginia, a wholesale distributor or third-party logistics provider shall obtain, and update annually, the following information from the selling wholesale distributor or third-party logistics provider:

1. A copy of the license to wholesale distribute or act as a third-party logistics provider from the resident state. If the resident state does not require licensure as a third-party logistics provider, documentation confirming active registration with the U.S. Food and Drug Administration is acceptable;

2. The most recent facility inspection report, if available;

3. A list of other names under which the wholesale distributor or third-party logistics provider is doing business, or was formerly known as;

4. A list of principals, directors, officers, or any shareholder who owns 10% or more of outstanding stock in any nonpublicly held corporation;

5. A list of all disciplinary actions by state and federal agencies;

6. A description, including the address, dimensions, and other relevant information, of each facility or warehouse used for drug storage and distribution or for the legal acts of a third-party logistics provider; and

7. A listing of any manufacturers for whom the wholesale distributor or third-party logistics provider is an authorized distributor of record.

B. If the selling wholesale distributor's or third-party logistics provider's facility has not been inspected by the resident board or the board's agent within three years of the contemplated purchase, the purchasing wholesale distributor or third-party logistics provider may conduct an inspection of the wholesale distributor's or third-party logistics provider's facility prior to the first purchase of drugs or devices from another wholesale distributor or third-party logistics provider to ensure compliance with applicable laws and regulations relating to the storage and handling of drugs or devices. A third party may be engaged to conduct the site inspection on behalf of the purchasing wholesale distributor or third-party logistics provider.

C. Prior to the first purchase of drugs from another wholesale distributor or third-party logistics provider not residing in and licensed in Virginia, the purchasing wholesale distributor or third-party logistics provider shall secure a national criminal background check of all of the wholesale distributor's or third-party logistics provider's owners, corporate officers, and the person named as the responsible party with the resident board or licensing agency.

Part III
Manufacturers

18VAC110-50-150. Good manufacturing practices.

A. The Good Manufacturing Practice for Finished Pharmaceuticals regulations set forth in 21 CFR Part 211 are adopted by reference.

B. Each manufacturer or nonresident manufacturer of drugs shall comply with the requirements set forth in the federal regulations referred to in subsection A of this section.

~~Part IV~~
~~Pedigree Requirements~~

18VAC110-50-160. ~~Susceptible drugs.~~ (Repealed.)

~~A. The list of drugs susceptible to counterfeiting for which a pedigree is required shall be all prescription drugs in Schedules II through VI, except that a pedigree is not required for those prescription drugs that do not leave the normal distribution channel or those that include one or more of the following additional distributions or variations to the normal distribution channel:~~

~~1. Distribution by a manufacturer's exclusive distributor;~~

~~2. Distribution by a third-party logistics provider;~~

~~3. Drop shipments;~~

~~4. Distributions to a veterinarian for veterinary use;~~

~~5. Distribution from an authorized distributor of record to one other authorized distributor of record to an office-based healthcare practitioner authorized by law to dispense or administer such drug to a patient; and~~

~~6. Distributions for emergency medical reasons, defined as those in which (i) a state of emergency has been declared by the Governor in accordance with § 54.1-3307.3 of the Code of Virginia, or (ii) there is a documented shortage of a drug, where the failure to acquire and dispense a prescription drug could result in imminent danger to patient health, and the wholesale distributor, in lieu of a pedigree, complies with the following requirements:~~

~~a. Obtains and maintains documentation from the manufacturer attesting to a shortage of the prescription drug and its non-availability through normal distribution channels;~~

~~b. Purchases the prescription drug only through an authorized distributor of record and maintains the name of such distributor;~~

~~c. Maintains a list of pharmacies or other authorized entities to which the prescription drug was distributed; and~~

d. Notifies the board within 24 hours of such a distribution.

B. Not less than annually, the board shall evaluate whether the list of susceptible drugs in subsection A of this section should be amended. The board may modify the list under its authority to adopt exempt regulations, pursuant to § 2.2-4006 of the Administrative Process Act, in accordance with the following process:

1. The board shall conduct a public hearing on any proposed amendments to subsection A of this section. Thirty days prior to conducting such hearing, the board shall give written notice of the date, time, and place of the hearing to all persons requesting to be notified of the hearings and publish proposed amendments to the list in the Virginia Register of Regulations.

2. During the public hearing, interested parties shall be given reasonable opportunity to be heard and present information prior to final adoption of any amendments. Final amendments of the list shall also be published, pursuant to § 2.2-4031 of the Code of Virginia, in the Virginia Register of Regulations.

3. Final amendments to the list of susceptible drugs shall become effective upon filing with the Registrar of Regulations.

18VAC110-50-170. ~~Requirements of a pedigree.~~ (Repealed.)

A. For distributions of prescription drugs that require a pedigree in accordance with § 54.1-3307 of the Code of Virginia and 18VAC110-50-160, the pedigree shall list all distributions starting with the sale by a manufacturer through acquisition and sale by any wholesale distributor until final sale to a pharmacy or other person authorized to administer or dispense the prescription drug.

B. When required by law and regulation to provide a pedigree, a wholesale distributor shall provide an authenticated pedigree for drugs sold or returned to another wholesale distributor before or at the time the drug is shipped to such wholesale distributor.

C. The pedigree shall minimally include the following information on a prescription drug for which a pedigree is required:

1. The trade or generic name of the drug;

2. The dosage form and strength, the container size, number of containers, and lot number;

3. The name of the manufacturer of the finished drug product;

4. Each transaction in which the drug is shipped or received by a manufacturer or wholesale distributor showing the following:

a. The business name and address of each entity involved in the chain of the drug's physical custody;

b. Telephone number and other contact information needed to authenticate the pedigree;

c. Sales invoice number or other unique shipping document number that identify each transaction; and

d. The dates of the transactions to include shipping dates when a seller ships the product and the receiving dates when a purchaser receives the product.

5. A statement of certification that the information contained in the pedigree is true and accurate and the name and signature of the individual certifying the authenticity of the pedigree at the time of shipment of the drug.

D. The requirement for a pedigree shall be effective February 20, 2009.

18VAC110-50-180. ~~Authentication of a pedigree.~~ (Repealed.)

A. Each person who is engaged in the wholesale distribution of a drug, who is provided a pedigree as specified in 18VAC110-50-160 and attempts to further distribute that drug, shall affirmatively verify before any distribution of a prescription drug that each transaction listed on the pedigree has occurred.

B. Upon request of a wholesale distributor who is attempting to authenticate a pedigree for a drug as specified in 18VAC110-50-160, any manufacturer or wholesale distributor listed on the pedigree shall provide requested information in a timely manner, only for those applicable transactions outside the normal chain of distribution conducted by that manufacturer or wholesale distributor, to include the following:

1. Dates of receipt or shipment of the drug as well as the name, address, and other contact information of those entities from whom they received the drug or to whom they shipped the drug;

2. Lot number;

3. Sales invoice number or other unique shipping document numbers that identify each transaction; and

4. Name of the person who is providing the requested information.

C. The wholesale distributor shall record the above information and maintain the information in accordance with 18VAC110-20-190.

D. If a wholesale distributor that is attempting to authenticate the distribution of a drug back to a manufacturer is unable to authenticate each distribution, the wholesale distributor shall quarantine the drug and report to the board and the FDA within three business days after completing the attempted authentication.

18VAC110-50-190. ~~Recordkeeping.~~ (Repealed.)

A. Wholesale distributors shall establish and maintain inventories and records of all transactions relating to the receipt and distribution or other disposition of drugs as specified in 18VAC110-50-160, to include records of

~~authentication of pedigrees, for a period of not less than three years.~~

~~B. All records shall be made available to the board or its authorized agent upon request. If records are not kept on premises at the address of record, they shall be made available within 48 hours of such request.~~

VA.R. Doc. No. R17-4822; Filed April 17, 2017, 3:06 p.m.

BOARD OF COUNSELING

Proposed Regulation

Title of Regulation: **18VAC115-20. Regulations Governing the Practice of Professional Counseling (amending 18VAC115-20-49).**

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

Public Hearing Information:

May 19, 2017 - 9:30 a.m. - 9960 Mayland Drive, Conference Center, 2nd Floor, Henrico, VA 23233

Public Comment Deadline: July 14, 2017.

Agency Contact: Jaime Hoyle, Executive Director, Board of Counseling, 9960 Mayland Drive, Suite 300, Richmond, VA 23233, telephone (804) 367-4406, FAX (804) 527-4435, or email jaime.hoyle@dhp.virginia.gov.

Basis: Section 54.1-2400 of the Code of Virginia provides the Board of Counseling the authority to promulgate regulations to administer the regulatory system.

Purpose: The board decided to publish a Notice of Intended Regulatory Action in response to a petition for rulemaking to provide a clearer standard for students, greater consistency in approval of residencies by the board, portability of educational qualification for Virginia graduates, and for acceptance of practice by federal agencies.

In recent years, the Board of Counseling has worked towards greater professional identity for counseling to help the public understand the clinical services a licensed professional counselor is qualified to provide. Chapter 264 of the 2013 Acts of Assembly amended the definition of "counseling" and "professional counselor" to clarify professional identity and distinguish the profession from others that include the methodology of "counseling" in their scope of practice. However, the board continues to review applications for licensure from students whose educational programs are not clearly "counseling" in their identity. The lack of clarity in its regulations has been frustrating for the board and very problematic for some applicants who have obtained a post-graduate degree that may or may not qualify them for a residency and ultimately licensure.

CACREP was established in 1981 to achieve some consistency in counseling educational programs. It has been recognized by the Council of Higher Education Accreditation (CHEA), a national advocate and institutional voice for self-regulation of academic quality through accreditation. CHEA is an association of 3,000 degree-granting colleges and universities and recognizes 60 institutional and programmatic accrediting organizations. CHEA recognition provides assurance to the public and higher education institutions that CACREP is a legitimate accrediting body with authority granted by a regulating body who has reviewed the standards, processes, and policies of CACREP. CHEA recognition also assures the public that the programs that achieve CACREP accreditation are legitimate degree programs. Both CHEA and CACREP assist the public in avoiding spending money on illegitimate degrees promoted by degree mills and accreditation mills. One of the goals of CACREP is to establish a uniform set of educational requirements across the United States to facilitate portability of licensure from state to state.

There are 12 Virginia institutions that already have CACREP accreditation; two (Longwood and George Mason) are not currently accredited, but Longwood has begun the process and is working towards accreditation.

Three federal agencies have made graduation from a CACREP-accredited program a requirement for independent practice in counseling. The Department of Veterans Affairs released qualification standards that formally recognize licensed professional mental health counselors who have graduated from CACREP-accredited programs as mental health specialists within the Veterans Health Administration. The Department of Defense will require a CACREP-accredited clinical mental health counseling or mental health counseling degree in order to obtain the TRICARE Certified Mental Health Counselor credential, which grants the authority to provide independent care to TRICARE beneficiaries after December 31, 2016. Prior to this legislation, mental health counselors could not practice independently in the TRICARE system. Beginning in July 2011, only licensed professional counselors with a degree from a CACREP-accredited program can be employed as Fully Functioning Army Substance Abuse Program Practitioner. With a large military presence in Virginia, there is a need to equate graduation from a CACREP-accredited program with licensure to avoid public confusion and give licensees access to federal agencies.

Legislation recently passed in North Carolina mandates that licensure as a professional counselor will only be granted to persons who apply after July 1, 2022, if they have earned a master's degree in counseling from an institution that is accredited by CACREP. The delayed effective date of the proposed regulation would give Virginia applicants and institutions a similar timeframe for compliance.

Consistency and quality in educational preparation for professional counselors will provide greater assurance to clients seeking counseling services that they have been adequately prepared and appropriately licensed to protect public health and safety.

Substance: The amendment provides that after seven years from the effective date of the regulation, only programs that

are approved by CACREP or Council on Rehabilitation Education (CORE) are recognized as meeting the requirements for an educational program for licensure in professional counseling.

Issues: The primary advantage to the public is greater consistency in the educational programs of persons licensed as professional counselors in Virginia. There are no disadvantages to the public.

The primary advantage to the Commonwealth would be greater efficiency in reviewing applications for licensure, as it would eliminate the need to look at the current qualifications for an educational program and rely on accreditation by CACREP or CORE. It would facilitate approval of applicants to begin supervision and to be ultimately licensed with less delay in the process. There are no disadvantages to the Commonwealth.

The board is authorized under § 54.1-2400 of the Code of Virginia to establish the qualifications for licensure that are necessary to ensure the competence and integrity of licensees to engage in the practice of counseling. The primary issue raised with requiring CACREP (or CORE as an affiliate of CACREP) accreditation is the concept of granting a "monopoly" for one accrediting body over which the board has no direct control. The Board of Counseling has found that it has neither the resources nor the expertise to examine counseling programs across the country to determine their rigor or assess the quality of the education in those programs. The proposal to establish national accreditation for counseling programs is intended to provide clear guidance to applicants and a consistent standard on which to determine their qualification for licensure.

The reliance on an independent, national accrediting body is common for all health and mental health licensure in Virginia and other states. For example, the Board of Medicine recognizes the American Medical Association's Liaison Committee on Medical Education or the Committee for the Accreditation of Canadian Medical Schools or any other organization approved by the board. The Board of Social Work recognizes the Council on Social Work Education as the accrediting body for educational programs. Other boards have similar criteria for accreditation. The only health regulatory board that assesses the quality of professional education is the Board of Nursing, and it has a core of staff persons across the state employed for that purpose. Even the Board of Nursing is currently moving in the direction of requiring national accreditation for registered nursing education programs.

The only other accrediting body advocated by those opposed to CACREP is the Masters in Psychology and Counseling Accreditation Council (MPCAC). It appears that programs accredited by MPCAC are primarily psychology-related and would not meet the current requirements of the board for counseling education. 18VAC115-20-49 currently specifies that (i) there must be a sequence of academic study with the expressed intent to prepare counselors as documented by the institution and (ii) there must be an identifiable counselor training faculty and an identifiable body of students who complete that sequence of academic study. Accreditation by MPCAC would not qualify an educational program by current standards because its primary emphasis is psychology rather than counseling. CACREP is the only identified accrediting body for counseling education.

Concern was also expressed by retaliation from neighboring states. Yet, the General Assembly of North Carolina passed SB279 in October of 2015 to require a master's degree in counseling or related field from an institution that is accredited by CACREP for an applicant who applies on or after July 1, 2022 (seven years to grandfather those currently in process and allow all programs time to complete accreditation standards). The proposal in Virginia would likewise have a seven-year delayed effective date.

Accreditation by a professional, national body is the standard for measuring minimal competency for other health and mental health professions. It contributes to portability, eliminates uncertainty for applicants, and assures the educational foundation for safe and effective practice by licensees.

Therefore, the requirement to have applicants for licensure graduate from a degree program accredited by a national accrediting program is a foreseeable result of the statute requiring the board to ensure licensees have the necessary qualifications, competence, and integrity to engage in the practice of counseling given the limitations on the board's resources to perform such a service itself and the widespread use of this model across the health licensing boards. Any restraint on competition that results from this regulation is in accord with the General Assembly's policy as articulated in § 54.1-100 of the Code of Virginia and is necessary for the preservation of the health, safety, and welfare of the public and will further the public's need for assurances of initial professional ability.

Department of Planning and Budget's Economic Impact Analysis:

Summary of the Proposed Amendments to Regulation. Pursuant to a petition for rulemaking, the Board of Counseling (Board) proposes to add a requirement for all counseling programs leading to licensure as a professional counselor to be approved by the Council for Accreditation of Counseling and Related Educational Programs (CACREP)[1] or its affiliate, the Council on Rehabilitation Education (CORE).[2] This requirement would not be enforced until seven years after the effective date of the proposed regulation. Individuals licensed before that date will be able to obtain licensure under current standards. In most cases, individuals seeking licensure in Virginia after that point will have to meet educational requirements in programs that are approved by CACREP or CORE.

Result of Analysis. Costs will likely outweigh benefits for this proposed change.

Estimated Economic Impact.

Current Licensure Requirements:

Professional counselors may currently be licensed by examination or by endorsement.[3] Currently, 18VAC115-20-49[4] requires individuals seeking licensure by examination as a professional counselor to complete education, as specified in 18VAC115-20-51,[5] in a degree program that "is offered by a college or university accredited by a regional accrediting agency" and that: 1) has an academic study sequence designed to prepare counselors for practice, 2) has an identifiable counselor training faculty and student body and 3) the academic unit responsible for the counseling program have clear authority and primary responsibility for the core and specialty areas of counseling study. Current regulation also requires these individuals to complete the residency requirements in 18VAC115-20-52[6] and to pass a written examination as prescribed by the Board.

Current regulation requires individuals who are seeking licensure by endorsement to: 1) hold or have held a professional counselor license in another jurisdiction of the United States, 2) submit an application processing fee and initial licensure fee, 3) have no unresolved action against a currently or previously held license or certificate, 4) have a passing score on an examination required for counseling licensure in the jurisdiction in which licensure was obtained, 5) submit an affidavit of having read and understood the regulations and laws governing the practice of professional counseling in Virginia. Applicants for licensure by endorsement must also either have met the educational and experience requirements in 18VAC115-20-49, as well as 18VAC115-20-51 and 18VAC115-20-52, or be able to 1) provide documentation of education and supervised experience that met the criteria for licensure in the jurisdiction where he was initially licensed and 2) provide evidence of post-licensure clinical practice in counseling for 24 of the 60 months immediately preceding application for licensure in Virginia.

Proposed Amendment in this Action:

In 2014, the Board received a petition for rulemaking[7] asking that individuals seeking licensure as professional counselors be required to complete education approved by CACREP or an approved affiliate of CACREP that includes a minimum of 60 semester hour credits (90 quarter hour credits) of curricular experiences and a practicum of at least 100 hours and an internship of at least 600 hours. The petition also asked that this regulatory change be subject to a seven year delay. As a result of this petition, the Board proposes to limit educational programs that will qualify individuals for licensure to only those that are approved by CACREP or its affiliate CORE. As requested in the petition, the Board proposes to delay the enforcement of this requirement until seven years after the effective date of this proposed regulation.

Board staff reports that this change will benefit both the public and Commonwealth by providing greater consistency in the educational programs that qualify an individual for licensure and efficiency in reviewing applications for licensure. Board staff notes that other health professions use private credentialing groups to evaluate and approve educational programs.[8] While accrediting groups can serve an important role in ensuring the quality of education needed for licensure, in this case, the Board already ensures that individuals licensed as professional counselors receive an education adequate to prepare them for future practice by: 1) specifying the coursework that applicants for licensure must have completed at an accredited college or university, 2) requiring a fairly lengthy residency and 3) requiring passage of a licensure exam that measures the counseling knowledge of applicants. These other requirements are not being repealed and will remain in place. In Virginia, requiring CACREP education would not appear to improve the quality of counselors as there is no reported differential in complaints or efficacy of practice between counselors that have CACREP education and those that have non-CACREP education. Additionally, the agency background document notes, in response to opposition to this proposed regulation that, "there is no empirical evidence that students from CACREP programs are better prepared" than students from non-CACREP programs.

Board staff also reports that the CACREP accredited education in either mental health counseling or clinical mental health counseling will be required by the Department of Defense (DoD) for TRICARE certification which will allow these counselors to practice independently. Before rules for TRICARE were changed, all counselors had to treat clients with a referral from, and under the supervision of, a physician. Under the rules finally adopted by the DoD for TRICARE, two classes of counselors, mental health counselors and clinical mental health counselors, are eligible for a separate TRICARE certification (TCMHC) that allows them to practice independently as TRICARE providers so long as they meet certain requirements.

Individuals applying for TCMHC status before January 1, 2017, may receive that certification so long as they: 1) have a master's (or higher) degree from a CACREP approved program and 2) have passed the National Counselor Examination or 1) possess a master's (or higher) degree from a program accredited by CACREP or a regional accrediting institution and 2) have passed the National Clinical Mental Health Counselor Examination (NCMHC).[9] Individuals seeking TCMHC certification before 2017 will additionally have to show that they are licensed in the jurisdiction where they will practice and have a minimum of two years of post-education supervised practice that includes at least 3,000 hours of supervised clinical practice and 100 hours of face-to-face supervision.[10]

Individuals applying for TCMHC status after January 1, 2017, may receive that certification so long as they: 1) have passed the NCMHC, 2) are licensed in the jurisdiction where they practice 3) have a master's (or higher) degree from a CACREP approved program and 4) have a minimum of two years of post-education supervised practice that includes at least 3,000 hours of supervised clinical practice with at least 100 hours of face-to-face supervision. All licensed counselors who do not meet the TCMHC requirements, either because they did not graduate from a CACREP program or because their counseling degrees are not from one of the two qualifying program types, will be able to continue practicing as they do now (with a referral and under the supervision of a physician).

These TRICARE rules were further modified in the Defense Authorization Act for fiscal year 2016[11] which stated that:

> "During the period preceding January 1, 2021, for purposes of determining whether a mental health care professional is eligible for reimbursement under the TRICARE program as a TRICARE certified mental health counselor, an individual who holds a master's degree or doctoral degree in counseling from a program that is accredited by a covered institution shall be treated as holding such degree from a mental health counseling program or clinical mental health counseling program that is accredited by [CACREP]."

And further lists the accrediting groups that are included in the definition of "covered institutions." These accrediting agencies are:

The Accrediting Commission for Community and Junior Colleges Western Association of Schools and Colleges (ACCJC-WASC).

The Higher Learning Commission (HLC).

The Middle States Commission on Higher Education (MSCHE).

The New England Association of Schools and Colleges Commission on Institutions of Higher Education (NEASC-CIHE).

The Southern Association of Colleges and Schools (SACS) Commission on Colleges.

The WASC Senior College and University Commission (WASC-SCUC).

The Accrediting Bureau of Health Education Schools (ABHES).

The Accrediting Commission of Career Schools and Colleges (ACCSC).

The Accrediting Council for Independent Colleges and Schools (ACICS).

The Distance Education Accreditation Commission (DEAC).

Under current (new) rules for TRICARE, no counselors or members of the Armed Services are worse off since all counselors will be able to practice as they did under old rules. Mental health counselors and clinical mental health counselors who either meet the requirements for being grandfathered or who have graduated from CACREP approved programs will be better off as they will be able to practice independently within the TRICARE system so long as they meet other requirements. This TRICARE change will likely increase the number of health care providers that are able to provide mental health care within the TRICARE system, and therefore increase access for members of the Armed Services, only if there is currently an issue with getting physicians to refer patients and provide supervision which leaves some individuals unable to obtain needed treatment.

A report to Congress[12] completed by the DoD in June 2006, concluded that requiring referral and supervision by a psychiatrist might limit access to counseling services. As a consequence of this, DoD began allowing other health care providers like primary care physicians and pediatricians to provide referrals and supervision. There appears to be no update to this report that would indicate if any access limitation persisted after the changes implemented to broaden the types of health care providers who could provide referral and supervision. According to a search of accredited programs on the CACREP site, only about 40% of CACREP accredited master's programs in Virginia would qualify individuals for TCMHC designation.[13] According to a Board source, community counseling programs at CACREP accredited schools have been phased out and will be renamed as clinical mental health programs, when these schools seek re-accreditation. Assuming this is the case, two more programs would qualify individuals for TRICARE independent practice some time in the future. This would increase the percentage of relevant programs to 46%.

The Board reports that George Mason University is the only school with a counseling program in the state that does not have CACREP accreditation, or will not soon have CACREP accreditation, and George Mason does not currently have a mental health counseling or clinical mental health counseling program that qualifies graduates for TCMHC designation.[14] Given this, and excepting the clinical mental health programs and mental health programs at Longwood and Hampton Universities (see footnote 14), it appears that the majority of programs that would allow graduates to qualify for TCMHC status are already voluntarily certified. Requiring CACREP accreditation for all programs to facilitate TCMCH eligibility will benefit neither the schools that are currently accredited, as it will decrease their flexibility,[15] nor program graduates in general, as graduates of less than half of programs in the Commonwealth would qualify for the enhanced certification from TRICARE.

George Mason and its students, in particular, will not benefit from changing licensure requirements to facilitate TCMHC designation as neither of the counseling programs at George Mason would qualify graduates for TCMHC status. DPB

does not have information to indicate what percentage of counselors graduate from the 40% (or 46%) of programs that would qualify them for TCMHC designation. Whatever that percentage is, most would likely gain the benefit of that designation without this Board action as they already would be graduates of CACREP approved programs without promulgation of this proposed regulation. It is also worth noting that schools that have both mental health counseling programs or clinical mental health counseling programs and CACREP accreditation will have incentive to advertise the advantage that that will afford their students in being able to work with the DoD health care system. This would likely have the effect of steering students who may wish to work with service members and their families to programs that would lead to the ability to practice independently within the TRICARE system.

Costs of the Proposed Amendment:

Obtaining and maintaining CACREP accreditation appears to involve significant costs. According to CACREP's website, CAPREP charges the following fees: 1) application process fee - $2,500, 2) site visit fee - $2,000 per visitor for 2-5 persons, 3) annual maintenance fee (2016) - $3,299, and 4) student graduate certificate - $50. George Mason University reports that the direct costs of initially obtaining CACREP approval would be slightly less than $70,000.[16] These initial costs appear to be in line with the one empirical study DPB could identify that addressed this topic.[17] Another study provided to DPB[18] estimated initial costs for gaining CACREP accreditation of about $24,000. This study does not, however, account for the economic costs of faculty time spent on gaining CACREP accreditation so it likely underestimates the total economic costs that were accrued by the university that was the subject of the study.

George Mason will also incur initial indirect costs if CACREP accreditation is required due to how their current programs are structured. Currently, George Mason has two master's level counseling programs. Their Community Agency Counseling program requires 52 semester credit hours and their school counseling program requires 45 semester credit hours. Individuals who wish to pursue Board licensure (which requires 60 semester credit hours of master's level education) can pursue a 15 semester credit hour post-master's level certificate that allows student to meet current licensure programs. While current licensure only requires 60 semester credit hours to be completed, CACREP accreditation requires that accredited programs consist of 60 semester credit hours. Because of this, under the proposed regulation, George Mason would have to develop and add several classes to each of their master's programs to bring each up to 60 semester credit hours and would have to modify at least one class to bring it into alignment with CACREP requirements. George Mason would incur costs for developing these classes that are specifically geared to fill in different deficits each program would have in meeting CACREP accreditation standards. Included in these costs are costs for time spent developing curricula and syllabi and the cost of getting them approved.

George Mason also reports, because of their current staffing levels, their full-time faculty's contractual teaching loads[19] and CACREP's faculty/student ratio requirements[20] that they will need to hire one full-time tenure-line instructional faculty member at a cost of approximately $114,000 (salary plus fringe benefits), one part-time term instructional faculty member at a cost of approximately $72,000 (0.75 FTE salary plus fringe benefits) and approximately $26,000 for adjunct faculty costs to meet the additional course loads under CACREP standards. George Mason is reported to have six full-time core-eligible faculty members and one full-time non-core eligible faculty member (who will be considered adjunct faculty in this analysis and by CACREP standards that require core faculty to teach 50% of classes/educational hours). This means that George Mason would be able to teach approximately 58 FTE master's level students per year[21] with their current staff if they only had master's level classes to teach. This number is reduced by the doctoral level classes that would also be taught by core faculty at a rate of 1 to 2… that is, in order to maintain the 50% teaching ratio for core faculty, two less master's classes (one taught by core faculty and one taught by non-core faculty) could be taught for every doctoral class taught by core faculty. George Mason reports that their counseling programs have a total of 159 students, which equals 90 FTE students. Given these numbers, it appears likely that George Mason's staffing needs will increase under this proposed regulation.

Additionally, George Mason estimates that they will need to upgrade a part-time administrative wage position to full-time which will cost an additional $34,000 annually over George Mason's current costs of maintaining this position at a part-time hourly wage. Other annual costs for George Mason would include annual maintenance fees of $3,514 (for two counseling degree programs) and approximately $1,500 for approximately 30 CACREP student graduation certificates per year.

Most of these costs are particular to George Mason and may not be experienced by other universities with other staffing levels and teaching load ratios. Longwood University, for instance, is not an intense research institution and, therefore, has greater teaching load expectations than would George Mason or other research institutions. All totaled, George Mason estimates that their ongoing annual costs for maintaining CACREP accreditation would be over $250,000 per year.[22]

George Mason University also reports that being required to seek CACREP approval of its counseling program constrains future hiring decisions for faculty who provide instruction in counseling but whose degrees and backgrounds are in psychology, psychiatry or social work. They would be so constrained because CACREP's new standards require "a core faculty for the program that evidences a clear counseling

professional identity."[23] This is particularly concerning to George Mason as they have several adjunct faculty members who would not meet the grandfathering requirements in the 2016 CACREP standards even though they have been working with George Mason for many years because they have not worked full-time. George Mason reports that, in some cases, they have maintained the part-time teaching relationship between themselves and particular adjunct professors because the professors had other full-time jobs in relevant fields that precluded also being full-time faculty. George Mason is very concerned that they would be precluded from bringing these individuals, who they would rate as very qualified, on as core faculty.

DHP reports that counseling programs at 12 universities and colleges already have CACREP accreditation, two (at Longwood University and George Mason University) are not currently CACREP approved. The CACREP website additionally lists counseling programs at Liberty University and Virginia Commonwealth University as being "in process" of getting approval. DHP reports that Longwood University has also begun the process of gaining CACREP approval so George Mason University would be the learning institution most immediately affected by this proposed change. That is not to say, however, that counseling programs in other colleges and universities would be unaffected whether they are currently CACREP approved or not.

Currently, all CACREP approved programs in the Commonwealth have the flexibility to choose not to renew their CACREP accreditation should they judge in the future that it is not worth the costs involved. They would lose that flexibility if this proposed action goes forward. CACREP approval lasts eight years in most cases (in some cases, programs are approved for two years); after that schools must reapply for program approval under whatever iteration of CACREP standards are currently in place at the time of re-application. Because of this, if these programs must maintain CACREP accreditation, they will likely incur additional costs that may outweigh any perceived current benefit as they have to be re-approved and as CACREP standards change in the future. For instance, 2009 CACREP standards provide for grandfathering counseling program professors whose doctoral degree field is not in counseling even though they are competent to teach counseling skills.[24] 2016 standards will specify, however, that doctoral level professionals will not be permitted to hold core faculty positions in CACREP approved programs unless their training is in counseling (preferably at a CACREP accredited program) or they were "employed as full-time faculty members for a minimum of one full academic year before July 1, 2013."

This means that, theoretically, in order to be re-approved at the end of their accreditation period any time after June 30, 2016, programs that have staff whose training is in psychology, psychiatry and social work or clinical social work would have to replace these faculty members if they do not either have a counseling education or meet the requirements for grandfathering. A Board source reports that only programs who received CACREP accreditation prior to 2009 would possibly have staff that would not meet the 2016 requirements and that the one Virginia institution that was accredited prior to 2009 does not have any faculty that would be affected. Schools will also have future hiring decisions constrained by this new rule and any other future iterations of CACREP rules that are adopted by that organization. Also, by increasing required costs to start counseling programs, this proposed change may limit the number of counseling programs that are instituted in the future below the number that might be instituted if current regulations remain in place.

This proposed regulatory change could also adversely affect individuals seeking licensure as professional counselors by endorsement from the Board. As mentioned above, these individuals must currently meet the educational and experience requirements in 18VAC115-20-49, as well as 18VAC115-20-51 and 18VAC115-20-52 or must have met the education and supervised experience for licensure in the jurisdiction where they were initially licensed and provide evidence of post-licensure clinical practice in counseling for 24 of the 60 months immediately preceding application for licensure in Virginia. Further, no applicant for licensure by endorsement is required to have graduated from a CAPREP approved program. Under this proposed change, all applicants for licensure by endorsement would have to have a CACREP approved education unless they can show that worked in clinical practice for at least 24 of the 60 months immediately preceding application. Since fewer than 20% of colleges and universities with counseling programs nationwide[25] appear to have CACREP approval, this proposed change has the potential to shrink the pool of professional counselors licensed in other states who would be eligible for licensure in Virginia.

As noted above in the section on current licensure requirements, under existing regulation, there are multiple requirements to ensure the competency of applicants for licensure by examination. The Board currently requires that individuals licensed as professional counselors receive an education adequate to prepare them for future practice by 1) specifying the coursework that they must complete at an accredited college or university, 2) requiring a fairly lengthy residency and 3) requiring passage of a licensure exam that measures the counseling knowledge of applicants. These requirements are located in 18VAC115-20, sections 49, 51, 52 and 70, are not proposed for repeal as part of this action, and will remain in force. If a candidate can pass the examination for licensure, has completed the Board required education without having earned a degree from a CACREP/affiliate-accredited program, and successfully complete a 3,400-hour supervised residency, then the candidate has presumably demonstrated significant knowledge and experience. Given this, the additional value of requiring CACREP/affiliate-specific accreditation appears to be limited. Further, there is no known evidence in Virginia

that individuals who pass the examination, successfully complete the residency, and graduate from a program that meets all of the specifications already detailed in this regulation, but do not graduate from a CACREP/affiliate accredited program, are any less effective as professional counselors than graduates of CACREP/affiliate accredited programs.

A Board source provided an empirical study[26] that was originally completed as a thesis and later published in a journal which found approximately 82% of 453 ethics violations over an unspecified period of time in 31 states were committed by graduates of non-CACREP accredited schools. Given that the median time in practice of those committing ethics violations was about 7.5 years and the timeframe of data is not known, DPB cannot ascertain the percent of the population of counselors as a whole that had CACREP education over the duration of the study data. As a consequence, DPB has no basis to draw conclusions about whether the 82% of ethics violations reported in this study is high, low or on par when measured against the population of counselors as a whole. In any case, the Board mandates that education in ethics and Board staff has not reported that licensees in Virginia who graduated from non-CACREP accredited programs have a higher rate of ethics violations than those who graduated from CACREP accredited programs.

Another study[27] completed in 2005 and provided by the same Board source to DPB examined National Counseling Exam (NCE) scores from a five year period and concluded that gaining an education at a CACREP accredited program was correlated with higher scores on this exam. This may indicate that CACREP education provided a benefit to NCE test takers during the time period of the study (likely 1999 to 2004). Given the rapid development in counseling licensure since that time period, this benefit may not be the same or exist at all in Virginia today. Virginia has developed an academic study sequence that prepares applicants for the more rigorous[28] NCMHCE, and DPB has no recent or Virginia specific data to indicate that non-CACREP educated applicants and CACREP educated applicants have differential pass rates or scores on nationalized tests.

Given the significant costs associated with requiring CACREP accreditation, the uneven and uncertain benefits of doing so, and the lack of empirical evidence that this proposal is necessary to protect the health and safety of Virginians, the costs of this proposed change appear to outweigh its benefits.

Businesses and Entities Affected. The proposed amendment will affect all applicants for counseling licensure as well as any colleges or universities inside or outside of Virginia that currently do not have CACREP approval and who graduate students who may choose to seek initial or subsequent counseling licensure in Virginia.[29] The proposed amendment will also affect programs that already have CACREP approval as it will constrain their choice to drop CACREP approval in the future as costs increase.

Localities Particularly Affected. The proposed amendment will likely not particularly affect any locality.

Projected Impact on Employment. Seven years after its effective date, the proposed amendment will likely limit the number of individuals qualified to seek licensure by examination as professional counselors in Virginia to some unknown extent because it will likely make it more expensive to get the required education. Additionally, there will likely be fewer individuals who would be qualified to seek licensure by endorsement as they would need to have CACREP approved education or meet active practice requirements. This proposed change will also adversely affect the employment opportunities of doctoral level teaching professionals who have counseling activities within their scope of practice but who are not trained or licensed as professional counselors. This group would include psychologists, psychiatrists, and social workers.

Effects on the Use and Value of Private Property. The proposed amendment is unlikely to significantly affect the use and value of private property.

Real Estate Development Costs. The proposed amendment does not affect real estate development costs.

Small Businesses:

Definition. Pursuant to § 2.2-4007.04 of the Code of Virginia, small business is defined as "a business entity, including its affiliates, that (i) is independently owned and operated and (ii) employs fewer than 500 full-time employees or has gross annual sales of less than $6 million."

Costs and Other Effects. The proposed amendment would likely reduce the number of small business licensed professional counselors practicing in Virginia in the future below the number that would qualify to practice under current regulation.

Alternative Method that Minimizes Adverse Impact. Given that there are no health or safety problems identified by the Board that might be addressed by requiring CACREP approved education, one alternative that would minimize adverse impact would be maintain the status quo and continue to evaluate educational programs as it is done now.

Additionally, pursuing reciprocity agreements based on similar residency and testing requirements with counseling boards in other political jurisdictions might address any issues of portability without requiring universities, and thus applicants for licensure, to undergo the expense of CACREP accreditation.

Adverse Impacts:

Businesses. The proposed amendment would likely reduce the number of licensed professional counselors practicing independently in Virginia in the future below the number that would qualify to practice under current regulation.

Localities. The proposed amendment will not adversely affect localities.

Other Entities. The proposed amendment would require George Mason University to obtain CACREP approval for their counseling program within seven years if their counseling students are to remain eligible for licensure. It appears that George Mason will incur significant initial cost and ongoing costs to obtain this accreditation. The proposed amendment will likely also increase future costs at CACREP approved programs and will constrain those programs from dropping CACREP approval if they judge the costs of having that approval are no longer outweighed by the perceived benefits.

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[1]CACREP was established in 1981 and has been recognized by the Council for Higher Education Accreditation (CHEA). CHEA is an association of 3,000 degree-granting colleges and universities and recognizes 60 institutional and programmatic accrediting organizations. One of the goals of CACREP is to establish a uniform set of educational requirements across the United States.

[2]The Council on Rehabilitation Education (CORE) is a specialized accreditation organization that is recognized by the Council for Higher Education Accreditation (CHEA) and a member of the Association of Specialized and Professional Accreditors (ASPA). CORE accredits graduate programs which provide academic preparation for a variety of professional rehabilitation counseling positions. CORE also accredits undergraduate programs in Rehabilitation and Disability Studies.

[3]Individuals who are initially licensed in another political jurisdiction and subsequently move to Virginia are eligible to obtain licensure here without redoing their education so long as they meet certain criteria.

[4]To view each section of the current regulation, see http://law.lis.virginia.gov/admincode/title18/agency115/chapter20/.

[5]Counseling program coursework must include 60 semester hours or 90 quarter hours of graduate study in 12 core areas. The 12 core areas are: 1) professional counseling identity, function, and ethics, 2) theories of counseling and psychotherapy, 3) counseling and psychotherapy techniques, 4) human growth and development, 5) group counseling and psychotherapy theories and techniques, 6) career counseling and development theories and techniques, 7) appraisal, evaluation, and diagnostic procedures, 8) abnormal behavior and psychopathology, 9) multicultural counseling theories and techniques, 10) research, 11) diagnosis and treatment of addictive disorders, and 12) marriage and family systems theory. Programs that qualify graduates for licensure by examination must also require a supervised internship of at least 600 hours with 240 of those hours being face-to-face client contact.

[6]Applicants for licensure by examination must have completed a 3,400-hour supervised residency in the role of a professional counselor working with various populations, clinical problems, and theoretical approaches in six specified areas. The six specified areas are: 1) assessment and diagnosis using psychotherapy techniques, 2) appraisal, evaluation, and diagnostic procedures, 3) treatment planning and implementation, 4) case management and recordkeeping, 5) professional counselor identity and function, and 6) professional ethics and standards of practice.

[7]The petition for rulemaking and the public comments received in response to this petition may be viewed here: http://townhall.virginia.gov/L/ViewPetition.cfm?petitionId=210.

[8]The Board of Medicine, for instance, allows individuals to meet licensure in medicine requirements with educational programs approved by the American Medical Association's Liaison Committee on Medical Education, the Committee for the Accreditation of Canadian Medical Schools, or any other group approved by the Board of Medicine.

[9]The Board of Counseling already requires that applicants for licensure pass the more stringent NCMHC.

[10]Virginia's supervised residency requirements require at least this.

[11]Public Law 114-92 which was signed into law on November 25, 2015.

[12]Aspects of the Use of Licensed Professional Counselors in the Military Health System. Report to Congress. June 2006.

[13]A search of the CACREP website indicates that 32 master's programs are currently accredited in Virginia. Of those 32, 13 were either mental health counseling programs or clinical mental health counseling programs.

[14]Normally, an assumption could be made that programs that have sought private accreditation before passage of a law/regulation that requires it, do so voluntarily. In this case, it is reported that Longwood and Hampton are seeking/sought CACREP accreditation in anticipation of this regulatory action and/or in response to the recommendation of other groups like the American Counseling Association.

[15]For instance, these schools would not be able to drop CACREP accreditation if the DoD changes rules for TRICARE to make them less proscriptive.

[16]Initial costs include $1,000 fee for a representative of the program to complete CACREP's day long self-study workshop plus the cost of that representatives time, $6,000 to hire a consultant, $50 to purchase a CACREP accreditation manual, the $2,500 CACREP initial application fee, an estimated $10,000 in site visit fees, $20,000 to buy out the time of a counseling faculty member to oversee the 12 to 18 month approval process and $30,000 to hire a half-time administrative assistant.

[17]Patro, Fernando F. and Trotman, Frances K. "Investing in One's Future: Are the Costs of Pursuing Accreditation and Meeting Standards Worth it to an Institution of Higher Learning." Australian Universities Quality Forum 2007.

[18]Behan, Stephanie and Miller, Kristelle. "CACREP Accreditation: A Case Study." Journal of Humanistic Education and Development. December 1998. Vol 37.

[19]As an R1(intense research) institute, the full-time, core faculty of the counseling and development programs are expected to teach two classes each semester (2:2 schedule). For comparison's sake, a pure teaching institute would likely have an expectation that their core faculty would teach a 4:4 load.

[20]CACREP's 2016 standards require a ratio of full-time equivalent (FTE) students to FTE staff of not greater than 12:1, a student to supervisory faculty ratio of not greater than 6:1 for students completing a supervised practicum or internship, and a ratio of not greater that 6:1 for student supervisors to faculty who supervises them.

[21]Leaving aside doctoral classes, six core faculty can teach 72 credit hours (4 classes*3 credit hours*6 professors) per year to 12 students which is the ratio required by CACREP (if they teach 100% of the classes) or 36 credit hours to 24 students (again 100% of the classes) or can teach 48 students per year (with 50% core faculty/50% non-core faculty teaching). Applying an adjustment to the number of students in this math to account for the fact that 36 is 20% more that 30 (the number of credit hours that must be taken per year to get through the graduate program in two years) it looks like more than six core faculty would be needed if a program has more than approximately 58 FTE students per year (48*1.20=57.6). George Mason has a doctoral program and would have doctoral level teaching expectations for their core faculty which would lower the number of FTE master's level students that would trigger the need for additional faculty.

[22]George Mason University reports that these costs would have to be covered by increased student fees. However, as George Mason University is a publicly funded college, this proposed regulatory change also has the potential to increase fiscal costs for the Commonwealth and for the taxpayers who fund the state budget.

[23]This quote is from the frequently asked questions on CACREP's website at http://www.cacrep.org/for-programs/program-faqs-2/#FAQ13.

[24]Several other professions, including psychologists, psychiatrists and licensed social workers, have overlapping scopes of practice with counseling.

[25]Information obtained from https://www.petersons.com/search/schools?searchtype=26&page=1&result=false&searchterm=counseling. DPB arrived at this number by taking the first 100 entries on the list, removing any duplicate entries (to account for schools

that might have multiple programs listed) and any school whose programs would obviously not qualify for licensure and extrapolating that number to the larger list. When schools with counseling psychology were included, 96 of the first 100 entries would appear to be discrete schools with qualifying programs. Extrapolating using simple ratios yielded $\frac{100}{1665} = \frac{96}{x}$ $or\ x = \frac{96*1665}{100} = 1598.4$. Dividing the number of schools with CACREP programs by the total number of schools nationwide should yield the percentage of schools nationwide that are accredited by CACREP. 276/1598.4 = 17.2 % of schools that have both counseling programs and CACREP accreditation. When counseling psychology programs were removed, 86 or the first 100 entries would appear to be discrete schools with qualifying counseling programs. Extrapolating using simple ratios yielded $\frac{100}{1665} = \frac{86}{x}$ $or\ x = \frac{86*1665}{100} = 1431.$ Excluding counseling psychology schools leaves 276/1431 or 19.3% of schools that had both programs that appear to qualify individuals for licensure and CACREP accreditation. Using another sampling method by taking the last two entries on each page and again removing all duplicates and obviously irrelevant programs, DPB estimated that 18.67% of universities nationwide have CACREP accreditation. The Peterson site, although it has its issues (including ease of use and commercialism) is the best information that DPB can find to estimate the total number of schools with counseling programs in the United States.

[26]Even, Trigg and Robinson, Chester. "The Impact of CACREP: A Multiway Frequency Analysis of Ethics Violations and Sanctions." Journal of Counseling and Development. January 2013. Vol 91.

[27]Adams, Susan. "Does CACREP Accreditation Make a Difference? A Look at NCE Results and Answers." Journal of Professional Counseling: Practice, Theory and Research. Vol. 33. Num. 2. 2005.

[28]The Institutes of Medicine concluded that the NCMHCE was more rigorous in the study completed for the Department of Defense that lead to changes in TRICARE regulations.

[29]As the CACREP requirement would not be enforced until seven years after the effected date of the regulation, the adverse impacts of this regulation will be delayed.

Agency's Response to Economic Impact Analysis:

The Board of Counseling does not concur with the analysis of the Department of Planning and Budget on proposed amended regulations for 18VAC115-20, Regulations Governing the Practice of Professional Counseling. The board believes the economic impact analysis is incomplete or inaccurate in the following ways:

1. It states that many other health professions use "private credentialing groups to evaluate and approve educational programs." In fact, all of the 13 health regulatory boards require national accreditation for professional programs as the evidence of a quality education - with the exception of the Board of Counseling and the Board of Nursing. The Board of Nursing currently employs 11 on-site reviewers located throughout Virginia, in addition to staff at the Board of Nursing, to evaluate the quality of nursing education programs. At a recent meeting in May of 2016, the Board of Nursing voted to initiate rulemaking to require national accreditation of educational programs for registered nursing licensure. Currently, accreditation of a nursing program is voluntary, so it is interesting to note that the registered nursing program at George Mason University is nationally accredited. It is evident that universities, licensing boards, and employers are recognizing the essential role played by accrediting bodies in assuring professional competency.

2. The Department of Planning and Budget has taken issue with the fact that the Board of Counseling did not convene a Regulatory Advisory Panel. Such a panel is useful when the regulatory language is complex and requires expertise from a variety of sources. In this action, the regulation was very straightforward and based on a great deal of input from affected entities. The issue of accreditation has been discussed since 2010 at educational summits convened by the board for exchange among board members and counseling educators. At the summits convened in 2010 and 2012, representatives from all counseling programs were invited; 10 different institutions were represented in 2010, and 12 participated in 2012. George Mason University did not participate in the first two summits. In September of 2014, the board voted to initiate rulemaking to require accreditation of education programs and convened an educational summit in November of 2014 to engage the programs in a discussion of that proposal. Fifty educators were invited, and four faculty members from George Mason did attend and did participate. During the public comment period of the Notice of Intended Regulatory Action, comments were received from faculty members at George Mason. The board was well aware of its position and arguments against a requirement for accreditation – both from the written comments and the verbal discussion at the 2014 summit. Neither this board nor any board at the Department of Health Professions will accept comment offered outside of an official comment period on a regulatory stage. To do so would require an extension and notice to all parties that the comment period has been reopened. Therefore, comment on this regulatory proposal was not accepted at subsequent meetings after the close of the comment period.

3. The economic impact analysis has focused on the cost for accreditation but has failed to take note of the opportunity cost for graduates of nonaccredited programs. Increasingly, other states are requiring applicants for licensure to be graduates of CACREP-accredited programs; Ohio, Kentucky, and North Carolina have recently passed such laws. Portability will become an issue for non-CACREP graduates who may want to seek employment in other states. Employment in the federal system is also limited for graduates of non-accredited programs. Following a recommendation from the Institute of Medicine, TRICARE, the Army Substance Abuse program, and the Veterans Administration have adopted the standard of requiring a degree from a CACREP-accredited program. In a state that relishes the presence of the military and military families, it would seem that all educational programs would want to equip their graduates to serve that population and have those employment opportunities.

4. Accreditation by a professional accrediting body is the only reliable measure of educational quality. Licensing an applicant based on a review of a transcript conveys only the number of hours and titles of coursework completed; the board has neither the resources nor the expertise to review the

content of coursework, the credentials of the faculty, or the overall quality of the educational program. Accreditation is an arduous process because of the in-depth review required. In 2010, the Institute of Medicine (IOM) was requested by Congress to study the provision of mental health counseling services under TRICARE, which serves all of the uniformed services and their families – a population comprising more than nine million beneficiaries. The report noted that "the mental health care needs of this population are large and diverse, requiring a skilled group of professionals to diagnose and treat a variety of disorders." The IOM was asked to convene a committee to examine the credentials, preparation, and training of licensed mental health counselors to practice independently under the TRICARE program. The committee found that not all educational programs prepared graduates to practice independently, but that coursework required by programs accredited by CACREP did prepare them. Subsequently, the Department of Defense issued a final rule (beginning January 1, 2017) to certify only those providers who meet the quality standards recommended by the IOM and adopted by TRICARE, including "possession of a master's or higher-level degree from a Council for the Accreditation of Counseling and Related Educational Programs (CACREP) accredited mental health counseling program of education and training as well as having passed the national Clinical Mental health Counseling Examination."

5. Further evidence of the quality and significance of CACREP accreditation may be found in a decision by the National Board of Certified Counselors (NBCC), which recently announced that, beginning January 1, 2022, the NBCC credential would only be awarded to persons who graduated from CACREP-accredited programs. Thus, the body that awards national certification in counseling and related fields has recognized CACREP as the standard for measuring educational quality.

The board concludes that the economic impact analysis has presented a single perspective on the issue of accreditation and has neglected to present an analysis of the positive impact on employment and licensure and on the quality of counseling services in the Commonwealth.

Summary:

In response to a petition for rulemaking, the board is proposing to add a requirement for all counseling programs leading to a license as a professional counselor to be clinically focused and accredited by the Council for Accreditation of Counseling and Related Educational Programs (CACREP) or an approved affiliate, such as the Council on Rehabilitation Education. This requirement is phased in, allowing seven years from the effective date for students to complete their education in a non-CACREP program and for programs to achieve accreditation standards.

18VAC115-20-49. Degree program requirements.

A. The applicant shall have completed a graduate degree from a program that prepares individuals to practice counseling, as defined in § 54.1-3500 of the Code of Virginia, which is offered by a college or university accredited by a regional accrediting agency and which meets the following criteria:

1. There must be a sequence of academic study with the expressed intent to prepare counselors as documented by the institution;

2. There must be an identifiable counselor training faculty and an identifiable body of students who complete that sequence of academic study; and

3. The academic unit must have clear authority and primary responsibility for the core and specialty areas.

B. Programs that are approved by CACREP or CORE are recognized as meeting the requirements of subsection A of this section.

C. After (insert date of seven years from the effective date of the regulation), only programs that are approved by CACREP or CORE are recognized as meeting the requirements of subsection A of this section.

VA.R. Doc. No. R14-36; Filed April 17, 2017, 7:59 a.m.

TITLE 22. SOCIAL SERVICES

DEPARTMENT FOR AGING AND REHABILITATIVE SERVICES

Emergency Regulation

Title of Regulation: **22VAC30-20. Provision of Vocational Rehabilitation Services (amending 22VAC30-20-90).**

Statutory Authority: § 51.5-131 of the Code of Virginia.

Effective Dates: April 17, 2017, through October 16, 2018.

Agency Contact: Vanessa S. Rakestraw, Ph.D., CRC, Policy Analyst, Department for Aging and Rehabilitative Services, 8004 Franklin Farms Drive, Richmond, VA 23229, telephone (804) 662-7612, FAX (804) 662-7663, TTY (800) 464-9950, or email vanessa.rakestraw@dars.virginia.gov.

Preamble:

Section 2.2-4011 A of the Code of Virginia states that regulations that an agency finds are necessitated by an emergency situation may be adopted by an agency upon consultation with the Attorney General, and the necessity for the action is at the sole discretion of the Governor.

In the event that the Department for Aging and Rehabilitative Services cannot provide the full range of vocational rehabilitation services to all eligible individuals who apply for these services because of insufficient resources, an order of selection may be implemented to

determine those persons to be provided services. Currently, the department uses the four priority categories set out in the regulation. The Rehabilitation Services Administration, the federal agency that regulates the state-federal vocational rehabilitation program, is requiring that the department reduce the number of priority categories based on a determination that the current priority categories II and III are not different enough to warrant two separate categories.

The amendment reduces the number of categories for order of selection to three by combining priority categories II and III.

22VAC30-20-90. Order of selection for services.

A. In the event that the full range of vocational rehabilitation services cannot be provided to all eligible individuals who apply for services because of insufficient resources, an order of selection system may be implemented by the commissioner following consultation with the State Rehabilitation Council. The order of selection shall determine those persons to be provided services. It shall be the policy of the department to encourage referrals and applications of all persons with disabilities and, to the extent resources permit, provide services to all eligible persons.

The following order of selection is implemented when services cannot be provided to all eligible persons:

1. Persons eligible and presently receiving services under an individualized plan for employment;

2. Persons referred and needing diagnostic services to determine eligibility; and

3. Persons determined to be eligible for services, but not presently receiving services under an individualized plan for employment, shall be served according to the following order of priorities:

a. Priority I. An individual with a most significant disability in accordance with the definition in 22VAC30-20-10;

b. Priority II. An individual with a significant disability that results in a serious functional ~~limitations~~ limitation in ~~two~~ at least one functional ~~capacities~~ capacity; and

c. Priority III. ~~An individual with a significant disability that results in a serious functional limitation in one functional capacity; and~~

~~d. Priority IV.~~ Other persons determined to be disabled, in order of eligibility determination.

B. An order of selection shall not be based on any other factors, including (i) any duration of residency requirement, provided the individual is present in the state; (ii) type of disability; (iii) age, gender, race, color, or national origin; (iv) source of referral; (v) type of expected employment outcome; (vi) the need for specific services or anticipated cost of services required by the individual; or (vii) the income level of an individual or an individual's family.

C. In administering the order of selection, the department shall (i) implement the order of selection on a statewide basis; (ii) notify all eligible individuals of the priority categories in the order of selection, their assignment to a particular category and their right to appeal their category assignment; (iii) continue to provide all needed services to any eligible individual who has begun to receive services under an individualized plan for employment prior to the effective date of the order of selection, irrespective of the severity of the individual's disability; and (iv) ensure that its funding arrangements for providing services under the state plan, including third-party arrangements and awards under the establishment authority, are consistent with the order of selection. If any funding arrangements are inconsistent with the order of selection, the department shall renegotiate these funding arrangements so that they are consistent with the order of selection.

D. Consultation with the State Rehabilitation Council shall include (i) the need to establish an order of selection, including any reevaluation of the need; (ii) priority categories of the particular order of selection; (iii) criteria for determining individuals with the most significant disabilities; and (iv) administration of the order of selection.

VA.R. Doc. No. R17-4951; Filed April 14, 2017, 3:41 p.m.

STATE BOARD OF SOCIAL SERVICES

Final Regulation

REGISTRAR'S NOTICE: The State Board of Social Services is claiming an exemption 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 or the appropriation act where no agency discretion is involved. The State Board of Social Services will receive, consider, and respond to petitions by any interested person at any time with respect to reconsideration or revision.

Title of Regulation: **22VAC40-41. Neighborhood Assistance Tax Credit Program (amending 22VAC40-41-30).**

Statutory Authority: §§ 58.1-439.20 and 63.2-217 of the Code of Virginia.

Effective Date: June 15, 2017.

Agency Contact: Wanda Stevenson, Neighborhood Assistance Program Technician, Department of Social Services, 801 East Main Street, Richmond, VA 23219, telephone (804) 726-7924, or email wanda.stevenson@dss.virginia.gov.

Summary:

The amendments modify provisions pertaining to allocation of Neighborhood Assistance tax credits to conform to Chapter 147 of the 2017 Acts of Assembly.

22VAC40-41-30. Allocation of tax credits.

A. The available tax credits will be allocated among all approved organizations as follows:

1. Any amounts legislatively set aside for special purposes will be allocated for these purposes.

2. ~~At~~ In any year in which the available amount of tax credits exceeds the previous year's available amount, at least 10% of the ~~available~~ excess amount ~~of tax credits each year~~ shall be allocated to approved organizations ~~not receiving~~ that did not receive any allocations in the preceding year~~; however, if~~. If the amount of ~~requested~~ tax credits ~~for approved organizations~~ requested by organizations not receiving allocations in the preceding year is less than 10% of the ~~available~~ excess amount ~~of tax credits~~, the unallocated portion of such 10% shall be allocated to other approved organizations.

3. Approved organizations that received a tax credit allocation within the last four years will be given an allocation based on the average amount of tax credits actually used in prior years. The allocation process may include a determination of the reasonableness of requests, caps, and percentage reductions in order to stay within the total available funding.

B. During the program year, approved organizations that have used at least 75% of their allocation may request additional allocations of tax credits within the limits described in this section. Requests will be evaluated on reasonableness, and tax credits will be reallocated on a first-come basis as they become available. An exception may be made for organizations that have received a written commitment for a donation of real estate.

C. Maximum allocation of tax credits.

1. An organization shall receive an allocation of tax credits as specified in § 58.1-439.20 C of the Code of Virginia.

2. For the process of determining the maximum allocation for an organization whose purpose is to support and benefit another approved organization, the combined allocation will not exceed the maximum cap set by § 58.1-439.20 of the Code of Virginia.

D. Organizations may release all or a portion of their unused tax credit allocation to be reallocated in accordance with subsection B of this section.

VA.R. Doc. No. R17-5053; Filed April 20, 2017, 11:04 a.m.

Proposed Regulation

Title of Regulation: **22VAC40-211. Resource, Foster and Adoptive Family Home Approval Standards (amending 22VAC40-211-10 through 22VAC40-211-100).**

Statutory Authority: §§ 63.2-217 and 63.2-319 Code of Virginia.

Public Hearing Information: No public hearings are scheduled.

Public Comment Deadline: July 14, 2017.

Agency Contact: Em Parente, Program Consultant, Department of Social Services, 801 East Main Street, Richmond, VA 23219, telephone (804) 726-7538, FAX (804) 726-7895, or email em.parente@dss.virginia.gov.

Basis: Sections 63.2-217 and 63.2-901.1 of the Code of Virginia provide general authority to the State Board of Social Services to develop regulations for foster and adoptive home approval standards and specific authority related to waivers for relative providers.

Purpose: Proposed amendments to the regulation will address changes in Virginia law and improve consistency with federal law. Other changes clarifying procedures and requirements will benefit foster and adoptive families, local departments of social services (LDSS) staff and other child welfare staff, and children in foster care by ensuring that foster children are placed in safe and appropriate homes. Requiring training for LDSS staff and other child welfare staff who complete mutual family assessments of prospective foster and adoptive family homes and provide annual in-service training for foster and adoptive parents will protect the health, safety, and welfare of Virginia's foster care children by improving the quality of the approval process and contributing to the ongoing development of skills and knowledge of the families caring for children placed in their homes. Certain changes are intended to ensure consistency between this regulation and 22VAC40-131 for foster homes approved by licensed child-placing agencies (LCPA); consistency in the approval process for both is a requirement to meet federal guidelines for accessing Title IV-E funding.

Substance: Substantive proposed changes include adding the definition of "kinship foster parent"; changing language to restrict waivers to relative/kinship foster homes; requiring that LDSS staff and other child welfare staff who complete mutual family assessments, previously referred to as home studies, receive training to do so; requiring foster and adoptive parents to report substantial changes to their home or circumstances; requiring that LDSS provide mandated reporter training to foster and adoptive parents; and requiring that approved foster and adoptive parents complete in-service training annually.

Issues: Training for LDSS staff, other child welfare staff completing mutual family assessments, and foster and adoptive parents is currently provided by the Consortium for Resource, Adoptive and Foster Family Training (CRAFFT) regional coordinators. The CRAFFT program is funded by state and federal moneys and administered by Virginia Department of Social Services. Therefore, the provision of training will not pose a disadvantage to the LDSS. Because CRAFFT coordinators are regionally based, they are able to offer LDSS staff and other child welfare staff trainings both at the regional offices and also to travel to larger agencies or clusters of agencies to provide training. The training to be required is currently recommended. Before the regulation

becomes effective, many LDSS staff will have already completed this training.

LDSS are currently required to make in-service training available to foster and adoptive families and 10 hours of in-service training annually is recommended. CRAFFT coordinators provide in-service training on a regional basis for families to assist those LDSS that do not have their own trainers and to ensure that local training is available to families throughout the state. It is anticipated that CRAFFT in-service events will be better attended after the regulation goes into effect, but it will not be necessary to significantly expand either the CRAFFT program or the provision of foster and adoptive parent in-service trainings offered by the LDSS. The requirement that foster and adoptive families complete in-service training annually will require that LDSS staff track training hours and monitor foster and adoptive parent compliance, which may pose somewhat of a disadvantage to those LDSS not already doing so.

The regulatory action poses no disadvantage to the public or the Commonwealth; proposed changes will benefit foster and adoptive families, LDSS staff and other child welfare staff, and children in foster care by ensuring that foster children are placed in safe and appropriate homes.

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 amend its regulation that governs approval of resource, foster and adoptive homes to: update some definitions and all references to home studies in this regulation, as well as to remove references to respite home providers in places where standards only apply to resource, foster and adoptive homes. The Board also proposes to clarify that required annual in-service training must be completed as a condition of provider re-approval and to change the requirement for a medical physical examination so that it is required within 13 months of provider approval.

Result of Analysis. Benefits likely outweigh costs for all proposed regulatory changes.

Estimated Economic Impact. Current regulation contains many references to home studies that must be done in order to assess the suitability of resource, foster care or adoptive homes providers. Board staff reports that this language is obsolete because the mandated assessment tool since 2013 for providers has been the mutual family assessment (MFA).[1] Board staff also reports that, even though past home study formats are now obsolete, some local Departments of Social Services (LDSS) may have been using older forms that do not track with MFA requirements. To encourage consistent assessments across all localities and to ensure that LDSSs are clear about what the assessment standards are, the Board now proposes to remove all references to "home studies" in this regulation and replace them with references to "mutual family assessments" (or "MFA"). These changes will benefit all involved parties as it will make the process of provider approval more consistent and predictable. Board staff reports that all forms for the MFA are available on the State Department of Social Services website at no cost; so no LDSSs are likely to incur costs on account of these changes.

Current regulation lumps references to respite care providers in with language that speaks to approval of resource, foster and adoptive home provider approval. Because individuals who are only applying to provide respite care require training (and assessment) on fewer core competencies[2] than do foster and adoptive home providers,[3] the Board now proposes to remove references to respite care providers from regulatory language that sets rules for foster and adoptive home provider approval. These changes will benefit all interested parties as they remove language that might confuse readers as to what is expected of respite care providers. No entities are likely to incur costs on account of these changes.

Current regulation requires annual in-service training for all approved foster and adoptive providers. The Board proposes to specify that providers must complete their required in-service training as a condition of re-approval. Board staff reports that most, if not all LDSSs track in-service completion to ensure that foster and adoptive home providers remain in compliance. To the extent that some LDSSs may not be doing that already, they may incur some small time costs for documenting and tracking in-service training.

Current regulation requires that applicants have a complete physical examination within the 12 months prior to application approval. Because many if not most insurance companies limit coverage of physicals to one in any 12-month period, the Board proposes to change this requirement so that a physical is required in the 13 months prior to approval. This change will benefit applicant providers in that it will eliminate any possibility that they would have to pay out of pocket for a physical that would normally be covered by insurance if it were performed more than 12 months after their last physical.

Businesses and Entities Affected. These proposed regulatory changes will affect all respite care, resource, foster and adoptive homes that require state approval as well as the 120 LDSSs that approve them.

Localities Particularly Affected. LDSSs will be particularly affected only to the extent that they do not already document and track required in-service training for providers. Since in-service training is already required, there are likely few to no LDSSs that do not already complete such documentation.

Projected Impact on Employment. These proposed regulatory changes are unlikely to affect employment in the Commonwealth.

Effects on the Use and Value of Private Property. These proposed regulatory changes are unlikely to affect the use or value of private property in the Commonwealth.

Real Estate Development Costs. These proposed regulatory changes are unlikely to affect real estate development costs in the Commonwealth.

Small Businesses:

Definition. Pursuant to § 2.2-4007.04 of the Code of Virginia, small business is defined as "a business entity, including its affiliates, that (i) is independently owned and operated and (ii) employs fewer than 500 full-time employees or has gross annual sales of less than $6 million."

Costs and Other Effects. No small businesses are likely to be affected by these proposed regulatory changes.

Alternative Method that Minimizes Adverse Impact. No small businesses are likely to be affected by these proposed regulatory changes.

Adverse Impacts:

Businesses. No businesses are likely to be adversely affected by these proposed regulatory changes.

Localities. Localities in the Commonwealth are unlikely to see any adverse impacts on account of these proposed regulatory changes.

Other Entities. No other entities are likely to be adversely affected by these proposed changes.

[1]MFAs became the statewide assessment tool in 2013 but LDSSs in some parts of the state have been using this format longer than that as part of a pilot program.

[2]The core competencies for respite care providers are: 1. Factors that contribute to neglect, emotional maltreatment, physical abuse, and sexual abuse, and the effects thereof; 2. Conditions and experiences that may cause developmental delays and affect attachment; 3. Reunification as the primary child welfare goal, the process and experience of reunification; 4. Importance of visits and other contacts in strengthening relationships between the child and his birth family, including his siblings; 5. The professional team's role in supporting the transition to permanency and preventing unplanned placement disruptions; 6. Impact of multiple placements on a child's development; 7. Cultural, spiritual, social, and economic similarities and differences between a child's primary family and foster or adoptive family; 8. Preparing a child for family visits and helping him manage his feelings in response to family contacts; 9. Developmentally appropriate, effective, and nonphysical disciplinary techniques; 10. Maintaining a home and community environment that promotes safety and well-being; 11. Promoting a child's sense of identity, history, culture, and values; 12. Respecting a child's connection to his birth family, previous foster families, and adoptive families; and 13. Being nonjudgmental in caring for the child, working with his family, and collaborating with other members of the team. Respite care workers will be trained, and assessed for provider approval, on these competencies.

[3]Foster and adoptive home providers are trained and assessed on a longer list of core competencies that include: 1. Factors that contribute to neglect, emotional maltreatment, physical abuse, and sexual abuse, and the effects thereof; 2. Conditions and experiences that may cause developmental delays and affect attachment; 3. Stages of normal human growth and development; 4. Concept of permanence for children and selection of the permanency goal; 5. Reunification as the primary child welfare goal, the process and experience of reunification; 6. Importance of visits and other contacts in strengthening relationships between the child and his birth family, including his siblings; 7. Legal and social processes and implications of adoption; 8. Support of older youth's transition to independent living; 9. The professional team's role in supporting the transition to permanency and preventing unplanned placement disruptions; 10. Relationship between child welfare laws, the local department's mandates, and how the local department carries out its mandates; 11. Purpose of service planning; 12. Impact of multiple placements on a child's development; 13. Types of and response to loss, and the factors that influence the experience of separation, loss, and placement; 14. Cultural, spiritual, social, and economic similarities and differences between a child's primary family and foster or adoptive family; 15. Preparing a child for family visits and helping him manage his feelings in response to family contacts; 16. Developmentally appropriate, effective and nonphysical disciplinary techniques; 17. Promoting a child's sense of identity, history, culture, and values; 18. Respecting a child's connection to his birth family, previous foster families and/or adoptive families; 19. Being nonjudgmental in caring for the child, working with his family, and collaborating with other members of the team; 20. Roles, rights, and responsibilities of foster parents and adoptive parents; 21. Maintaining a home and community environment that promotes safety and well-being and 22. Mandated child abuse and neglect reporter laws and responsibilities.

Agency's Response to Economic Impact Analysis: The Department of Social Services reviewed the economic impact analysis prepared by the Department of Planning and Budget and concurs.

Summary:

The proposed amendments require (i) foster and adoptive parents to report substantial changes to their homes or circumstances; (ii) local departments of social services (LDSS) to provide mandated reporter training to foster and adoptive parents; (iii) approved foster and adoptive parents to complete in-service training annually; and (iv) training for LDSS staff and other child welfare staff who complete mutual family assessments of prospective foster and adoptive family homes. Other proposed amendments include clarifying that waivers are restricted to relative or kinship foster homes, updating procedures for maintaining foster and adoptive provider approval status, and clarifying or updating terms and definitions.

CHAPTER 211
~~RESOURCE,~~ FOSTER AND ADOPTIVE ~~FAMILY~~ HOME APPROVAL STANDARDS FOR LOCAL DEPARTMENTS OF SOCIAL SERVICES

22VAC40-211-10. Definitions.

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

"Adoptive parent" means any provider selected and approved by a parent or a ~~child placing agency~~ local department for the placement of a child with the intent of adoption.

"Adult" means any person 18 years of age or over.

"Applicant" means an individual or couple applying to be approved as a ~~resource,~~ foster ~~and/or~~ or adoptive home provider or to provide respite services.

"Background checks" means a sworn statement or affirmation disclosing whether the individual has a criminal conviction, is the subject of any pending charges within or outside the Commonwealth of Virginia, and is the subject of a founded complaint of abuse or neglect within or outside the Commonwealth; criminal history record information~~,~~; child abuse and neglect central registry check~~,~~; and any other

requirement as set forth in § 63.2-901.1 of the Code of Virginia.

"Caretaker" means any individual having the responsibility of providing care for a child and includes the following: (i) parent or other person legally responsible for the child's care; (ii) ~~any other person who has assumed caretaking responsibility by virtue of an agreement with the legally responsible person~~ an adult who by law, social custom, express or implied acquiescence, collective consensus, agreement, or any other legally recognizable basis has an obligation to look after the well-being of a child left in his care; and (iii) ~~person~~ persons responsible by virtue of their ~~position~~ positions of conferred authority~~; or (iv) adult person residing in the home with the child~~.

"Central registry" means a subset of the child abuse and neglect information system and is the name index with identifying information on an individual named as an abuser ~~and/or~~ or neglector in founded child abuse ~~and/or~~ or neglect complaints or reports not currently under administrative appeal, maintained by the department.

"Child" means any natural person under 18 years of age.

"Child-placing agency" means any person who places children in foster ~~homes,~~ or adoptive homes or independent living arrangements pursuant to § 63.2-1819 of the Code of Virginia or a local board of social services that places children in foster homes or adoptive homes pursuant to § 63.2-900, 63.2-903 or 63.2-1221 of the Code of Virginia. Officers, employees, or agents of the Commonwealth, or any locality acting within the scope of their authority as such, who serve as or maintain a child-placing agency, shall not be required to be licensed.

"Child abuse and neglect information system" means the computer system that collects and maintains information regarding incidents of child abuse and neglect involving parents or other caretakers. The computer system is composed of three parts: the statistical information system with nonidentifying information, the central registry of founded complaints not on appeal, and a database that can be accessed only by the department and local departments that contains all nonpurged child protective services reports. This system is the official state automated system.

"Commissioner" means the commissioner of the department, his designee or authorized representative.

"Corporal punishment" means punishment administered through the intentional infliction of pain or discomfort to the body through actions such as, but not limited to, (i) striking, or hitting with any part of the body or with an implement; (ii) pinching, pulling, or shaking; or (iii) any similar action that normally inflicts pain or discomfort.

"Department" means the State Department of Social Services.

~~"Dual approval process"~~ "Dually approved" means ~~a process that includes a home study, mutual selection, interviews, training and background checks to be completed on all~~ applicants have met the required standards to be ~~considered for approval~~ approved as a ~~resource,~~ foster~~, or~~ and adoptive family home provider.

"Foster care placement" means placement of a child through (i) an agreement between the parents or guardians and the local board of social services where the legal custody remains with the parents or guardians or (ii) an entrustment or commitment of the child to the local board of social services or licensed child-placing agency.

"Foster parent" means an approved provider who gives 24-hour substitute family care, room and board, and services for children or youth committed or entrusted to a child-placing agency.

~~"Fully approved" means a decision by the local department that the provider has met all requirements to be approved as a resource, foster, adoptive, or respite home provider.~~

"In-service training" means the ongoing instruction received by providers after they complete their preservice training.

"Interstate Compact on the Placement of Children" means a uniform law that has been enacted by all 50 states, the District of Columbia, and the U.S. Virgin Islands that establishes orderly procedures for the interstate placement of children and sets responsibility for those involved in placing those children.

"Kinship foster parent" means an approved relative provider who gives 24-hour substitute family care, room and board, and services for children or youth committed or entrusted to a child-placing agency.

"Local department" means the local department of social services of any county or city in ~~this~~ the Commonwealth.

"Parent" means the birth or adoptive parent of a child.

"Preservice training" means the instruction received by providers during the initial approval process.

"Provider" means ~~a resource,~~ an approved foster, adoptive, or ~~respite family~~ kinship foster parent, or an individual approved to provide respite services. Individuals who wish to provide only respite services must meet all standards in this chapter unless there is a noted exception for respite providers.

~~"Resource parent" means an approved provider who is committed both to support reunification and also to be prepared to adopt the child if the child and family do not reunify.~~

"Respite care" means the provision of the service of temporary care for children on an emergency or planned basis for the purposes of providing placement stability, supporting the achievement of timely permanency, and promoting connections to relatives. Respite care services shall not exceed 14 consecutive days.

~~"Respite parent" means an approved provider who gives temporary care to children on an emergency or planned basis.~~

22VAC40-211-20. Approval of provider homes.

A. When applicants are approved in accordance with ~~these~~ the standards of this chapter, they are approved as ~~foster families, adoptive families, resource families, or respite families~~ foster or adoptive providers. The approved provider shall~~, however,~~ be allowed to choose to provide only foster ~~care,~~ or adoptive care~~, or respite care should they not wish to serve as a resource family~~.

B. If the relative provider cannot meet the standards described in ~~these sections~~ this chapter, the local department may, upon its discretion, request a ~~variance~~ waiver on certain standards in accordance with 22VAC40-211-90. If the ~~variance~~ waiver is not allowed, the local department shall not approve the home for the placement of children.

C. ~~These~~ The standards of this chapter apply to adoptive home providers until the final order of adoption is issued for a specific child. The standards continue to apply after the final order of adoption if the provider wishes to continue as an approved foster care provider.

D. ~~Respite care families shall not serve as foster, adoptive, or resource families without completion of all requirements to be fully approved as foster, adoptive, or resource families~~.

~~E. Emergency approval of a provider may be granted in accordance with guidance developed by the department~~ Local departments may grant emergency approval of a provider.

1. Emergency approvals shall include:

a. ~~Background~~ Completed background checks; and

b. A home visit by the local department prior to or on the day of the placement.

2. Emergency approvals shall not exceed 60 days.

3. Emergency approval of a provider may be granted when the placement:

a. Is with a relative;

b. Is with an adult known to the family; or

c. Will facilitate the child remaining in the community.

~~F.~~ E. All local department-approved ~~resource, foster, adoptive, and respite~~ providers shall:

1. Be at least 18 years of age;

2. Agree not to use corporal punishment with the child in their care or allow others to do so and shall sign an agreement to that effect; and

3. Sign a ~~statement~~ confidentiality agreement indicating ~~their understanding of the confidentiality of information related to the child in their care~~ that the individual completing the mutual family assessment for the local department explained the confidential nature of the information related to the child in his care and of the requirement to maintain that confidentiality.

~~G.~~ F. If the approval process results in the local department's denial of the application, the local department shall notify the applicant in writing of its decision. A copy of the letter shall be filed in the applicant's record.

22VAC40-211-30. Background checks, ~~and~~ health standards, and driving record.

A. All background checks must be in accordance with applicable federal and state laws and regulations. Convictions of offenses as set out in § 63.2-1719 of the Code of Virginia shall preclude approval of an application to become a provider.

B. Documentation of the results of the background check shall be maintained in the applicant's record. Background check information shall not be disseminated to any other party~~,~~ nor shall it be archived except in the local department's provider file.

C. The ~~provider~~ applicant and all other household members who come in contact with children shall submit to tuberculosis assessment, screening, or tests in compliance with Virginia Department of Health requirements. The applicant and other caretakers residing in the home shall submit the results of a physical examination administered within the ~~12-month~~ 13-month period prior to approval, from a licensed health care professional that comments on each applicant's or caretaker's mental or physical condition relative to taking care of a child.

D. The local department shall obtain a Department of Motor Vehicle driver record check for ~~any provider~~ all applicants or other adults in the home who are expected to transport children and shall consider the results of the driver record check in the approval process.

1. If an applicant will transport children, the applicant shall have a valid driver's license and automobile liability insurance.

2. The vehicle used to transport the child shall have a valid registration and inspection sticker.

22VAC40-211-40. ~~Home study~~ Mutual family assessment requirements.

A. An applicant ~~to become a provider~~ shall complete and submit an application in accordance with department requirements and on department-approved forms or other forms that address all of the department's requirements.

B. Upon submission of a completed provider application, the local department is responsible for ensuring the initiation of the approval process. If at any point in the approval process the local department determines the home may not be approved, the application may be denied, and the process ended.

C. Local departments shall conduct a minimum of three face-to-face interviews on three separate days with each applicant, at least one interview shall be in the applicant's home. If there are two individuals listed as applicants, at least one interview must be with both individuals. At least one interview shall be with all individuals who reside in the home.

D. The local department shall obtain at least three references from persons who have knowledge of each applicant's character and applicable experience with children and caretaking of others. At least one reference per ~~person~~ applicant shall be from a nonrelative.

E. Local departments shall ask if ~~a prospective resource, foster, adoptive, or respite provider~~ an applicant previously applied to, or was approved by, another local department or licensed child-placing agency. The local department shall have the applicant sign a request to release information from the other agency in order to obtain information about previous applications and performance and shall use that information in considering approval of the applicant.

F. As part of the approval process, the local department shall conduct a ~~home study~~ mutual family assessment (MFA). The ~~home study~~ MFA shall address all elements required by this standard and be documented by a combination of narrative and other data collection formats, and shall be signed and dated by the individual completing the ~~home study~~ MFA and the director of the local department or his designee. The information contained in the ~~home study~~ MFA shall include:

1. Demographic information including:

a. Age of applicant;

b. Marital status and history including verifications; and

c. Family composition and history.

2. Financial information (not required for applicants to be only respite providers) including:

a. Employment information on applicant;

b. Assets and resources of applicant; and

c. Debts and obligations of applicant.

3. List of individuals involved in completing the ~~home study~~ MFA process and their roles.

4. Narrative documentation shall include information from the interviews, references, observations and other available information~~,~~ and shall be used to assess and document that the applicant:

a. Is knowledgeable about the necessary care for children and physically and mentally capable of providing the necessary care for children;

b. Is able to articulate a reasonable process for managing emergencies and ensuring the adequate care, safety, and protection of children;

c. Expresses attitudes that demonstrate the capacity to love and nurture a child born to someone else;

d. Expresses appropriate motivation to foster ~~or~~ and adopt;

e. Shows stability in all household relationships;

f. Has the financial resources to provide for current and ongoing household needs; and

g. Has complied with 22VAC40-211-70.

G. The individual completing the MFA for the local department shall have met the training requirements. The local department worker shall have knowledge related to foster care and adoption policy and the skills and standards for developing the MFA and approving a foster or adoptive home.

22VAC40-211-50. Approval period and documentation of approval.

A. The approval period for a provider is 36 months.

B. The approved provider shall be given an approval certificate specifying the following:

1. Type of approval ~~(resource, foster, adoptive, or respite family home provider)~~;

2. Date when the approval became effective and the date when the approval lapses; ~~and~~

3. Gender, age, and number of children recommended for placement; and

4. The signature and title of the individual or individuals approving the home.

C. Documentation shall be maintained on the provider and child:

1. The local department's file on the child shall contain:

a. A copy of the provider's approval certificate; or

b. A copy of the licensed child-placing agency license, documentation verifying that required background checks have been received by the child-placing agency and providing the dates of such, and the provider home approval certificate or letter if the provider is approved by a licensed child placing agency.

2. All information on the provider able to be maintained in the department's official child welfare data system shall be maintained in that system.

3. The local department's file on the provider shall contain but not be limited to:

a. A copy of the provider's approval certificate;

b. A copy of the background check results;

c. A copy of the Child Protective Services check;

d. The application;

e. Reference letters;

f. A copy of the ~~home study~~ mutual family assessment (MFA) and supporting documentation;

g. Documentation of orientation and training;

h. Documentation of contacts and visits in the provider's home;

i. Medical information;

j. A copy of the signed confidentiality agreement and the corporal punishment agreement; and

k. Any other documents set out in guidance as part of the approval process.

4. Local departments shall require the provider to maintain legible written information on each child in ~~their~~ the provider's care including:

a. Identifying information on the child;

b. Name, address, and work telephone number of the local department caseworker and local department after hours emergency contact information;

c. Name, address, and home ~~and/or~~ or work telephone numbers of persons authorized to pick up the child;

d. Name of persons not authorized to call or visit the child;

e. Educational records, report cards and other school-related documentation;

f. Medical information pertinent to the health care of the child including all licensed health care providers' names, addresses and telephone numbers and medical care authorization form;

g. Correspondence related to the child;

h. The service plan as well as other written child information provided by the local department;

i. The placement agreement between the provider and the local department; and

j. A copy of the signed confidentiality statement.

5. ~~Providers~~ The provider shall maintain files in a secure location in order to protect the confidentiality of that information. The file and its contents shall not be shared with anyone other than those approved by the local department and shall be returned to the local department if the child leaves the provider's home.

6. The local department and its representatives shall have access to all records.

7. The provider shall notify the local department of any significant changes in the provider's circumstances that impact the conditions of the original approval.

~~7.~~ 8. Significant changes in the circumstances of the provider that would impact the conditions of ~~their~~ provider approval require an addendum updating the ~~home study~~ MFA.

~~8.~~ 9. The local department shall revoke or suspend the approval of a provider when a change in the circumstances of the provider results in the provider's temporary inability to meet standards. Reinstating the approval requires resolution of the circumstances that caused the suspension and shall be documented in an addendum to the provider's record. Any child placed with a provider at the time approval is suspended shall be immediately removed. No other children may be placed with the provider during the period of suspension. A suspension does not change the approval period. A provider whose approval has been revoked must submit a new application.

22VAC40-211-60. Training.

A. The local department shall ensure that preservice training is provided for ~~resource,~~ foster and adoptive ~~family home~~ providers. This training shall address but not be limited to the following core competencies:

1. Factors that contribute to neglect, emotional maltreatment, physical abuse, and sexual abuse, and the effects thereof;

2. Conditions and experiences that may cause developmental delays and affect attachment;

3. Stages of normal human growth and development;

4. Concept of permanence for children and selection of the permanency goal;

5. Reunification as the primary child welfare goal, the process and experience of reunification;

6. Importance of visits and other contacts in strengthening relationships between the child and his birth family, including his siblings;

7. Legal and social processes and implications of adoption;

8. Support of older youth's transition to independent living;

9. The professional team's role in supporting the transition to permanency and preventing unplanned placement disruptions;

10. Relationship between child welfare laws, the local department's mandates, and how the local department carries out its mandates;

11. Purpose of service planning;

12. Impact of multiple placements on a child's development;

13. Types of and response to loss, and the factors that influence the experience of separation, loss, and placement;

14. Cultural, spiritual, social, and economic similarities and differences between a child's primary family and foster or adoptive family;

15. Preparing a child for family visits and helping him manage his feelings in response to family contacts;

16. Developmentally appropriate, effective and nonphysical disciplinary techniques;

17. Promoting a child's sense of identity, history, culture, and values;

18. Respecting a child's connection to his birth family, previous foster families ~~and/or~~ or adoptive families;

19. Being nonjudgmental in caring for the child, working with his family, and collaborating with other members of the team;

20. Roles, rights, and responsibilities of foster parents and adoptive parents; ~~and~~

21. Maintaining a home and community environment that promotes safety and well-being; and

22. Mandated child abuse and neglect reporter laws and responsibilities.

B. Local departments shall ensure that each foster and adoptive home provider receives annual in-service training.

1. Training shall be relevant to the needs of children and families and may be structured to include multiple types of training modalities (for example, online foster parent training courses; seminars and conferences).

2. The department shall provide opportunities for training on an annual basis.

C. The provider is required to complete preservice and annual in-service trainings. As a condition of reapproval each provider shall complete in-service training.

D. Local departments shall explain confidentiality requirements to providers and require providers to keep confidential all information regarding the child, his family, and the circumstances that resulted in the child coming into care.

22VAC40-211-65. Training for individuals providing only respite care ~~providers~~.

A. The local department shall ensure that preservice training is provided for respite care providers. This training shall address, but not be limited to, the following core competencies:

1. Factors that contribute to neglect, emotional maltreatment, physical abuse, and sexual abuse, and the effects thereof;

2. Conditions and experiences that may cause developmental delays and affect attachment;

3. Reunification as the primary child welfare goal, the process and experience of reunification;

4. Importance of visits and other contacts in strengthening relationships between the child and his birth family, including his siblings;

5. The professional team's role in supporting the transition to permanency and preventing unplanned placement disruptions;

6. Impact of multiple placements on a child's development;

7. Cultural, spiritual, social, and economic similarities and differences between a child's primary family and foster or adoptive family;

8. Preparing a child for family visits and helping him manage his feelings in response to family contacts;

9. Developmentally appropriate, effective, and nonphysical disciplinary techniques;

10. Maintaining a home and community environment that promotes safety and well-being;

11. Promoting a child's sense of identity, history, culture, and values;

12. Respecting a child's connection to his birth family, previous foster families, and adoptive families; and

13. Being nonjudgmental in caring for the child, working with his family, and collaborating with other members of the team.

B. The department shall provide opportunities annually for in-service training.

22VAC40-211-70. Standards for the home of the provider.

A. The home shall have sufficient appropriate space and furnishings for each child receiving care in the home including:

1. Space to keep clothing and other personal belongings;

2. Accessible basin and toilet facilities;

3. Safe, comfortable sleeping furnishings;

4. Sleeping space on the first floor of the home for a child unable to use stairs unassisted, other than a child who can easily be carried; and

5. Space for recreational activities.

B. All rooms used by the child shall be heated in winter, dry, and well-ventilated and have appropriate access to exits in case of emergency.

C. Rooms and study space used by the child shall have adequate lighting.

D. The provider and children shall have access to a working telephone in the home.

E. Multiple children sharing a bedroom shall each have adequate space including closet and storage space. Bedrooms shall have adequate square footage for each child to have personal space.

F. Children over the age of two years shall not share a bed.

G. Children over the age of two shall not share a bedroom with an adult unless the local department approves and documents a plan to allow the child to sleep in the adult's bedroom due to documented needs, disabilities or other specified conditions. Children of any age cannot share a bed with an adult.

H. Children of the opposite sex over the age of three shall not sleep in the same room.

I. Children under age seven or children with significant and documented cognitive or physical disabilities shall not use the top bunk of bunk beds.

J. The home and grounds shall be free from litter and debris and present no hazard to the safety of the child receiving care.

1. The provider shall permit a fire inspection of the home by appropriate authorities if conditions indicate a need and the local department requests such an inspection.

2. Possession of any weapons, including firearms, in the home shall comply with federal and state laws and local ordinances. The provider shall store any firearms and other weapons with the activated safety mechanisms, in a locked closet or cabinet. Ammunition shall be stored in a separate and locked area. The key or combination to the locked

closet or cabinet shall be maintained out of the reach of all children in the home.

3. Providers shall ensure that household pets are not a health or safety hazard in accordance with state laws and local ordinances and the local department shall request verification of provider compliance.

4. Providers shall keep cleaning supplies and other toxic substances stored away from food and locked as appropriate. Medications shall be out of reach of children and locked as appropriate. Medications shall be stored separately from food, except those medicines that require refrigeration.

5. Every home shall have an operable smoke detector, the specific requirements of which shall be coordinated through the local fire marshal. If a locality does not have a local fire marshal, the state fire marshal shall be contacted.

6. Every home shall contain basic first aid supplies.

K. The number of children in the provider's home shall not exceed eight. Factors to consider in determining capacity include, but are not limited to:

1. The physical accommodations of the home;

2. The capabilities and skills of the provider to manage the number of children;

3. The needs and special requirements of the child;

4. Whether the child's best interest requires placement in a certain type of home;

5. Whether any individuals in the home, including the provider's children, require special attention or services of the provider that interfere with the provider's ability to ensure the safety of all children in the home; and

6. Whether the foster care provider is also a child care provider.

L. During the approval process, the provider shall develop a written emergency plan that includes, but is not limited to, fire and natural disasters. The plan shall include:

1. How the provider plans to maintain the safety and meet the needs of the child in ~~their~~ the provider's home during a disaster;

2. How the provider shall evacuate the home, if necessary, in a disaster; and

3. How the provider shall relocate in the event of a large scale evacuation.

M. Providers shall arrange for responsible adults to be available who can serve in the caretaker's role in case of an emergency. If the planned or long-term absence of the provider is required, the local department shall be notified of and approve any substitute arrangements the provider wishes to make.

N. In the event of a large scale evacuation due to a disaster, if the provider cannot reach the local department, the provider shall call the State Child Abuse Hotline to notify the department of the provider's location and contact information.

22VAC40-211-80. Standards of care for continued approval.

A. The provider shall provide care that does not discriminate on the basis of race, color, sex, national origin, age, religion, political beliefs, sexual orientation, disability, or family status.

B. The provider shall ensure the child receives meals and snacks appropriate to his daily nutritional needs. The child shall receive a special diet if prescribed by a licensed health care provider or designee or in accordance with religious or ethnic requirements or other special needs.

C. The provider shall ensure that he can be responsive to the special mental health ~~or~~ and medical needs of the child.

D. The provider shall establish rules that encourage desired behavior and discourage undesired behavior. The provider shall not use corporal punishment or give permission to others to do so and shall sign an agreement to this effect.

E. The provider shall provide clean and seasonal clothing appropriate for the age and size of the child.

~~F. If a provider transports the child, the provider shall have a valid driver's license and automobile liability insurance. These will be checked at approval and reapproval but verification may be required at any time deemed necessary.~~

~~G. The vehicle used to transport the child shall have a valid registration and inspection sticker.~~

~~H.~~ F. Providers and any other adults who transport children shall use functioning child restraint devices in accordance with requirements of Virginia law.

G. In the reapproval process the local department shall verify that the requirements for approval, including background checks, are still being met by the provider.

22VAC40-211-90. Allowing a ~~variance~~ waiver.

A. The local department may request and the provider may receive a ~~variance~~ waiver from the department on a standard if the ~~variance~~ waiver does not jeopardize the safety and proper care of the child or violate federal or state laws or local ordinances.

B. If a provider is granted a ~~variance~~ waiver and is in compliance with all other requirements of this chapter, the provider is considered fully approved.

C. Any ~~variances~~ waivers granted are considered on a case-by-case basis and must be reviewed on an annual basis by the department.

22VAC40-211-100. Monitoring and reapproval of providers.

A. The local department's representative shall visit the home of the approved provider as often as necessary but at least quarterly to provide support to and monitor the performance

of the provider and shall document these visits in the provider record.

1. When a child is placed in the home, these visits may coincide with the monthly visits to the child.

2. If there is no child placed in the home, the quarterly visit may be replaced by telephone contact.

B. The reapproval process shall include a minimum of one interview with the provider in his home and the following activities:

1. A review of the previous home approval information;

2. Updating the ~~home study~~ mutual family assessment (MFA) and any information that has changed and consideration of new information since the previous approval;

3. Completing state criminal record and child protective services background checks;

4. Obtaining the results of a new tuberculosis assessment, screening, or tests in compliance with Virginia Department of Health requirements and documenting the absence of tuberculosis in a communicable form;

5. Reviewing the confidentiality and the corporal punishment requirements and completing new confidentiality and corporal punishment agreements;

6. A reassessment of the above information to determine reapproval;

7. A case record addendum indicating that the above requirements were met; and

8. Documentation of in-service training received.

C. If the reapproval process results in the local department's decision to revoke or suspend the provider's approval, the local department shall notify the provider in writing of its decision. A copy of the notification letter shall be stored in the provider's record.

D. If monitoring efforts indicate that significant changes in the circumstances of the provider have occurred and would impact the conditions of ~~their~~ the provider's approval, an addendum shall be completed and included with ~~home study~~ the MFA and appropriate action taken.

E. The case record addendum (i) shall contain all requirements of this chapter and be documented by a combination of narrative and other data collection formats~~,~~ and (ii) shall be signed and dated by the individual completing the addendum and the director of the local department or his designee.

VA.R. Doc. No. R13-3458; Filed April 21, 2017, 8:39 a.m.

Final Regulation

Titles of Regulations: **22VAC40-700. Child Protective Services Central Registry Information (repealing 22VAC40-700-10, 22VAC40-700-20, 22VAC40-700-30).**

22VAC40-705. Child Protective Services (amending 22VAC40-705-10 through 22VAC40-705-90, 22VAC40-705-110 through 22VAC40-705-140, 22VAC40-705-160, 22VAC40-705-180, 22VAC40-705-190).

22VAC40-720. Child Protective Services Release of Information to Family Advocacy Representatives of the United States Armed Forces (repealing 22VAC40-720-10, 22VAC40-720-20).

Statutory Authority: § 63.2-217 of the Code of Virginia.

Effective Date: July 1, 2017.

Agency Contact: Mary Walter, Child Protective Services Consultant, Department of Social Services, 801 East Main Street, Richmond, VA 23219, telephone (804) 726-7569, FAX (804) 726-7499, or email mary.walter@dss.virginia.gov.

Summary:

The regulatory action repeals Child Protective Services Central Registry Information (22VAC40-700) and Child Protective Services Release of Information to Family Advocacy Representatives of the United States Armed Forces (22VAC40-720) and incorporates the provisions of those chapters into Child Protective Services (22VAC40-705).

The amendments include adding (i) definitions for "near fatality," "response time," and "sex trafficking"; (ii) a requirement for reports to be acted upon and the victim child to be interviewed within a determined response time; (iii) a federal requirement to notify relatives within 30 days of removal; (iv) a requirement for a risk assessment to be completed for all investigations; (v) a requirement to interview and observe all children residing in a home in which another child is the subject of a neglect or abuse investigation with parental permission; (vi) provisions for suspending certain investigations; (vii) retention requirements for serious sexual abuse records; (viii) a requirement to notify school boards for all employees in founded investigations and to notify the individual of this action; and (ix) training requirements for all Child Protective Services staff.

The amendments include removing (i) a requirement to invalidate reports for substance exposed infant if the mother sought counseling, (ii) the directive for not rendering founded dispositions for substance exposed infants, and (iii) a reference to exact timeframes for emergency removals.

The amendments generally (i) clarify the definitions of "caretaker," "preponderance of the evidence," and "mental abuse or neglect"; (ii) clarify the responsibilities for mandated reporting of and a local department of social services response to substance abuse exposed newborns; (iii) clarify the release of information to the Military Family Advocacy, when there is a legitimate interest, and while there is a pending criminal investigation; (iv) reorganize and renumber sections for clarity; and (v) update references to the Code of Virginia.

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.

22VAC40-705-10. Definitions.

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

"Abuser or neglector" means any person who is found to have committed the abuse [~~and/or~~ or] neglect of a child pursuant to Chapter 15 (§ 63.2-1500 et seq.) of Title 63.2 of the Code of Virginia.

"Administrative appeal rights" means the child protective services appeals procedures for a local level informal conference and a state level hearing pursuant to § 63.2-1526 of the Code of Virginia, under which an individual who is found to have committed abuse [~~and/or~~ or] neglect may request that the local department's records be amended.

"Alternative treatment options" means treatments used to prevent or treat illnesses or promote health and well-being outside the realm of modern conventional medicine.

"Appellant" means anyone who has been found to be an abuser [~~and/or~~ or] neglector and appeals the founded disposition to the director of the local department of social services, an administrative hearing officer, or to circuit court.

"Assessment" means the process by which child protective services workers determine a child's and family's needs.

"Caretaker" means any individual having the responsibility of providing care [~~for~~ and supervision of] a child and includes the following: (i) [a] parent or other person legally responsible for the child's care; (ii) [~~any other person who has assumed caretaking responsibility by virtue of an agreement with the legally responsible person;~~ an individual who by law, social custom, expressed or implied acquiescence, collective consensus, agreement, or any other legally recognizable basis has an obligation to look after a child left in his care; and] (iii) persons responsible by virtue of their positions of conferred authority [~~; and (iv) adult persons residing in the home with the child~~].

"Case record" means a collection of information maintained by a local department, including written material, letters, documents, tapes, photographs, film or other materials regardless of physical form about a specific child protective services investigation, family or individual.

"Central Registry" means a subset of the child abuse and neglect information system and is the name index with identifying information of individuals named as an abuser [~~and/or~~ or] neglector in founded child abuse [~~and/or~~ or] neglect complaints or reports not currently under administrative appeal, maintained by the department.

"Certified substance abuse counselor" means a person certified to provide substance abuse counseling in a state-approved public or private substance abuse program or facility.

"Child abuse and neglect information system" means the computer system ~~which~~ that collects and maintains information regarding incidents of child abuse and neglect involving parents or other caretakers. The computer system is composed of three parts: the statistical information system with nonidentifying information, the Central Registry of founded complaints not on appeal, and a database that can be accessed only by the department and local departments that contains all nonpurged [~~CPS~~ child protective services] reports. This system is the official state automated system.

"Child protective services" means the identification, receipt and immediate response to complaints and reports of alleged child abuse [~~and/or~~ or] neglect for children under 18 years of age. It also includes assessment, and arranging for and providing necessary protective and rehabilitative services for a child and his family when the child has been found to have been abused or neglected or is at risk of being abused or neglected.

"Child protective services worker" means one who is qualified by virtue of education, training and supervision and is employed by the local department to respond to child protective services complaints and reports of alleged child abuse [~~and/or~~ or] neglect.

"Chronically and irreversibly comatose" means a condition caused by injury, disease or illness in which a patient has suffered a loss of consciousness with no behavioral evidence of self-awareness or awareness of surroundings in a learned manner other than reflexive activity of muscles and nerves for low-level conditioned response and from which to a reasonable degree of medical probability there can be no recovery.

"Collateral" means a person whose personal or professional knowledge may help confirm or rebut the allegations of child abuse [~~and/or~~ or] neglect or whose involvement may help ensure the safety of the child.

"Complaint" means any information or allegation of child abuse [~~and/or~~ or] neglect made orally or in writing pursuant to § 63.2-100 of the Code of Virginia.

"Consultation" means the process by which the alleged abuser [~~and/or~~ or] neglector may request an informal meeting to discuss the investigative findings with the local department prior to the local department rendering a founded disposition of abuse [~~and/or~~ or] neglect against that person pursuant to § 63.2-1526 A of the Code of Virginia.

"Controlled substance" means a drug, substance or marijuana as defined in § 18.2-247 of the Code of Virginia including those terms as they are used or defined in the Drug Control Act, Chapter 34 (§ 54.1-3400 et seq.) of Title 54.1 of the Code of Virginia. The term does not include alcoholic beverages or tobacco as those terms are defined or used in Title [~~3.1~~ 3.2] or Title 4.1 of the Code of Virginia.

"Department" means the Virginia Department of Social Services.

"Differential response system" means that local departments of social services may respond to valid reports or complaints of child abuse or neglect by conducting either a family assessment or an investigation.

"Disposition" means the determination of whether or not child abuse [~~and/or~~ or] neglect has occurred.

"Documentation" means information and materials, written or otherwise, concerning allegations, facts and evidence.

"Family Advocacy Program representative" means the professional employed by the United States Armed Forces who has responsibility for the program designed to address prevention, identification, evaluation, treatment, rehabilitation, follow-up and reporting of family violence, pursuant to ~~22VAC40-720-20~~ 22VAC40-705-140.

"Family assessment" means the collection of information necessary to determine:

1. The immediate safety needs of the child;

2. The protective and rehabilitative services needs of the child and family that will deter abuse or neglect;

3. Risk of future harm to the child; and

4. Alternative plans for the child's safety if protective and rehabilitative services are indicated and the family is unable or unwilling to participate in services. These arrangements may be made in consultation with the [~~caretaker(s)~~ caretaker] of the child.

"First source" means any direct evidence establishing or helping to establish the existence or nonexistence of a fact. Indirect evidence and anonymous complaints do [~~no~~ not] constitute first source evidence.

"Founded" means that a review of the facts shows by a preponderance of the evidence that child abuse [~~and/or~~ or] neglect has occurred. A determination that a case is founded shall be based primarily on first source evidence; in no instance shall a determination that a case is founded be based solely on indirect evidence or an anonymous complaint.

[~~"He" means he or she.~~

~~"His" means his or her.~~]

"Identifying information" means name, social security number, address, race, sex, and date of birth.

"Indirect evidence" means any statement made outside the presence of the child protective services worker and relayed to the child protective services worker as proof of the contents of the statement.

"Informed opinion" means that the child has been informed and understands the benefits and risks, to the extent known, of the treatment recommended by conventional medical providers for his condition and the alternative treatment being considered as well as the basis of efficacy for each, or lack thereof.

"Investigation" means the collection of information to determine:

1. The immediate safety needs of the child;

2. The protective and rehabilitative services needs of the child and family that will deter abuse or neglect;

3. Risk of future harm to the child;

4. Alternative plans for the child's safety if protective and rehabilitative services are indicated and the family is unable or unwilling to participate in services;

5. Whether or not abuse or neglect has occurred;

6. If abuse or neglect has occurred, who abused or neglected the child; and

7. A finding of either founded or unfounded based on the facts collected during the investigation.

"Investigative narrative" means the written account of the investigation contained in the child protective services case record.

"Legitimate interest" means a lawful, demonstrated privilege to access the information as defined in § ~~63.2-104~~ 63.2-105 of the Code of Virginia.

"Licensed substance abuse treatment practitioner" means a person who (i) is trained in and engages in the practice of substance abuse treatment with individuals or groups of individuals suffering from the effects of substance abuse or dependence, and in the prevention of substance abuse or dependence and (ii) is licensed to provide advanced substance abuse treatment and independent, direct and unsupervised treatment to such individuals or groups of individuals, and to plan, evaluate, supervise, and direct substance abuse treatment provided by others.

"Life-threatening condition" means a condition that if left untreated more likely than not will result in death and for which the recommended medical treatments carry a probable chance of impairing the health of the individual or a risk of terminating the life of the individual.

"Local department" means the city or county local agency of social services or department of public welfare in the Commonwealth of Virginia responsible for conducting investigations or family assessments of child abuse [~~and/or~~ or] neglect complaints or reports pursuant to § 63.2-1503 of the Code of Virginia.

"Local department of jurisdiction" means the local department in the city or county in Virginia where the alleged victim child resides or in which the alleged abuse [~~and/or~~ or] neglect is believed to have occurred. If neither of these is known, then the local department of jurisdiction shall be the local department in the county or city where the abuse [~~and/or~~ or] neglect was discovered.

"Mandated reporters" means those persons who are required to report suspicions of child abuse [~~and/or~~ or] neglect pursuant to § 63.2-1509 of the Code of Virginia.

"Monitoring" means contacts with the child, family and collaterals which provide information about the child's safety and the family's compliance with the service plan.

"Multidisciplinary teams" means any organized group of individuals representing, but not limited to, medical, mental health, social work, education, legal and law enforcement, which will assist local departments in the protection and prevention of child abuse and neglect pursuant to § 63.2-1503 K of the Code of Virginia. Citizen representatives may also be included.

"Near fatality" means an act that, as certified by a physician, places the child in serious or critical condition. Serious or critical condition is a life-threatening condition or injury.

"Notification" means informing designated and appropriate individuals of the local department's actions and the individual's rights.

"Particular medical treatment" means a process or procedure that is recommended by conventional medical providers and accepted by the conventional medical community.

"Preponderance of evidence" means [~~the evidence as a whole shows that the facts are more probable and credible than not~~ just enough evidence to make it more likely than not that the asserted facts are true]. It is evidence which is of greater weight or more convincing than the evidence offered in opposition.

"Purge" means to delete or destroy any reference data and materials specific to subject identification contained in records maintained by the department and the local department pursuant to §§ 63.2-1513 and 63.2-1514 of the Code of Virginia.

"Reasonable diligence" means the exercise of justifiable and appropriate persistent effort.

"Report" means either a complaint as defined in this section or an official document on which information is given concerning abuse [~~and~~ or] neglect. ~~A~~ Pursuant to § 63.2-1509 of the Code of Virginia, a report is required to be made by persons designated herein and by local departments in those situations in which a response to a complaint from the general public reveals suspected child abuse [~~and/or~~ or] neglect pursuant to ~~subdivision 5 of~~ the definition of abused or neglected child in § 63.2-100 of the Code of Virginia.

"Response time" means [~~the urgency in which a valid report of suspected child abuse or neglect is initiated by the local department based on the child's immediate safety or other factors~~ a reasonable time for the local department to initiate a valid report of suspected child abuse or neglect based upon the facts and circumstances presented at the time the complaint or report is received].

"Safety plan" means an immediate course of action designed to protect a child from abuse or neglect.

"Service plan" means a plan of action to address the service needs of a child [~~and/or~~ or] his family in order to protect a child and his siblings, to prevent future abuse and neglect, and to preserve the family life of the parents and children whenever possible.

["Sex trafficking" means the recruitment, harboring, transportation, provision, obtaining, patronizing, or soliciting of a person for the purpose of a commercial sex act as defined in § 18.2-357.1 of the Code of Virginia.]

"State automated system" means the "child abuse and neglect information system" as previously defined.

[~~"Substance abuse counseling or treatment services" are services provided to individuals for the prevention, diagnosis, treatment, or palliation of chemical dependency, which may include attendant medical and psychiatric complications of chemical dependency.~~]

"Sufficiently mature" is determined on a case-by-case basis and means that a child has no impairment of his cognitive ability and is of a maturity level capable of having intelligent views on the subject of his health condition and medical care.

"Terminal condition" means a condition caused by injury, disease or illness from which to a reasonable degree of medical probability a patient cannot recover and (i) the patient's death is imminent or (ii) the patient is chronically and irreversibly comatose.

"Unfounded" means that a review of the facts does not show by a preponderance of the evidence that child abuse or neglect occurred.

"Valid report or complaint" means the local department of social services has evaluated the information and allegations of the report or complaint and determined that the local department shall conduct an investigation or family assessment because the following elements are present:

1. The alleged victim child or children are under the age of 18 [years] at the time of the complaint or report;

2. The alleged abuser is the alleged victim child's parent or other caretaker;

3. The local department receiving the complaint or report is a local department of jurisdiction; and

4. The circumstances described allege suspected child abuse or neglect.

"Withholding of medically indicated treatment" means the failure to respond to the infant's life-threatening condition by providing treatment (including appropriate nutrition, hydration, and medication) which in the treating physician's or physicians' reasonable medical judgment will most likely be effective in ameliorating or correcting all such conditions.

22VAC40-705-20. General policy regarding complaints or reports of child abuse and neglect.

It is the policy of the Commonwealth of Virginia to require complaints [~~and/or~~ or] reports of child abuse and neglect for the following purposes:

1. Identifying abused and neglected children;

2. Assuring protective services to such identified children;

3. Preventing further abuse and neglect;

4. Preserving the family life of the parents and children, where possible, by enhancing parental capacity for adequate care.

22VAC40-705-30. Types of abuse and neglect.

A. Physical abuse occurs when a caretaker creates or inflicts, threatens to create or inflict, or allows to be created or inflicted upon a child a physical injury by other than accidental means or creates a substantial risk of death, disfigurement, or impairment of bodily functions, including, but not limited to, a child who is with his parent or other person responsible for his care either (i) during the manufacture or attempted manufacture of a Schedule I or II controlled substance or (ii) during the unlawful sale of such substance by that child's parents or other person responsible for his care, where such manufacture, or attempted manufacture or unlawful sale would constitute a felony violation of § 18.2-248 of the Code of Virginia.

B. Physical neglect occurs when there is the failure to provide food, clothing, shelter, necessary medical treatment, or supervision for a child to the extent that the child's health or safety is endangered. This also includes abandonment and situations where the parent's or caretaker's own incapacitating behavior or absence prevents or severely limits the performing of child caring tasks pursuant to § 63.2-100 of the Code of Virginia. This also includes a child under the age of 18 years whose parent or other person responsible for his care knowingly leaves the child alone in the same dwelling as a person, not related by blood or marriage, who has been convicted of an offense against a minor for which registration is required as a violent sexual offender pursuant to § 9.1-902 of the Code of Virginia. In situations where the neglect is the result of family poverty and there are no outside resources available to the family, the parent or caretaker shall not be determined to have neglected the child; however, the local department may provide appropriate services to the family.

1. Physical neglect may include multiple occurrences or a one-time critical or severe event that results in a threat to health or safety.

2. Physical neglect may include failure to thrive.

a. Failure to thrive occurs as a syndrome of infancy and early childhood ~~which~~ that is characterized by growth failure, signs of severe malnutrition, and variable degrees of developmental retardation.

b. Failure to thrive can only be diagnosed by a physician and is caused by nonorganic factors.

3. Physical neglect may include medical neglect.

~~C.~~ a. Medical neglect occurs when there is the failure by the caretaker to obtain or follow through with a complete regimen of medical, mental, or dental care for a condition ~~which~~ that if untreated could result in illness or developmental delays ~~pursuant to § 63.2-100 of the Code of Virginia~~. However, a decision by parents or other persons legally responsible for the child to refuse a particular medical treatment for a child with a life-threatening condition shall not be deemed a refusal to provide necessary care if (i) such decision is made jointly by the parents or other person legally responsible for the child and the child; (ii) the child has reached 14 years of age and sufficiently mature to have an informed opinion on the subject of his medical treatment; (iii) the parents or other person legally responsible for the child and the child have considered alternative treatment options; and (iv) the parents or other person legally responsible for the child and the child believe in good faith that such decision is in the child's best interest.

b. Medical neglect also includes withholding of medically indicated treatment.

~~1.~~ (1) A child who, in good faith, is under treatment solely by spiritual means through prayer in accordance with the tenets and practices of a recognized church or religious denomination ~~pursuant to § 63.2-100 of the Code of Virginia~~ shall not for that reason alone be considered a neglected child in accordance with § 63.2-100 of the Code of Virginia.

~~2.~~ (2) For the purposes of this ~~regulation~~ chapter, "withholding of medically indicated treatment" does not include the failure to provide treatment (other than appropriate nutrition, hydration, or medication) to an infant when in the treating physician's or physicians' reasonable medical judgment:

~~a.~~ (a) The infant is chronically and irreversibly comatose;

~~b.~~ (b) The infant has a terminal condition and the provision of such treatment would~~: (1) Merely~~ (i) merely prolong dying; ~~(2) Not~~ (ii) not be effective in ameliorating or correcting all of the infant's life-threatening conditions; ~~(3) Otherwise~~ (iii) otherwise be futile in terms of the survival of the infant; or ~~(4) Be~~ (iv) be virtually futile in terms of the survival of the infant and the treatment itself under such circumstances would be inhumane.

~~D.~~ C. Mental abuse or neglect occurs when a caretaker creates or inflicts, threatens to create or inflict, or allows to be created or inflicted upon a child a mental injury by other than accidental means or creates a substantial risk of impairment of mental functions.

1. Mental abuse or neglect includes acts of omission by the caretaker resulting in harm to a child's psychological or emotional health or development.

2. [~~Professional documentation~~ Documentation] supporting a nexus between the actions or inactions of the caretaker and the mental dysfunction or threat of dysfunction demonstrated by the child is required in order to make a founded disposition.

3. Mental abuse or neglect may include failure to thrive.

~~1.~~ a. Failure to thrive occurs as a syndrome of infancy and early childhood ~~which~~ that is characterized by growth failure, signs of severe malnutrition, and variable degrees of developmental retardation.

~~2.~~ b. Failure to thrive can only be diagnosed by a physician and is caused by nonorganic factors.

~~E.~~ D. Sexual abuse occurs when ~~there is~~ the child's [~~parents or other persons responsible for the care~~ caretaker] commits or allows to be committed any act of sexual exploitation [, including sex trafficking as defined in 22VAC40-705-10,] or any sexual act upon a child in violation of the law ~~which is committed or allowed to be committed by the child's parents or other persons responsible for the care of the child pursuant to § 63.2-100 of the Code of Virginia~~.

22VAC40-705-40. Complaints and reports of suspected child abuse [~~and/or~~ or] neglect.

A. Persons who are mandated to report are those individuals defined in § 63.2-1509 of the Code of Virginia.

1. Mandated reporters shall report immediately any suspected abuse or neglect that they learn of in their professional [or official] capacity~~. No person shall be required to make a report pursuant to § 63.2-1509 of the Code of Virginia if~~ unless the person has actual knowledge that the same matter has already been reported to the local department or the department's toll-free child abuse and neglect hotline.

2. Pursuant to § 63.2-1509 of the Code of Virginia, [if information is received by a teacher, staff member, resident, intern, or nurse in the course of his professional services ~~mandated reporters~~] in a hospital, school, or other similar institution, [such person] may ~~in place of said report, immediately notify~~ make reports of suspected abuse or neglect immediately to the person in charge of the institution or department, or his designee, who shall then make such report forthwith [. If the initial report of suspected abuse or neglect is made to the person in charge of the institution or department, or his designee, such person shall (i) notify the teacher, staff member, resident, intern, or nurse who made the initial report when the report of suspected child abuse or neglect is made to the local department or to the department's toll-free child abuse and neglect hotline; (ii) provide the name of the individual receiving the report; and (iii) forward any communication resulting from the report, including any information about any actions taken regarding the report, to the person who made the initial report. ~~on the mandated reporters' behalf. This person shall notify the mandated reporter when and to whom he made the report, as well as forward any other communication resulting from the report, including any action taken, to the mandated reporter.~~]

3. Mandated reporters shall disclose all information that is the basis for the suspicion of child abuse or neglect and shall make available, upon request, to the local department any records and reports that document the basis for the complaint [~~and/or~~ or] report.

4. ~~A~~ Pursuant to § 63.2-1509 D of the Code of Virginia, a mandated reporter's failure to report as soon as possible, but no longer than 24 hours after having reason to suspect a reportable offense of child abuse or neglect, shall result in a fine.

[5. In cases evidencing acts of rape, sodomy, or object sexual penetration as defined in Article 7 (§ 18.2-61 et seq.) of Chapter 4 of Title 18.2 of the Code of Virginia, a person who knowingly and intentionally fails to make the report required pursuant to § 63.2-1509 of the Code of Virginia shall be guilty of a Class 1 misdemeanor.

~~5. A person who knowingly and intentionally fails to make a report in cases of rape, sodomy, or object sexual penetration shall be guilty of a Class 1 misdemeanor.~~]

~~5.~~ 6. Pursuant to § 63.2-1509 B of the Code of Virginia, ~~a "reason~~ certain specified facts indicating that a newborn may have been exposed to a controlled substance prior to birth [~~are sufficient~~ constitute a reason] to suspect that a child is abused or neglected~~"~~. [~~This~~ Such facts] shall include (i) a finding made by a health care provider within six weeks of the birth of a child that the results of toxicology studies of the child indicate the presence of a controlled substance that was not prescribed for the mother by a physician; (ii) a finding made by a health care provider within six weeks of the birth of a child that the child was born dependent on a controlled substance that was not prescribed by a physician for the mother and has demonstrated withdrawal symptoms; (iii) a diagnosis made by a health care provider at any time following a child's birth that the child has an illness, disease, or condition which, to a reasonable degree of medical certainty, is attributable to in utero exposure to a controlled substance that was not prescribed by a physician for the mother or the child; or (iv) a diagnosis made by a health care provider at any time following a child's birth that the child has a fetal alcohol spectrum disorder attributable to in utero exposure to alcohol. [When "reason to suspect" is based upon this subsection, such fact shall be included in the report along with the facts relied upon by the person making the report.] ~~Any report made pursuant to § 63.2-1509 A of the Code of Virginia constitutes a valid report of abuse or neglect and requires a child protective services investigation or family assessment, unless the mother sought treatment or counseling as required in this section and pursuant to § 63.2-1505 B of the Code of Virginia.~~

a. Pursuant to § 63.2-1509 [B] of the Code of Virginia, whenever a health care provider makes a finding [~~pursuant to § 63.2-1509 A of the Code of Virginia~~ or diagnosis], then the health care provider or his designee must make a report to child protective services immediately. ~~Pursuant to § 63.2-1509 D of the Code of Virginia, a health care provider who fails to make a~~

~~report pursuant to § 63.2-1509 A of the Code of Virginia is subject to a fine.~~

b. When a [valid] report or complaint alleging abuse or neglect is made pursuant to § 63.2-1509 ~~A~~ B of the Code of Virginia, then the local department must immediately assess the [~~infant's~~ child's] circumstances and any threat to the [~~infant's~~ child's] health and safety. Pursuant to 22VAC40-705-110 A, the local department must conduct an initial safety assessment.

c. When a [valid] report or complaint alleging abuse or neglect is made pursuant to § 63.2-1509 ~~A~~ B of the Code of Virginia, then the local department must immediately determine whether to petition a juvenile and domestic relations district court for any necessary services or court orders needed to ensure the safety and health of the [~~infant~~ child].

~~d. Within five days of receipt of a report made pursuant to § 63.2-1509 A of the Code of Virginia, the local department shall invalidate the complaint if the following two conditions are met: (i) the mother of the infant sought substance abuse counseling or treatment during her pregnancy prior to the infant's birth and (ii) there is no evidence of child abuse and/or neglect by the mother after the infant's birth.~~

~~(1) The local department must notify the mother immediately upon receipt of a complaint made pursuant to § 63.2-1509 A of the Code of Virginia. This notification must include a statement informing the mother that, if the mother fails to present evidence within five days of receipt of the complaint that she sought substance abuse counseling/treatment during the pregnancy, the report will be accepted as valid and an investigation or family assessment initiated.~~

~~(2) If the mother sought counseling or treatment but did not receive such services, then the local department must determine whether the mother made a substantive effort to receive substance abuse treatment before the child's birth. If the mother made a substantive effort to receive treatment or counseling prior to the child's birth, but did not receive such services due to no fault of her own, then the local department should invalidate the complaint or report.~~

[d. Following the receipt of a report made pursuant to § 63.2-1509 B of the Code of Virginia, the local department may determine that no further action is required pursuant to § 63.2-1505 B of the Code of Virginia if the mother of the infant sought or received substance abuse counseling or treatment.

(1) The local department must notify the mother immediately upon receipt of a complaint made pursuant to § 63.2-1509 B of the Code of Virginia. This notification must include a statement informing the mother that, if the mother fails to present evidence that she sought or received substance abuse counseling or treatment during the pregnancy, then the local department shall conduct an investigation or family assessment.

(2) If the mother sought counseling or treatment but did not receive such services, then the local department must determine whether the mother made a good faith effort to receive substance abuse treatment before the child's birth. If the mother made a good faith effort to receive treatment or counseling prior to the child's birth, but did not receive such services due to no fault of her own, then the local department may determine no further action is required.]

[(3) ~~d.~~] If the mother sought [or received] substance abuse counseling or treatment, but there is evidence, other than exposure to a controlled substance, that the child may be abused or neglected, then the local department ~~may initiate the~~ shall conduct an investigation or family assessment.

e. [~~Substance~~ For purposes of this chapter, substance] abuse counseling or treatment includes, but is not limited to, education about the impact of alcohol, controlled substances and other drugs on the fetus and on the maternal relationship; education about relapse prevention to recognize personal and environmental cues ~~which~~ that may trigger a return to the use of alcohol or other drugs.

f. The substance abuse counseling or treatment should attempt to serve the purposes of improving the pregnancy outcome, treating the substance abuse disorder, strengthening the maternal relationship with existing children and the infant, and achieving and maintaining a sober and drug-free lifestyle.

g. The substance abuse counseling or treatment services must be provided by a professional. Professional substance abuse treatment or counseling may be provided by a certified substance abuse counselor or a licensed substance abuse treatment practitioner.

~~h. Facts indicating that the infant may have been exposed to controlled substances prior to birth are not sufficient, in and of themselves, to render a founded disposition of abuse or neglect. The local department must establish, by a preponderance of the evidence, that the infant was abused or neglected according to the statutory and regulatory definitions of abuse and neglect.~~

[h. Facts solely indicating that the infant may have been exposed to controlled substances prior to birth are not sufficient to render a founded disposition of abuse or neglect in an investigation.]

[i. ~~h.~~] The local department may provide assistance to the mother in locating and receiving substance abuse counseling or treatment.

B. Persons who may report child abuse [~~and/or~~ or] neglect include any individual who suspects that a child is being abused [~~and/or~~ or] neglected pursuant to § 63.2-1510 of the Code of Virginia.

C. Complaints and reports of child abuse [~~and/or~~ or] neglect may be made anonymously. ~~An anonymous complaint, standing alone, shall not meet the preponderance of evidence standard necessary to support a founded determination.~~

D. Any person making a complaint [~~and/or~~ or] report of child abuse [~~and/or~~ or] neglect shall be immune from any civil or criminal liability in connection therewith, unless ~~the court decides~~ it is proven that such person acted in bad faith or with malicious intent pursuant to § 63.2-1512 of the Code of Virginia.

E. When the identity of the reporter is known to the department or local department, these agencies shall ~~make every effort to protect~~ not disclose the reporter's identity [unless court ordered or required under § 63.2-1503 D of the Code of Virginia]. Upon request, the local department shall advise the person who was the subject of an unfounded investigation if the complaint or report was made anonymously.

F. If a person suspects that he is the subject of a report or complaint of child abuse [~~and/or~~ or] neglect made in bad faith or with malicious intent, that person may petition the court for access to the record including the identity of the reporter or complainant pursuant to § 63.2-1514 of the Code of Virginia.

G. Any person age 14 years or older who makes or causes to be made a knowingly false complaint or report of child abuse [~~and/or~~ or] neglect and is convicted shall be guilty of a Class 1 misdemeanor for a first offense pursuant to § 63.2-1513 of the Code of Virginia.

1. A subsequent conviction results in a Class 6 felony.

2. Upon receipt of notification of such conviction, the department will retain a list of convicted reporters.

3. The subject of the records may have the records purged upon presentation of ~~proof~~ a certified copy of such conviction.

[4. The subject of the records shall be notified in writing that the records have been purged.]

H. To make a complaint or report of child abuse [~~and/or~~ or] neglect, a person may telephone the department's toll-free child abuse and neglect hotline or contact a local department of jurisdiction pursuant to § 63.2-1510 of the Code of Virginia.

1. The local department of jurisdiction that first receives a complaint or report of child abuse [~~and/or~~ or] neglect shall assume responsibility to ensure that a family assessment or an investigation is conducted.

2. A local department may ask another local department that is a local department of jurisdiction to assist in conducting the family assessment or investigation. If assistance is requested, the local department shall comply.

3. A local department may ask another local department through a cooperative agreement to assist in conducting the family assessment or investigation.

4. If a local department employee is suspected of abusing [~~and/or~~ or] neglecting a child, the complaint or report of child abuse [~~and/or~~ or] neglect shall be made to the juvenile and domestic relations district court of the county or city where the alleged abuse [~~and/or~~ or] neglect was discovered. The judge shall assign the report to a local department that is not the employer of the subject of the report, or, if the judge believes that no local department in a reasonable geographic distance can be impartial in responding to the reported case, the judge shall assign the report to the court service unit of his court for evaluation pursuant to §§ 63.2-1509 and 63.2-1510 of the Code of Virginia. The judge may consult with the department in selecting a local department to respond.

5. In cases where an employee at a private or state-operated hospital, institution, or other facility or an employee of a school board is suspected of abusing or neglecting a child in such hospital, institution, or other facility or public school, the local department shall request the department and the relevant private or state-operated hospital, institution, or other facility or school board to assist in conducting a joint investigation in accordance with regulations adopted [~~by the board~~ in 22VAC40-730], in consultation with the Departments of Education, Health, Medical Assistance Services, Behavioral Health and Developmental Services, Juvenile Justice, and Corrections.

22VAC40-705-50. Actions to be taken upon receipt of a complaint or report.

A. All complaints and reports of suspected child abuse [~~and/or~~ or] neglect shall be recorded in the child abuse and neglect information system and either screened out or determined to be valid ~~within five days of~~ upon receipt and if valid, acted on within the determined response time. A record of all reports and complaints made to a local department or to the department, regardless of whether the report or complaint was found to be a valid complaint of abuse [~~and/or~~ or] neglect, shall be [~~retained for~~ purged] one year [~~from~~ after] the date of the [report or] complaint unless a subsequent report [or complaint] is made.

B. In all valid complaints or reports of child abuse [~~and/or~~ or] neglect the local department of social services shall determine whether to conduct an investigation or a family assessment. A valid complaint or report is one in which:

1. The alleged victim child or children are under the age of 18 years at the time of the complaint [~~and/or~~ or] report;

2. The alleged abuser is the alleged victim child's parent or other caretaker;

3. The local department receiving the complaint or report [~~is a local department of~~ has] jurisdiction; and

4. The circumstances described allege suspected child abuse [~~and/or~~ or] neglect as defined in § 63.2-100 of the Code of Virginia.

C. The local department shall not conduct a family assessment or investigate complaints or reports of child abuse [~~and/or~~ or] neglect that fail to meet all of the criteria in subsection B of this section.

D. The local department shall report certain cases of suspected child abuse or neglect to the local attorney for the Commonwealth and the local law-enforcement agency pursuant to § 63.2-1503 D of the Code of Virginia.

E. Pursuant to § 63.2-1503 ~~J~~ D of the Code of Virginia, the local ~~departments~~ department shall develop, where practical, a memoranda of understanding for responding to reports of child abuse and neglect with local law enforcement and the local office of the commonwealth's attorney.

F. The local department shall report to the following when the death of a child is involved:

1. When abuse [~~and/or~~ or] neglect is suspected in any case involving the death of a child, the local department shall report the case immediately to the regional medical examiner and the local law-enforcement agency pursuant to § 63.2-1503 E of the Code of Virginia.

2. When abuse [~~and/or~~ or] neglect is suspected in any case involving the death of a child, the local department shall report the case immediately to the attorney for the Commonwealth and the local law-enforcement agency pursuant to § 63.2-1503 D of the Code of Virginia.

3. The local department shall contact the department immediately upon receiving a complaint involving the death of a child and at the conclusion of the investigation.

4. The department shall immediately, upon receipt of information, report on all child fatalities to the state board in a manner consistent with department policy and procedures approved by the board. At a minimum, the report shall contain information regarding any prior statewide child protective services involvement of the family, alleged perpetrator, or victim.

G. Valid complaints or reports shall be screened for high priority based on the following:

1. The immediate danger to the child;

2. The severity of the type of abuse or neglect alleged;

3. The age of the child;

4. The circumstances surrounding the alleged abuse or neglect;

5. The physical and mental condition of the child; and

6. Reports made by mandated reporters.

H. The local department shall [~~initiate an immediate response but not later than~~ respond] within the determined response time. The response shall be a family assessment or an investigation. Any valid report may be investigated, but in accordance with § 63.2-1506 C of the Code of Virginia, those cases shall be investigated that involve~~:~~ (i) sexual abuse, (ii) a child fatality, (iii) abuse or neglect resulting in a serious injury as defined in § 18.2-371.1 of the Code of Virginia, (iv) a child having been taken into the custody of the local department of social services, or (v) a caretaker at a state-licensed child day care center, religiously exempt child day center, regulated family day home, private or public school, or hospital or any institution.

1. The purpose of an investigation is to collect the information necessary to determine or assess the following:

a. Immediate safety needs of the child;

b. Whether or not abuse or neglect has occurred;

c. Who abused or neglected the child;

d. To what extent the child is at risk of future harm~~, either immediate or longer term~~;

e. What types of services can meet the needs of this child or family; and

f. If services are indicated and the family appears to be unable or unwilling to participate in services, what alternate plans will provide for the child's safety.

2. The purpose of a family assessment is to engage the family in a process to collect the information necessary to determine or assess the following:

a. Immediate safety needs of the child;

b. The extent to which the child is at risk of future harm~~, either immediate or longer term~~;

c. The types of services that can meet the needs of this child or family; and

d. If services are indicated and the family appears to be unable or unwilling to participate in services, the plans that will be developed in consultation with the family to provide for the child's safety. These arrangements may be made in consultation with the [~~caretaker(s)~~ caretaker] of the child.

3. The local department shall use reasonable diligence to locate any child for whom a report or complaint of suspected child abuse [~~and/or~~ or] neglect has been received and determined valid ~~or~~ and persons who are the subject of a valid report if the whereabouts of such persons are unknown to the local department pursuant to § 63.2-1503 F of the Code of Virginia.

4. The local department shall document its attempts to locate the child and family.

5. In the event the alleged victim child or children cannot be found [after the local department has exercised reasonable diligence], the time the child cannot be found shall not be computed as part of the [~~45-60-day~~] time

frame to complete the investigation, pursuant to subdivision B 5 of § 63.2-1505 of the Code of Virginia.

22VAC40-705-60. Authorities of local departments.

When responding to valid complaints or reports, local departments have the following authorities:

1. To talk to any child suspected of being abused [~~and/or~~ or] neglected, or child's siblings, without the consent of and outside the presence of the parent or other caretaker, as set forth by § 63.2-1518 of the Code of Virginia.

2. To take or arrange for photographs and x-rays of a child who is the subject of a complaint without the consent of and outside the presence of the parent or other caretaker, as set forth in § 63.2-1520 of the Code of Virginia.

3. To take a child into custody on an emergency removal ~~for up to 72 96 hours~~ under such circumstances as set forth in § 63.2-1517 of the Code of Virginia.

a. A child protective services ~~(CPS)~~ worker planning to take a child into ~~72 96 hour~~ emergency custody shall first consult with a supervisor. However, this requirement shall not delay action on the ~~CPS~~ child protective services worker's part if a supervisor cannot be contacted and the situation requires immediate action.

b. When circumstances warrant that a child be taken into emergency custody during a family assessment, the report shall be reassigned immediately [~~to~~ as] an investigation.

c. Any person who takes a child into custody pursuant to § 63.2-1517 of the Code of Virginia shall be immune from any civil or criminal liability in connection therewith, unless it is proven that such person acted in bad faith or with malicious intent.

d. The local department shall have the authority to have a complete medical examination made of the child including a written medical report and, when appropriate, photographs and x-rays pursuant to § 63.2-1520 of the Code of Virginia.

e. When a child in ~~72 96 hour~~ emergency custody is in need of immediate medical or surgical treatment, the local director of social services or his ~~designee(s)~~ designee may consent to such treatment when the parent does not provide consent and a court order is not immediately obtainable.

f. When a child is not in the local department's custody, the local department cannot consent to medical or surgical treatment of the child.

g. When a child is removed, every effort must be made to obtain an emergency removal order within four hours. Reasons for not doing so shall be stated in the petition for an emergency removal order.

h. Every effort shall be made to provide notice of the removal in person to the parent or guardian as soon as practicable.

i. Within 30 days of removing a child from the custody of the parents or legal guardians, the local department shall exercise due diligence to identify and notify in writing all maternal and paternal grandparents and other adult relatives of the child [(including any other adult relatives suggested by the parents) and all parents who have legal custody of any siblings of the child being removed] and explain the options they have to participate in the care and placement of the child, [~~unless the local department determines such notification is not in the best interest of the child~~ subject to exceptions due to family or domestic violence]. These notifications shall be documented in the state automated system. When notification to any of these relatives is not made, the [~~child protective services worker~~ local department] shall document the reasons in the state automated system.

22VAC40-705-70. Collection of information.

A. When conducting an investigation the local department shall seek first-source information about the allegation of child abuse [~~and/or~~ or] neglect. When applicable, the local department shall include in the case record: police reports; depositions; photographs; physical, medical and psychological reports; and any electronic recordings of interviews.

B. When completing a family assessment, the local department shall gather all relevant information in collaboration with the family, to the degree possible, in order to determine the child and family services needs related to current safety or future risk of harm to the child.

C. All information collected for a family assessment or an investigation must be entered in the state automated system and maintained according to § 63.2-1514 for unfounded investigations or family assessments or according to ~~22VAC40-700-30~~ 22VAC40-705-130 for founded investigations. The automated record entered in the ~~statewide automation~~ state automated system is the official record. When documentation is not available in electronic form, it must be maintained in the hard copy portion of the record. Any hard copy information, including photographs and recordings, shall be noted as an addendum to the official record.

22VAC40-705-80. Family assessment and investigation contacts.

A. During the course of the family assessment, the child protective services ~~(CPS)~~ worker shall ~~make and record~~ document in writing in the state automated system the following contacts and observations. When any of these contacts or observations is not made, the child protective services worker shall document in writing why the specific contact or observation was not made.

1. The child protective services worker shall conduct a face-to-face interview with and observe the alleged victim child ~~and siblings~~ within the determined response time.

2. The child protective services worker shall conduct a face-to-face interview with and observe all minor siblings residing in the home.

[3. The child protective services worker shall conduct a face-to-face interview with and observe all other children residing in the home with parental permission.]

~~2.~~ [~~3.~~ 4.] The child protective services worker shall conduct a face-to-face interview with the alleged victim child's parents or guardians [~~and/or~~ or] any caretaker named in the report.

~~3.~~ [~~4.~~ 5.] The child protective services worker shall observe the family environment, contact pertinent collaterals, and review pertinent records in consultation with the family.

B. During the course of the investigation, the child protective services ~~(CPS)~~ worker shall ~~make and record~~ document in writing in the state automated system the following contacts and observations. When any of these contacts or observations is not made, the ~~CPS~~ child protective services worker shall ~~record~~ document in writing why the specific contact or observation was not made.

1. The child protective services worker shall conduct a face-to-face interview with and observation of the alleged victim child ~~and siblings~~ within the determined response time. All interviews with alleged victim children must be electronically recorded except when the child protective services worker determines that:

a. The child's safety may be endangered by electronically recording his statement;

b. The age [~~and/or~~ or] developmental capacity of the child makes electronic recording impractical;

c. A child refuses to participate in the interview if electronic recording occurs; [~~or~~]

d. In the context of a team investigation with law-enforcement personnel, the team or team leader determines that ~~audio taping~~ electronic recording is not appropriate [~~.~~; or]

e. The victim provided new information as part of a family assessment and it would be detrimental to reinterview the victim and the child protective services worker provides a detailed narrative of the interview in the investigation record.

In the case of an interview conducted with a nonverbal child where none of the above exceptions apply, it is appropriate to electronically record the questions being asked by the child protective services worker and to describe, either verbally or in writing, the child's responses. A child protective services worker shall document in detail in the record and discuss with supervisory personnel the basis for a decision not to electronically record an interview with the alleged victim child.

A child protective services finding may be based on the written narrative of the child protective services worker in cases where an electronic recording is unavailable due to equipment failure or the above exceptions.

2. The child protective services worker shall conduct a face-to-face interview and observe all minor siblings residing in the home.

[3. The child protective services worker shall conduct a face-to-face interview with and observe all other children residing in the home with parental permission.]

~~2.~~ [~~3.~~ 4.] The child protective services ~~(CPS)~~ worker shall conduct a face-to-face interview with the alleged abuser [~~and/or~~ or] neglector.

a. The ~~CPS~~ child protective services worker shall inform the alleged abuser [~~and/or~~ or] neglector of his right to ~~tape~~ electronically record any communication pursuant to § 63.2-1516 of the Code of Virginia.

b. If requested by the alleged abuser [~~and/or~~ or] neglector, the local department shall provide the necessary equipment in order to electronically record the interview and retain a copy of the electronic recording.

~~3.~~ [~~4.~~ 5.] The child protective services worker shall conduct a face-to-face interview with the alleged victim child's parents or guardians.

~~4.~~ [~~5.~~ 6.] The child protective services worker shall observe the environment where the alleged victim child lives. This requirement may be waived in complaints [or reports] of child abuse and neglect [~~involving caretakers~~ that took place] in state licensed and religiously exempted child [~~care~~ day] centers, regulated and unregulated family day [~~care~~] homes, private and public schools, group residential facilities, hospitals [,] or institutions [where the alleged abuser or neglector is an employee or volunteer at such facility].

~~5.~~ [~~6.~~ 7.] The child protective services worker shall observe the site where the alleged incident took place.

~~6.~~ [~~7.~~ 8.] The child protective services worker shall conduct interviews with collaterals who have pertinent information relevant to the investigation and the safety of the child.

~~7.~~ [~~8.~~ 9.] Pursuant to § 63.2-1505 of the Code of Virginia, local departments may obtain and consider statewide criminal history record information from the Central Criminal Records Exchange [and the Central Registry] on any individual who is the subject of a child abuse and neglect investigation where there is evidence of child abuse or neglect and the local department is evaluating the safety of the home and whether removal is necessary to ensure the child's safety. The local department may also obtain a criminal record check [and a Central Registry check] on all adult household members residing in the home of the alleged abuser [~~and/or~~ or] neglector and where the child visits. Pursuant to § 19.2-389 of the Code of Virginia, local

departments are authorized to receive criminal history information on the person who is the subject of the investigation as well as other adult members of the household for the purposes in § 63.2-1505 of the Code of Virginia. The results of the criminal record history search may be admitted into evidence if a child abuse or neglect petition is filed in connection with the child's removal. Local departments are prohibited from dissemination of this information [~~excepted~~ except] as authorized by the Code of Virginia.

[22VAC40-705-90. Family assessment and investigative protocol.

A. In conducting a family assessment or an investigation, the child protective services ~~(CPS)~~ worker may enter the home if permitted to enter by an adult person who resides in the home. Only in those instances where the ~~CPS~~ child protective services worker has probable cause to believe that the life or health of the child would be seriously endangered within the time it would take to obtain a court order or the assistance of a law-enforcement officer, may a ~~CPS~~ child protective services worker enter the home without permission. A child protective services worker shall document in detail in the record and discuss with supervisory personnel the basis for the decision to enter the house without permission.

B. Before conducting a family assessment or investigation, the child protective services worker shall explain the responsibilities and authorities of ~~CPS~~ child protective services so that the parent or other caretaker can be made aware of the possible benefits and consequences of completing the family assessment or investigation. The explanation must be provided orally and in writing.

C. The child protective services worker may transport a child without parental consent only when the local department has assumed custody of that child by virtue of ~~72-96-hour~~ the emergency removal authority pursuant to § 63.2-1517 of the Code of Virginia, by an emergency removal court order pursuant to § 16.1-251 of the Code of Virginia, or by a preliminary removal order pursuant to § 16.1-252 of the Code of Virginia.

D. When a child protective services worker has reason to believe that the caretaker in a valid report of child abuse or neglect is abusing substances and such behavior may be related to the matter being investigated or assessed, the worker may request that person to consent to substance abuse screening or may petition the court to order such screening.

1. Local departments must develop guidelines for such screening.

2. Guidelines may include child protective services worker administration of urine screening.]

22VAC40-705-110. Assessments in family assessments and investigations.

A. In both family assessments and investigations the child protective services worker shall conduct an initial safety assessment of the child's circumstances and threat of danger or harm, and where appropriate shall make a safety plan to provide for the protection of the child.

B. In all ~~founded cases and in~~ completed family assessments and investigations, the child protective services worker shall ~~make~~ conduct a risk assessment to determine whether or not the child is in jeopardy of future abuse [~~and/or~~ or] neglect and whether or not intervention is necessary to protect the child.

C. In investigations, the child protective services worker shall make a [~~dispositional assessment~~ disposition of either founded or unfounded as defined in 22VAC40-705-10] after collecting and ~~synthesizing~~ assessing information about the alleged abuse or neglect.

D. In all investigations with a founded disposition, the child protective services worker shall assess the severity of the abuse or neglect and shall assign a level. The three levels of founded dispositions are:

1. Level 1. This level includes those injuries or conditions, real or threatened, that result in or were likely to have resulted in serious harm to a child.

2. Level 2. This level includes injuries or conditions, real or threatened, that result in or were likely to have resulted in moderate harm to a child.

3. Level 3. This level includes injuries or conditions, real or threatened, that result in or were likely to have resulted in minimal harm to a child.

22VAC40-705-120. ~~Complete the family assessment or investigation~~ Extensions [~~;~~ and] suspensions [~~; track changes; local conferences~~].

A. The local department shall promptly notify the alleged abuser [~~and/or~~ or] neglector and the alleged victim's parents or guardians of any extension of the deadline for the completion of the family assessment or investigation pursuant to ~~§ 63.2-1506 B 3 or subdivision 5 of~~ § 63.2-1505 B 5 or § 63.2-1506 B 3 of the Code of Virginia. The child protective services worker shall document the notifications and the reason for the need for additional time in the case record.

B. ~~At the completion of the family assessment, the subject of the report shall be notified orally and in writing of the results of the assessment.~~ Pursuant to § 63.2-1505 B 5 of the Code of Virginia, [~~in~~ when] an investigation involving the death of a child or alleged sexual abuse of a child [~~while waiting for records that are necessary to make a finding and the records are not available to the local department due to circumstances beyond the local department's control, the time during which the records are unavailable shall not be computed as part of the determination deadlines set out in § 63.2-1505 B 5 of the Code of Virginia~~ is delayed because of the unavailability of

the records, the deadlines shall be suspended]. When such unavailability of records occurs, the local department shall promptly notify the alleged abuser or neglector and the alleged victim's parents or guardians that the records are unavailable and the effect of the unavailability on the completion of the investigation. The child protective services worker shall document the notifications and the reason for the suspension in the case record. Upon receipt of the records necessary to make a finding, the local department shall complete the investigation.

C. The subject of the report shall be notified immediately if during the course of completing the family assessment the situation is reassessed and determined to meet the requirements, as specified in § 63.2-1506 B 7 of the Code of Virginia, to be investigated.

D. The subject of the report or complaint may consult with the local department to hear and refute evidence collected during the investigation. [~~Whenever~~ If] a criminal charge is also filed against the alleged abuser for the same conduct involving the same victim child as investigated by the local department, [~~sharing the evidence prior to the court hearing is prohibited. No~~ pursuant to § 63.2-1516.1 B of the Code of Virginia, no] information gathered during a joint investigation with law enforcement shall be released by the local department [prior to the conclusion of the criminal investigation] unless authorized by the investigating law-enforcement agency or the local attorney for the Commonwealth [~~pursuant to § 63.2-1516.1 B of the Code of Virginia~~].

[~~E. Local conference.~~

~~1. If the alleged abuser and/or neglector is found to have committed abuse or neglect, that alleged abuser and/or neglector may, within 30 days of being notified of that determination, submit a written request for an amendment of the determination and the local department's related records pursuant to § 63.2-1526 A of the Code of Virginia. The local department shall conduct an informal conference in an effort to examine the local department's disposition and reasons for it and consider additional information about the investigation and disposition presented by the alleged abuser and/or neglector.~~

~~2. The local conference shall be conducted in accordance with 22VAC40-705-190.~~]

22VAC40-705-130. [~~Report~~ Reporting of] family assessment or investigation conclusions.

A. Unfounded investigation.

~~A.~~ 1. Pursuant to § 63.2-1514 of the Code of Virginia, the local department shall report all unfounded case dispositions to the child abuse and neglect information system when disposition is made.

~~1.~~ 2. The department shall retain ~~unfounded~~ complaints or reports with an unfounded disposition in the child abuse and neglect information system to provide local departments with information regarding prior investigations.

~~2.~~ 3. This record shall be kept separate from the Central Registry and accessible only to the department and to local departments.

~~3.~~ 4. The record of the ~~unfounded case~~ investigation with an unfounded disposition shall be purged one year after the date of the complaint or report if there are no subsequent ~~founded or unfounded~~ complaints [~~and/or~~ or] reports regarding the individual against whom allegations of abuse [~~and/or~~ or] neglect were made or regarding the same child in that one year.

~~4. The record of the family assessment shall be purged three years after the date of the complaint or report if there are no subsequent complaints and/or reports regarding the individual against whom allegations of abuse and/or neglect were made or regarding the same child in those three years.~~

~~5. If the individual against whom allegations of abuse and/or neglect were made or if the same child is involved in subsequent complaints and/or reports, the information from all complaints and/or reports shall be maintained until the last purge date has been reached.~~

~~6.~~ 5. The individual against whom an unfounded disposition for allegations of abuse [~~and/or~~ or] neglect ~~were~~ was made may request in writing that the local department retain the record for an additional period of up to two years.

~~7.~~ 6. The individual against whom allegations of abuse [~~and/or~~ or] neglect were made may request in writing that both the local department and the department shall immediately purge the record ~~after a court rules~~ upon presentation of a certified copy of a court order that there has been a civil action that determined that the complaint or report was made in bad faith or with malicious intent pursuant to § 63.2-1514 of the Code of Virginia.

B. Founded investigation.

~~B.~~ 1. The local department shall report all founded ~~case~~ dispositions to the child abuse and neglect information system for inclusion in the Central Registry pursuant to ~~subdivision 5 of § 63.2-1505~~ § 63.2-1515 of the Code of Virginia ~~and 22VAC40-700-30~~.

2. Identifying information about the abuser [~~and/or~~ or] neglector and the victim child or children reported include demographic information, type of abuse or neglect, and date of the complaint.

3. The identifying information shall be retained based on the determined level of severity of the abuse or neglect pursuant to ~~the regulation dealing with retention in the Central Registry, 22VAC40-700-30~~ 22VAC40-705-110:

a. Eighteen years past the date of the complaint for all complaints determined by the local department to be founded as Level 1.

b. Seven years past the date of the complaint for all complaints determined by the local department to be founded as Level 2.

c. Three years past the date of the complaint for all complaints determined by the local department to be founded as Level 3.

4. Pursuant to § 63.2-1514 A of the Code of Virginia, all records related to founded, Level 1 dispositions of sexual abuse shall be maintained by the local department for a period of 25 years from the date of the complaint. This applies to all investigations with founded dispositions on or after July 1, 2010. This retention timeframe will not be reflected in the Central Registry past the purge dates set out in this subsection.

C. Family assessments.

1. The record of the family assessment shall be purged three years after the date of the complaint or report if there are no subsequent complaints or reports regarding the individual against whom allegations of abuse or neglect were made or regarding the same child in those three years.

2. The individual against whom allegations of abuse or neglect were made may request in writing that both the local department and the department shall immediately purge the record upon presentation of a certified copy of a court order that there has been a civil action that determined that the complaint or report was made in bad faith or with malicious intent pursuant to § 63.2-1514 of the Code of Virginia.

D. In all family assessments or investigations, if the individual against whom the allegations of abuse or neglect is involved in any subsequent complaint or report, the information from all complaints or reports shall be maintained until the last purge date has been reached.

22VAC40-705-140. Notification of findings.

A. Upon completion of the investigation or family assessment the local child protective services worker shall make notifications as provided in this section.

B. Individual against whom allegations of abuse [~~and/or~~ or] neglect were made.

1. When the disposition is unfounded, the child protective services worker shall inform the individual against whom allegations of abuse [~~and/or~~ or] neglect were made of this finding. This notification shall be in writing with a copy to be maintained in the case record. The individual against whom allegations of abuse [~~and/or~~ or] neglect were made shall be informed that he may have access to the case record and that the case record shall be retained by the local department for one year unless requested in writing by such individual that the local department retain the record for up to an additional two years.

a. If the individual against whom allegations of abuse [~~and/or~~ or] neglect were made or the subject child is involved in subsequent complaints, the information from all complaints shall be retained until the last purge date has been reached.

b. The local worker shall notify the individual against whom allegations of abuse [~~and/or~~ or] neglect were made of the procedures set forth in § 63.2-1514 of the Code of Virginia regarding reports or complaints alleged to be made in bad faith or with malicious intent.

c. ~~When~~ In accordance with § 32.1-283.1 D of the Code of Virginia when an unfounded disposition is made in an investigation that involves a child death, the child protective services worker shall inform the individual against whom allegations of abuse [~~and/or~~ or] neglect were made that the case record will be retained for the longer of 12 months or until the State Child Fatality Review Team has completed its review of the case ~~pursuant to § 32.1-283.1 D of the Code of Virginia~~.

2. When the abuser [~~and/or~~ or] neglector in a founded ~~complaint~~ disposition is a foster parent of the victim child, the local department shall place a copy of this notification letter in the child's foster care record and in the foster home provider record.

3. When the abuser or neglector in a founded disposition is a full-time, part-time, permanent, or temporary employee of a school division, the local department shall notify the relevant school board of the founded complaint pursuant to § 63.2-1505 B 7 of the Code of Virginia.

4. The local department shall notify the Superintendent of Public Instruction when an individual holding a license issued by the Board of Education is the subject of a founded complaint of child abuse or neglect and shall transmit identifying information regarding such individual if the local department knows the person holds a license issued by the Board of Education and after all rights to any appeal provided by § 63.2-1526 of the Code of Virginia have been exhausted.

~~3.~~ 5. No disposition of founded or unfounded shall be made in a family assessment. At the completion of the family assessment the subject of the report shall be notified orally and in writing of the results of the assessment. The child protective services worker shall notify the individual against whom allegations of abuse or neglect were made of the procedures set forth in § 63.2-1514 of the Code of Virginia regarding reports or complaints alleged to be made in bad faith or with malicious intent.

C. Subject child's parents or guardian.

1. When the disposition is unfounded, the child protective services worker shall inform the parents or guardian of the subject child in writing, when they are not the individuals against whom allegations of child abuse [~~and/or~~ or] neglect were made, that the ~~complaint~~ investigation involving their child ~~was determined to be~~ resulted in an unfounded disposition and the length of time the child's name and information about the case will be maintained.

The child protective services worker shall file a copy in the case record.

2. When the disposition is founded, the child protective services worker shall inform the parents or guardian of the child in writing, when they are not the abuser [~~and/or~~ or] neglector, that the complaint involving their child was determined to be founded and the length of time the child's name and information about the case will be retained in the Central Registry. The child protective services worker shall file a copy in the case record.

3. When the founded ~~case~~ disposition of abuse or neglect does not name the parents or guardians of the child as the abuser or neglector and when the abuse or neglect occurred in a licensed or unlicensed [child] day [~~care~~] center, a [~~regulated~~ licensed, registered, or approved] family day home, a private or public school, [~~a child-caring institution~~] or a [children's] residential facility [~~for juveniles~~], the parent or guardian must be consulted and must give permission for the child's name to be entered into the [~~central registry~~ Central Registry] pursuant to § 63.2-1515 of the Code of Virginia.

D. Complainant.

1. When an unfounded disposition is made, the child protective services worker shall notify the complainant, when known, in writing that the complaint was investigated and determined to be unfounded. The worker shall file a copy in the case record.

2. When a founded disposition is made, the child protective services worker shall notify the complainant, when known, in writing that the complaint was investigated and necessary action was taken. The local worker shall file a copy in the case record.

3. When a family assessment is completed, the child protective services worker shall notify the complainant, when known, that the complaint was assessed and necessary action taken.

E. Family Advocacy Program [of the United States Armed Forces].

~~When a founded disposition is made, the child protective services worker shall notify the Family Advocacy Program representative in writing as set forth in 22VAC40-720-20. When a family assessment is conducted and the family is determined to be in need of services, the child protective services worker may notify the Family Advocacy Program representative in writing as set forth in 22VAC40-720-20.~~

1. Pursuant to § 63.2-1503 N of the Code of Virginia, in all investigations with a founded disposition or family assessment that involve an active duty member of the United States Armed Forces or members of his household, information regarding the disposition, type of abuse or neglect, and the identity of the abuser or neglector shall be provided to the appropriate Family Advocacy Program representative. This notification shall be made in writing within 30 days after the administrative appeal rights of the abuser or neglector have been exhausted or forfeited.

2. The military member shall be advised that this information regarding the founded disposition or family assessment is being provided to the Family Advocacy Program representative and shall be given a copy of the written notification sent to the Family Advocacy Program representative.

3. [~~Pursuant to~~ In accordance with] § 63.2-105 of the Code of Virginia, when an active duty member of the United States Armed Forces or a member of his household is involved in an investigation, family assessment, or provision of services case, any information regarding child protective services reports, complaints, investigations, family assessments, and follow up may be shared with the appropriate Family Advocacy Program representative of the United States Armed Forces when the local department determines such release to be in the best interest of the child. In these situations, coordination between child protective services and the Family Advocacy Program is intended to facilitate identification, treatment, and service provision to the military family.

4. When needed by the Family Advocacy Program representative to facilitate treatment and service provision to the military family, any other additional information not prohibited from being released by state or federal law or regulation shall also be provided to the Family Advocacy Program representative when the local department determines such release to be in the best interest of the child.

22VAC40-705-160. Releasing information.

A. In the following instances of mandatory disclosure the local department shall release child protective services information. The local department may do so without any written release.

1. Report to attorney for the Commonwealth and law enforcement pursuant to § 63.2-1503 D of the Code of Virginia.

2. Report to the regional medical examiner's office pursuant to ~~§§ 32.1-283.1 C and~~ § 63.2-1503 E ~~F~~ of the Code of Virginia.

~~3. If a court mandates disclosure of information from a child abuse and neglect case record, the local department must comply with the request. The local department may challenge a court action for the disclosure of the case record or any contents thereof. Upon exhausting legal recourse, the local department shall comply with the court order.~~

~~4. When a family assessment or investigation is completed, the child protective services worker shall notify the complainant/reporter that either a complaint/report is unfounded or that necessary action is being taken.~~

~~5.~~ 3. Any individual, including an individual against whom allegations of child abuse [~~and/or~~ or] neglect were made, may exercise his ~~Privacy Protection Act~~ [rights under the] Government Data Collection and Dissemination Practices Act (§ 2.2-3800 et seq. of the Code of Virginia) [~~rights~~] to access personal information related to himself ~~which~~ that is contained in the case record including, with the individual's notarized consent, a search of the Central Registry ~~pursuant to § 2.2-3704 of the Code of Virginia~~.

~~6.~~ 4. When the material requested includes personal information about other individuals, the local department shall be afforded a reasonable time in which to redact those parts of the record relating to other individuals.

~~7.~~ 5. Pursuant to the Child Abuse Prevention and Treatment Act, as amended (42 USC § 5101 et seq.), and federal regulations (45 CFR Part 1340), the local department shall provide case-specific information about child abuse and neglect reports and investigations to citizen review panels when requested.

~~8.~~ 6. Pursuant to the Child Abuse Prevention and Treatment Act, as amended (42 USC § 5101 et seq.), the department shall develop guidelines to allow for public disclosure in instances of child fatality or near fatality.

~~9.~~ 7. An individual's right to access information under the ~~Privacy Protection Act~~ Government Data Collection and Dissemination Practices Act is stayed during criminal prosecution pursuant to § ~~2.2-3802~~ 63.2-1526 C of the Code of Virginia.

~~10.~~ 8. The local department shall disclose and release to the United States Armed Forces Family Advocacy Program child protective services information as required pursuant to ~~22VAC40-720-20~~ 22VAC40-705-140.

~~11.~~ 9. Child protective services shall, on request by the Division of Child Support Enforcement, supply information pursuant to § 63.2-103 of the Code of Virginia.

~~12.~~ 10. The local department shall release child protective services information to a court appointed special advocate pursuant to § 9.1-156 A of the Code of Virginia.

~~13.~~ 11. The local department shall release child protective services information to a court-appointed guardian ad litem pursuant to § 16.1-266 ~~E~~ G of the Code of Virginia.

B. The local department may use discretion in disclosing or releasing child protective services case record information, investigative and on-going services to parties having a legitimate interest when the local department deems disclosure to be in the best interest of the child. The local department may disclose such information without a court order and without a written release pursuant to § 63.2-105 of the Code of Virginia.

~~C. The local department shall not release the identity of persons reporting incidents of child abuse or neglect, unless court ordered, in accordance with § 63.2-1526 of the Code of Virginia, 42 USC § 5101 et seq., and federal regulations (45 CFR Part 1340).~~

~~D.~~ C. Prior to disclosing information to any individuals or organizations, and to be consistent with § ~~63.2-104~~ 63.2-105 of the Code of Virginia, ~~pursuant to § 63.2-1500 of the Code of Virginia,~~ the local department must ~~be satisfied that~~ consider the factors described in subdivisions 1, 2, and 3 of this subsection as some of the factors necessary to determine whether a person has a legitimate interest and the disclosure of information is in the best interest of the child:

1. The information will be used only for the purpose for which it is made available;

2. Such purpose shall be related to the goal of child protective or rehabilitative services; and

3. The confidential character of the information will be preserved to the greatest extent possible.

D. In the following instances, the local department shall not release child protective services information:

1. The local department shall not release the identity of persons reporting incidents of child abuse or neglect, unless court ordered [or as required under § 63.2-1503 D of the Code of Virginia], in accordance with § 63.2-1526 of the Code of Virginia, 42 USC § 5101 et seq., and federal regulations (45 CFR Part 1340).

2. In all complaints or reports that are being investigated jointly with law enforcement, no information shall be released by the local department [prior to the conclusion of the criminal investigation] unless authorized by the law-enforcement officer or his supervisor or the attorney for the Commonwealth pursuant to § 63.2-1516.1 B of the Code of Virginia.

22VAC40-705-180. Training.

A. The department shall implement a uniform training plan for child protective services workers and supervisors. The plan shall establish minimum standards for all child protective services workers and supervisors in the Commonwealth of Virginia.

B. Workers and supervisors shall complete skills and policy training specific to child abuse and neglect investigations and family assessments within the first two years of their employment.

C. All child protective services workers and supervisors shall complete a minimum of 24 contact hours of continuing education or training annually. This requirement begins after completion of initial training mandates [~~and no later than three years from the date of hire~~].

[22VAC40-705-190. Appeals.

A. Appeal is the process by which the abuser ~~and/or~~ or neglector may request amendment of the record when the investigation into the complaint has resulted in a founded disposition of child abuse ~~and/or~~ or neglect.

B. If the alleged abuser ~~and/or~~ or neglector is found to have committed abuse or neglect, that alleged abuser ~~and/or~~ or neglector may, within 30 days of being notified of that determination, submit a written request for an amendment of the determination and the local department's related records, pursuant to § 63.2-1526 A of the Code of Virginia. The local department shall conduct an informal conference in an effort to examine the local department's disposition and reasons for it and consider additional information about the investigation and disposition presented by the alleged abuser ~~and/or~~ or neglector. The local department shall notify the child abuse and neglect information system that an appeal is pending.

C. Whenever an appeal is requested and a criminal charge is also filed against the appellant for the same conduct involving the same victim child as investigated by the local department, the appeal process shall be stayed until the criminal prosecution in circuit court is completed pursuant to § 63.2-1526 C of the Code of Virginia. During such stay, the appellant's right of access to the records of the local department regarding the matter being appealed shall also be stayed. Once the criminal prosecution in circuit court has been completed, the local department shall advise the appellant in writing of his right to resume his appeal within the ~~time frames~~ timeframe provided by law and regulation pursuant to § 63.2-1526 C of the Code of Virginia.

D. The local department shall conduct an informal, local conference and render a decision on the appellant's request to amend the record within 45 days of receiving the request. If the local department either refuses the appellant's request for amendment of the record as a result of the local conference, or if the local department fails to act within 45 days of receiving such request, the appellant may, within 30 days thereafter and in writing, request the commissioner for an administrative hearing pursuant to § 63.2-1526 A of the Code of Virginia.

E. The appellant may request, in writing, an extension of the 45-day requirement for a specified period of time, not to exceed an additional 60 days. When there is an extension period, the 30-day ~~time frame~~ timeframe to request an administrative hearing from the Commissioner of the Department of Social Services shall begin on the termination of the extension period pursuant to § 63.2-1526 A of the Code of Virginia.

F. Upon written request, the local department shall provide the appellant all information used in making its determination. Disclosure of the reporter's name or information which may endanger the well-being of a child shall not be released. The identity of collateral witnesses or any other person shall not be released if disclosure may endanger their life or safety. Information prohibited from being disclosed by state or federal law or regulation shall not be released. In case of any information withheld, the appellant shall be advised of the general nature of the information and the reasons, of privacy or otherwise, that it is being withheld, pursuant to § 63.2-1526 A of the Code of Virginia.

G. The director of the local department, or a designee of the director, shall preside over the local conference. With the exception of the director of the local department, no person whose regular duties include substantial involvement with child abuse and neglect cases shall preside over the local conference pursuant to § 63.2-1526 A of the Code of Virginia.

1. The appellant may be represented by counsel pursuant to § 63.2-1526 A of the Code of Virginia.

2. The appellant shall be entitled to present the testimony of witnesses, documents, factual data, arguments or other submissions of proof pursuant to § 63.2-1526 A of the Code of Virginia.

3. The director of the local department, or a designee of the director, shall notify the appellant, in writing, of the results of the local conference within 45 days of receipt of the written request from the appellant unless the ~~time frame~~ timeframe has been extended as described in subsection E of this section. The director of the local department, or the designee of the director, shall have the authority to sustain, amend, or reverse the local department's findings. Notification of the results of the local conference shall be mailed, certified with return receipt, to the appellant. The local department shall notify the child abuse and neglect information system of the results of the local conference.

H. If the appellant is unsatisfied with the results of the local conference, the appellant may, within 30 days of receiving notice of the results of the local conference, submit a written request to the commissioner for an administrative hearing pursuant to § 63.2-1526 B of the Code of Virginia.

1. The commissioner shall designate a member of his staff to conduct the proceeding pursuant to § 63.2-1526 B of the Code of Virginia.

2. A hearing officer shall schedule a hearing date within 45 days of the receipt of the appeal request unless there are delays due to subpoena requests, depositions or scheduling problems.

3. After a party's written motion and showing good cause, the hearing officer may issue subpoenas for the production of documents or to compel the attendance of witnesses at the hearing. The victim child and that child's siblings shall not be subpoenaed, deposed or required to testify, pursuant to § 63.2-1526 B of the Code of Virginia.

4. Upon petition, the juvenile and domestic relations district court shall have the power to enforce any subpoena that is not complied with or to review any refusal to issue a subpoena. Such decisions may not be further appealed except as part of a final decision that is subject to judicial review pursuant to § 63.2-1526 B of the Code of Virginia.

5. Upon providing reasonable notice to the other party and the hearing officer, a party may, at his own expense,

depose a nonparty and submit that deposition at, or prior to, the hearing. The victim child and the child's siblings shall not be deposed. The hearing officer is authorized to determine the number of depositions that will be allowed pursuant to § 63.2-1526 B of the Code of Virginia.

6. The local department shall provide the hearing officer a copy of the investigation record prior to the administrative hearing. By making a written request to the local department, the appellant may obtain a copy of the investigation record. The appellant shall be informed of the procedure by which information will be made available or withheld from him.

In any case of information withheld, the appellant shall be advised of the general nature of the information and the reasons that it is being withheld pursuant to § 63.2-1526 B of the Code of Virginia.

7. The appellant and the local department may be represented by counsel at the administrative hearing.

8. The hearing officer shall administer an oath or affirmation to all parties and witnesses planning to testify at the hearing pursuant to § 63.2-1526 B of the Code of Virginia.

9. The local department shall have the burden to show that the preponderance of the evidence supports the founded disposition. The local department shall be entitled to present the testimony of witnesses, documents, factual data, arguments or other submissions of proof.

10. The appellant shall be entitled to present the testimony of witnesses, documents, factual data, arguments or other submissions of proof.

11. The hearing officer may allow either party to submit new or additional evidence at the administrative hearing if it is relevant to the matter being appealed.

12. The hearing officer shall not be bound by the strict rules of evidence. However, the hearing officer shall only consider that evidence, presented by either party, which is substantially credible or reliable.

13. The hearing officer may allow the record to remain open for a specified period of time, not to exceed 14 days, to allow either party to submit additional evidence unavailable for the administrative hearing.

14. In the event that new or additional evidence is presented at the administrative hearing, the hearing officer may remand the case to the local department for reconsideration of the findings. If the local department fails to act within 14 days or fails to amend the findings to the satisfaction of the appellant, then the hearing officer shall render a decision, pursuant to § 63.2-1526 B of the Code of Virginia.

I. Within 60 days of the close of receiving evidence, the hearing officer shall render a written decision. The hearing officer shall have the authority to sustain, amend, or reverse the local department's findings. The written decision of the hearing officer shall state the findings of fact, conclusions based on regulation and policy, and the final disposition. The decision will be sent to the appellant by certified mail, return receipt requested. Copies of the decision shall be mailed to the appellant's counsel, the local department and the local department's counsel. The hearing officer shall notify the child abuse and neglect information system of the hearing decision. The local department shall notify all other prior recipients of the record of the findings of the hearing officer's decision.

J. The hearing officer shall notify the appellant of the appellant's further right of review in circuit court in the event that the appellant is not satisfied with the written decision of the hearing officer. Appeals are governed by Part 2A of the Rules of the Supreme Court of Virginia. The local department shall have no further right of review pursuant to § 63.2-1526 B of the Code of Virginia.

K. In the event that the hearing officer's decision is appealed to circuit court, the department shall prepare a transcript for that proceeding. That transcript or narrative of the evidence shall be provided to the circuit court along with the complete hearing record. If a court reporter was hired by the appellant, the court reporter shall prepare the transcript and provide the court with a transcript.]

VA.R. Doc. No. R13-3636; Filed April 17, 2017, 11:21 a.m.

EXECUTIVE ORDER NUMBER 64 (2017)

ADVANCING VIRGINIA'S PRESERVATION STEWARDSHIP

Importance of the Issue

Building upon the celebration of the 50th anniversary in 2016 of both the National Historic Preservation Act and the establishment of the Virginia Historic Landmarks Commission, the predecessor organization to the Department of Historic Resources, the Commonwealth has the opportunity and responsibility to renew and strengthen its commitment to historic preservation.

The Commonwealth's real estate holdings include a rich and diverse collection of properties with historic, architectural, archaeological, and cultural significance—some of national and international importance. The economic and social vitality of communities throughout Virginia is enhanced by the maintenance and renovation of these and other historic resources. Preserving our past is a cornerstone for Virginia's New Economy. Further, reinvestment in the Commonwealth's historic buildings promotes environmental sustainability and energy efficiency, resulting in less waste and lower expenditures of taxpayer dollars.

Meanwhile, new threats to historic resources are emerging. Climate change and impacts such as sea level rise pose significant threats to historic resources, and now is the perfect time for state agencies to assess and address these threats.

Numerous laws and regulations already direct state agencies to consider impacts to historic properties owned by the Commonwealth and to consult with the Department of Historic Resources. This includes provisions dealing with major state projects (§ 10.1-1188), the sale or lease of surplus state property (§ 2.2-1156), and proposed demolition of state property (§ 2.2-2402). Moreover, state agencies are required by the Biennial Budget Bill (§ 4-4.01 (q)) to consider the impact of projects that may directly affect state-owned properties listed in the Virginia Landmarks Register (VLR). It is important that we reaffirm these provisions and act to ensure adequate stewardship of our historic resources.

The Department of Historic Resources is directed by law (§ 10.1-2202.3) to prepare a biennial report on the stewardship of state-owned property that identifies significant state-owned properties that are eligible for listing on the VLR but are not yet listed landmarks. The 2015 report lists 13 state-owned properties, including nine associated with institutions of higher education that could and should be listed. Four of those significant properties have since been listed, but a higher success rate would reflect the level of commitment earned by our Commonwealth's storied past.

Accordingly, by virtue of the authority vested in me as Governor under Article V of the Constitution of Virginia and under the laws of the Commonwealth, and in order to effectuate Article XI, section 1 of Virginia's Constitution and numerous laws of the Commonwealth, I hereby direct all executive branch agencies, authorities, departments, and all institutions of higher education to work with the Director of the Department of Historic Resources to recognize the value of their historic resources, to take steps to preserve and utilize these resources, and to maintain the legacy entrusted to them by the public.

Scope and Guidance

In carrying out this order, the Department of Historic Resources (DHR) shall continue to provide leadership, technical expertise, and guidance to help state agencies, authorities, departments, and institutions of higher learning improve stewardship of historic properties they own or control. In addition, state agencies, authorities, departments, and institutions of higher learning are encouraged to, in coordination with the Director of DHR:

(1) Pursue listing on the VLR historically significant properties they own or control, including conducting the necessary research and analysis to prepare VLR nominations, so that these resources can be recorded for the education and enjoyment of all. This shall be an ongoing responsibility, and special effort should be made to add certain types of properties that are under-represented on the VLR, especially those related to institutions of higher education and the history of African Americans, Virginia Indians, and women;

(2) Celebrate the historic sites in their ownership by using the state's highway marker program, which helps educate the public about Virginia's rich history and promotes tourism in the Commonwealth;

(3) Prepare treatment plans, historic structure reports, and preservation master plans to guide stewardship of historic properties they own or control, and integrate the management of such properties into strategic and master plans, in order to ensure proper maintenance, rehabilitation, and active use of properties listed on or eligible for listing on the VLR;

(4) Explore long term leases and resident curator agreements for vacant state-owned historic buildings or other structures, thereby leveraging private investment in the rehabilitation and maintenance of under-utilized resources;

(5) Proactively pursue energy efficiency measures and address deferred maintenance backlogs as outlined in Executive Order No. 31, with the goal of preservation and conservation.

Effective Date of the Executive Order

This Executive Order shall be effective upon its signing and shall remain in force and effect until rescinded by further executive order.

Given under my hand and under the Seal of the Commonwealth of Virginia, this 28th day of April, 20l7.

/s/ Terence R. McAuliffe
Governor

AIR POLLUTION CONTROL BOARD

Notice of Periodic Review and Small Business Impact Review

Pursuant to Executive Order 17 (2014) and §§ 2.2-4007.1 and 2.2-4017 of the Code of Virginia, the Department of Environmental Quality, on behalf of the Air Pollution Control Board, is conducting a periodic review and small business impact review of **9VAC5-5, Public Participation Guidelines**. The review of this regulation will be guided by the principles in Executive Order 17 (2014).

The purpose of this review is to determine whether this regulation should be repealed, amended, or retained in its current form. Public comment is sought on the review of any issue relating to this regulation, including whether the regulation (i) is necessary for the protection of public health, safety, and welfare or for the economical performance of important governmental functions; (ii) minimizes the economic impact on small businesses in a manner consistent with the stated objectives of applicable law; and (iii) is clearly written and easily understandable.

The comment period begins May 15, 2017, and ends June 5, 2017.

Comments may be submitted online to the Virginia Regulatory Town Hall at http://www.townhall.virginia.gov/L/Forums.cfm. Comments may also be sent to Melissa Porterfield, Office of Regulatory Affairs, Department of Environmental Quality, P.O. Box 1105, Richmond, VA 23218, telephone (804) 698-4238, FAX (804) 698-4019, or email melissa.porterfield@deq.virginia.gov.

Comments must include the commenter's name and address (physical or email) information in order to receive a response to the comment from the agency. Following the close of the public comment period, a report of both reviews will be posted on the Town Hall and a report of the small business impact review will be published in the Virginia Register of Regulations.

DEPARTMENT OF ENVIRONMENTAL QUALITY

Gardy's Mill Solar, LLC Notice of Intent for Small Renewable Energy (Solar) Project Permit by Rule - Westmoreland County

Gardy's Mill Solar, LLC, has provided the Department of Environmental Quality with a notice of intent to submit the necessary documentation for a permit by rule for a small renewable energy (solar) project. The proposed project will be located in Westmoreland County along Gardy's Mill Road near Gray's Corner. The project will have a maximum generating capacity of 11 megawatts alternating current (AC) across roughly 197 acres on multiple parcels and will connect to the grid through distribution powerlines that run along Gardy's Mill road.

Contact Information: Mary E. Major, Department of Environmental Quality, 629 East Main Street, P.O. Box 1105, Richmond, VA 23218, telephone (804) 698-4423, FAX (804) 698-4510, or email mary.major@deq.virginia.gov.

Mt. Jackson Solar I, LLC Notice of Intent for Small Renewable Energy (Solar) Project Permit by Rule - Shenandoah County

Mt. Jackson Solar I, LLC has provided the Department of Environmental Quality a notice of intent to submit the necessary documentation for a permit by rule for a small renewable solar energy project in Mount Jackson. The project will be located on 512 acres across multiple parcels on land west of Turkey Knob Road, north of Wissler Road, south of Walker Road, and east of Georgetown Road. The solar project conceptually consists of approximately 66,000 335-watt panels plus six 2.7-megawatt inverters that will provide a maximum 15.65 megawatts of nameplate capacity.

Contact Information: Mary E. Major, Department of Environmental Quality, 629 East Main Street, P.O. Box 1105, Richmond, VA 23218, telephone (804) 698-4423, FAX (804) 698-4510, or email mary.major@deq.virginia.gov.

Notice of Periodic Review and Small Business Impact Review

Pursuant to Executive Order 17 (2014) and §§ 2.2-4007.1 and 2.2-4017 of the Code of Virginia, the Department of Environmental Quality is conducting a periodic review and small business impact review of **9VAC15-11, Public Participation Guidelines**. The review of this regulation will be guided by the principles in Executive Order 17 (2014).

The purpose of this review is to determine whether this regulation should be repealed, amended, or retained in its current form. Public comment is sought on the review of any issue relating to this regulation, including whether the regulation (i) is necessary for the protection of public health, safety, and welfare or for the economical performance of important governmental functions; (ii) minimizes the economic impact on small businesses in a manner consistent with the stated objectives of applicable law; and (iii) is clearly written and easily understandable.

The comment period begins May 15, 2017, and ends June 5, 2017.

Comments may be submitted online to the Virginia Regulatory Town Hall at http://www.townhall.virginia.gov/L/Forums.cfm. Comments may also be sent to Melissa Porterfield, Office of Regulatory Affairs, Department of Environmental Quality, P.O. Box 1105, Richmond, VA 23218, telephone (804) 698-4238, FAX

(804) 698-4019, or email melissa.porterfield@deq.virginia.gov.

Comments must include the commenter's name and address (physical or email) information in order to receive a response to the comment from the agency. Following the close of the public comment period, a report of both reviews will be posted on the Town Hall and a report of the small business impact review will be published in the Virginia Register of Regulations.

VIRGINIA LOTTERY

Director's Orders

The following Director's Orders of the Virginia Lottery were filed with the Virginia Registrar of Regulations on April 26, 2017. The orders may be viewed at the Virginia Lottery, 600 East Main Street, Richmond, Virginia, or at the office of the Registrar of Regulations, 201 North 9th Street, 2nd Floor, Richmond, Virginia.

Director's Order Number Fifty (17)

Virginia Lottery's "2017 RIR Torque Club Ticket Giveaway" Promotion Final Rules for Operation (effective April 29, 2017)

Director's Order Number Fifty-Four (17)

Certain Virginia Instant Game Lotteries; End of Games.

In accordance with the authority granted by §§ 2.2-4002 B 15 and 58.1-4006 A of the Code of Virginia, I hereby give notice that the following Virginia Lottery instant games will officially end at midnight on April 21, 2017:

Game 1739	2017
Game 1716	Tripling Bonus Crossword
Game 1715	5X The Money (TOP)
Game 1705	Amazing 8's (TOP)
Game 1698	Lucky Loot Tripler (TOP)
Game 1686	Triple Play
Game 1684	Hot Winnings
Game 1680	Hog Mania
Game 1645	Jacks Are Wild (TOP)
Game 1635	10X The Money (TOP)
Game 1633	Bonus Ball Bingo
Game 1624	Blackjack
Game 1576	$3,000,000 Fortune
Game 1571	Cash Blast
Game 1563	$5,000 Bankroll (TOP)
Game 1561	$2,500,000 Cash Windfall
Game 1472	$4,000,000 Mega Multiplier (TOP)

The last day for lottery retailers to return for credit unsold tickets from any of these games will be June 5, 2017. The last day to redeem winning tickets for any of these games will be October 18, 2017, 180 days from the declared official end of the game. Claims for winning tickets from any of these games will not be accepted after that date. Claims that are mailed and received in an envelope bearing a postmark of the United States Postal Service or another sovereign nation of October 18, 2017, or earlier, will be deemed to have been received on time. This notice amplifies and conforms to the duly adopted State Lottery Board regulations for the conduct of lottery games.

This Director's Order becomes effective on April 13, 2017, and shall remain in full force and effect unless amended or rescinded by further Director's Order.

Director's Order Number Fifty-Five (17)

Virginia Lottery's "2017 VIP NASCAR® Awards Banquet Giveaway Promotion" Final Rules for Operation (effective April 29, 2017)

Director's Order Number Fifty-Six (17)

Virginia Lottery's Computer-Generated Game "Print 'n Play Bonus Bingo" Final Rules for Game Operation (This Director's Order is effective nunc pro tunc to April 9, 2017, and shall remain in full force and effect unless amended or rescinded by further Director's Order)

Director's Order Number Fifty-Seven (17)

Virginia Lottery's Computer-Generated Game "Print 'n Play $50,000 Blackjack" Final Rules for Game Operation (This Director's Order is effective nunc pro tunc to April 9, 2017, and shall remain in full force and effect unless amended or rescinded by further Director's Order)

Director's Order Number Fifty-Eight (17)

Virginia Lottery's Computer-Generated Game "Print 'n Play Blackjack" Final Rules for Game Operation (This Director's Order is effective nunc pro tunc to April 9, 2017, and shall remain in full force and effect unless amended or rescinded by further Director's Order)

Director's Order Number Fifty-Nine (17)

Virginia Lottery's Computer-Generated Game "Print 'n Play Daily Crossword" Final Rules for Game Operation (This Director's Order is effective nunc pro tunc to April 9, 2017, and shall remain in full force and effect unless amended or rescinded by further Director's Order)

Director's Order Number Sixty (17)

Virginia Lottery's Computer-Generated Game "Print 'n Play Diamond Club Crossword" Final Rules for Game Operation (This Director's Order is effective nunc pro tunc to April 9, 2017, and shall remain in full force and effect unless amended or rescinded by further Director's Order)

Director's Order Number Sixty-One (17)

Virginia Lottery's Computer-Generated Game "Print 'n Play Gold Rush Crossword" Final Rules for Game Operation (This Director's Order is effective nunc pro tunc to April 9, 2017, and shall remain in full force and effect unless amended or rescinded by further Director's Order)

Director's Order Number Sixty-Two (17)

Virginia Lottery's Computer-Generated Game "Print 'n Play High Roller Bingo" Final Rules for Game Operation (This Director's Order is effective nunc pro tunc to April 9, 2017, and shall remain in full force and effect unless amended or rescinded by further Director's Order)

Director's Order Number Sixty-Three (17)

Virginia Lottery's Computer-Generated Game "Print 'n Play Hot 'n Spicy Bingo" Final Rules for Game Operation (This Director's Order is effective nunc pro tunc to April 9, 2017, and shall remain in full force and effect unless amended or rescinded by further Director's Order)

Director's Order Number Sixty-Four (17)

Virginia Lottery's Computer-Generated Game "Print 'n Play Safari Bingo" Final Rules for Game Operation (This Director's Order is effective nunc pro tunc to April 9, 2017, and shall remain in full force and effect unless amended or rescinded by further Director's Order)

Director's Order Number Sixty-Five (17)

Virginia Lottery's Computer-Generated Game "Print 'n Play Smokin Hot Crossword" Final Rules for Game Operation (This Director's Order is effective nunc pro tunc to April 9, 2017, and shall remain in full force and effect unless amended or rescinded by further Director's Order)

Director's Order Number Sixty-Six (17)

Certain Virginia Print 'n Play Games; End of Games.

Virginia Lottery's Print 'n Play Blackjack Classic (167 16);

Virginia Lottery's Print 'n Play Bullseye Bingo (168 16);

Virginia Lottery's Print 'n Play Extreme Crossword (127 16);

Virginia Lottery's Print 'n Play Gold Bar Bingo (130 16);

Virginia Lottery's Print 'n Play High Stakes Blackjack (131 16);

Virginia Lottery's Print 'n Play Horoscope Crossword (169 16);

Virginia Lottery's Print 'n Play Lucky Bingo (133 16);

Virginia Lottery's Print 'n Play Money Bag Crossword (170 16);

Virginia Lottery's Print 'n Play Platinum Crossword (128 16);

Virginia Lottery's Print 'n Play Rockin' Bingo (171 16)

(This Director's Order is effective nunc pro tunc to April 8, 2017, and shall remain in full force and effect unless amended or rescinded by further Director's Order)

Director's Order Number Seventy-Six (17)

Virginia Lottery's Scratch Game 1788 "Triple Your Money" Final Rules for Game Operation (effective April 24, 2017)

Director's Order Number Seventy-Seven (17)

Virginia Lottery's Scratch Game 1781 "20X The Money" Final Rules for Game Operation (effective April 24, 2017)

Director's Order Number Seventy-Eight (17)

Virginia's Computer-Generated Lottery Game "Bank A Million" Final Rules for Game Operation (This Director's Order becomes effective on April 24, 2017, fully replaces any and all Virginia Lottery "Bank A Million" Game Rules, and shall remain in full force and effect unless amended or rescinded by further Director's Order)

BOARD OF MEDICAL ASSISTANCE SERVICES

Notice of Intent to Amend the Virginia State Plan for Medical Assistance (Pursuant to § 1902(a)(13) of the Social Security Act (42 USC § 1396a(a)(13)))

The Virginia Department of Medical Assistance Services (DMAS) hereby affords the public notice of its intention to amend the Virginia State Plan for Medical Assistance to provide for changes to the Methods and Standards for Establishing Payment Rates for Long-Term Care (12VAC30-90).

This notice is intended to satisfy the requirements of 42 CFR 447.205 and of § 1902(a)(13) of the Social Security Act, 42 USC § 1396a(a)(13). A copy of this notice is available for public review from William Lessard, Provider Reimbursement Division, Department of Medical Assistance Services, 600 Broad Street, Suite 1300, Richmond, VA 23219. This notice also is available for public review on the Virginia Regulatory Town Hall on the General Notices page at https://townhall.virginia.gov/L/generalnotice.cfm.

DMAS is specifically soliciting input from stakeholders, providers, and beneficiaries on the potential impact of the proposed change in reimbursement for nursing facilities in the event of a disaster. Comments or inquiries may be submitted, in writing, within 30 days of this notice publication to Mr. Lessard and such comments are available for review at his address. Comments may also be submitted, in writing, on the

Virginia Regulatory Town Hall public comment forum at http://townhall.virginia.gov/L/Forums.cfm.

Reimbursement Changes Affecting Long-Term Care (12VAC30-90)

The Centers for Medicare and Medicaid Services announced a final rule in November 2016 entitled "Emergency Preparedness" (42 CFR 483.73) that requires long-term care facilities to establish and maintain an emergency preparedness program.

DMAS is submitting a state plan amendment to clarify reimbursement provisions relating to reimbursement to a disaster struck nursing facility. The disaster struck facility may continue to be reimbursed at the current rate for the evacuated individuals for up to 30 calendar days.

There will be no change in reimbursement to nursing facilities.

Contact Information: Emily McClellan, Regulatory Manager, Division of Policy and Research, Department of Medical Assistance Services, 600 East Broad Street, Suite 1300, Richmond, VA 23219, telephone (804) 371-4300, FAX (804) 786-1680, TDD (800) 343-0634, or email emily.mcclellan@dmas.virginia.gov.

STATE WATER CONTROL BOARD

Proposed Enforcement Action for Solenis, LLC

An enforcement action has been proposed for Solenis, LLC for violations of the State Water Control Law in Courtland, Virginia. A description of the proposed action is available at the Department of Environmental Quality office named below or online at www.deq.virginia.gov. Jennifer Coleman will accept comments by email at jennifer.coleman@deq.virginia.gov, FAX at (757) 518-2009, or postal mail at Department of Environmental Quality, Tidewater Regional Office, 5636 Southern Boulevard, Virginia Beach, VA 23462, from May 15, 2017, to June 14, 2017.

Correction to Public Notice - Public Comment Period Corrected for Old Trail Creekside IV, LLC

An enforcement action has been proposed for Old Trail Creekside IV, LLC, for violations at Old Trail Creekside Phase III in Albemarle County, Virginia. The State Water Control Board proposes to issue a consent order to Old Trail Creekside IV, LLC, to address noncompliance with State Water Control Law. A description of the proposed action is available at the Department of Environmental Quality office named below or online at www.deq.virginia.gov. Tamara Ambler will accept comments by email at tamara.ambler@deq.virginia.gov, FAX at (540) 574-7878, or postal mail at Department of Environmental Quality, Valley Regional Office, P.O. Box 3000, Harrisonburg, VA 22801, from April 17, 2017, to May 17, 2017.

Correction to Public Notice - Public Comment Period Corrected for PM Properties, Inc.

An enforcement action has been proposed for PM Properties, Inc. for violations at a facility in Verona, Virginia. The State Water Control Board proposes to issue a consent order to PM Properties, Inc. to address noncompliance with State Water Control Law. A description of the proposed action is available at the Department of Environmental Quality office named below or online at www.deq.virginia.gov. Tamara Ambler will accept comments by email at tamara.ambler@deq.virginia.gov, FAX at (540) 574-7878, or postal mail at Department of Environmental Quality, Valley Regional Office, P.O. Box 3000, Harrisonburg, VA 22801, from April 17, 2017, to May 17, 2017.

Notice of Periodic Review and Small Business Impact Review

Pursuant to Executive Order 17 (2014) and §§ 2.2-4007.1 and 2.2-4017 of the Code of Virginia, the Department of Environmental Quality, on behalf of the State Water Control Board, is conducting a periodic review and small business impact review of **9VAC25-11, Public Participation Guidelines**. The review of this regulation will be guided by the principles in Executive Order 17 (2014).

The purpose of this review is to determine whether this regulation should be repealed, amended, or retained in its current form. Public comment is sought on the review of any issue relating to this regulation, including whether the regulation (i) is necessary for the protection of public health, safety, and welfare or for the economical performance of important governmental functions; (ii) minimizes the economic impact on small businesses in a manner consistent with the stated objectives of applicable law; and (iii) is clearly written and easily understandable.

The comment period begins May 15, 2017, and ends June 5, 2017.

Comments may be submitted online to the Virginia Regulatory Town Hall at http://www.townhall.virginia.gov/L/Forums.cfm. Comments may also be sent to Melissa Porterfield, Office of Regulatory Affairs, Department of Environmental Quality, P.O. Box 1105, Richmond, VA 23218, telephone (804) 698-4238, FAX (804) 698-4019, or email melissa.porterfield@deq.virginia.gov.

Comments must include the commenter's name and address (physical or email) information in order to receive a response to the comment from the agency. Following the close of the public comment period, a report of both reviews will be posted on the Town Hall and a report of the small business impact review will be published in the Virginia Register of Regulations.

Water Quality Management Planning Regulation for the Roanoke River Basin Non-Total Maximum Daily Load Wasteload Allocation

The State Water Control Board (board) seeks written and oral comments from interested persons on proposed amendments to the Water Quality Management Planning Regulation (WQMP) for the Roanoke River Basin non-TMDL wasteload allocation. The board is seeking public comment through the Department of Environmental Quality (DEQ).

State mandate in § 62.1-44.15 of the Code of Virginia is the source of legal authority identified to promulgate this modification. The promulgating entity is the board. The scope and purpose of the State Water Control Law is to protect and to restore the quality of state waters, to safeguard clean waters from pollution, to prevent and to reduce pollution and to promote water conservation. The State Water Control Law in subdivision 10 of § 62.1-44.15 of the Code of Virginia mandates the board to adopt such regulations as it deems necessary to enforce the general water quality management program of the board in all or part of the Commonwealth. In addition, subdivision 14 of § 62.1-44.15 requires the board to establish requirements for the treatment of sewage, industrial wastes, and other wastes that are consistent with the purposes of this chapter. The specific effluent limits needed to meet the water quality goals are discretionary.

The proposed amendments are to 9VAC25-720-80 B and would modify the existing wasteload allocation for the South Hill Waste Water Treatment Plant (WWTP) (VA0069337), located in the Roanoke River Basin. The current WQMP was adopted by the Board at its August 31, 2004 meeting. As dictated in the WQMP, the South Hill WWTP is currently limited by an April through November, $CBOD_5$ wasteload allocation of 60.6 kg/d. The basis of the limit was a stream analysis and modeling effort conducted in 1991. In 1978, the Steady State CBOXYSAG model was calibrated and verified the South Hill discharge to Flat Creek. To be consistent with previous modeling efforts, the CBOXYSAG model was executed to generate effluent limits. The Virginia Pollutant Discharge Elimination System (VPDES) permit includes an expanded design flow of 3 MGD and corresponding seasonal limits for $CBOD_5$ and TKN. The basis of these limits is the utilization of the Regional Model for Free Flowing Streams Version 4.10. In order to be consistent with previous modeling efforts, the same parameters were used in the updated modeling software.

DEQ staff intends to recommend that the board adopt the following modification for 9VAC25-720-80 B, for the South Hill WWTP (VA0069337): revise the $CBOD_5$, Apr-Nov wasteload allocation of 60.6 kg/d to $CBOD_5$, Apr-Nov – 113.5 kg/d; and add $CBOD_5$, Dec-Mar – 204 kg/d; TKN, Apr-Nov – 45 kg/d; and TKN, Dec-Mar – 56.8 kg/d.

A public meeting on the proposed modification to the WQMP will be held on Monday, May 22, 2017, at 10 a.m. at the DEQ Blue Ridge Regional Office, 3019 Peters Creek Road, Roanoke, VA 24019. In the case of inclement weather, the alternate date for the public meeting will be Wednesday, May 24, 2017, at 10 a.m.

The public comment period begins May 22, 2017, and ends June 23, 2017. An advisory committee to assist in the modification of the WQMP will not be established. However, public comment on the use of an advisory committee is invited. Persons requesting the agency use an advisory committee and those interested in assisting should notify the DEQ contact person by the end of the comment period and provide their name, address, phone number, email address and the organization (if any) they are representing. Notification of the composition of the panel will be sent to all applicants.

Please note, all written comments should include the name, address, and telephone number of the person submitting the comments and should be sent to the DEQ contact person Amanda Gray, Department of Environmental Quality, 3019 Peters Creek Road, Roanoke, VA 24019, telephone (434) 582-6227, or email amanda.gray@deq.virginia.gov.

Total Maximum Daily Load Implementation Plan for the Little Calfpasture River

The Department of Environmental Quality (DEQ) and the Department of Conservation and Recreation (DCR) seek written and oral comments from interested persons on the development of a total maximum daily load (TMDL) implementation plan (IP) for the Little Calfpasture River in Rockbridge County. The draft TMDL Implementation Plan for the Little Calfpasture River can be found here at http://www.deq.virginia.gov/Programs/Water/WaterQualityInformationTMDLs/TMDL/TMDLImplementation/TMDLImplementationPlans.aspx.

The Little Calfpasture River was listed on the 1996 § 303(d) TMDL Priority List and Report as impaired due to violations of the state's general (benthic) standard for aquatic life. This impairment extends for 0.82 miles from the Lake Merriweather Dam to the confluence with the Maury River.

Section 303(d) of the Clean Water Act and § 62.1-44.19:7 C of the Code of Virginia require DEQ to develop TMDLs for pollutants responsible for each impaired water contained in Virginia's § 303(d) TMDL Priority List and Report. In addition, § 62.1-44.19:7 C of the Code of Virginia requires expeditious implementation of total maximum daily loads when appropriate. The IP should provide measurable goals and the date of expected achievement of water quality objectives. The IP should also include the corrective actions needed and their associated costs, benefits, and environmental impacts. DEQ completed a benthic TMDL for the Little Calfpasture River in January 2009. The TMDL was approved by the Environmental Protection Agency in April 2010. The TMDL report is available on the DEQ website at

http://www.deq.virginia.gov/Programs/Water/WaterQualityInformationTMDLs/TMDL/TMDLDevelopment/ApprovedTMDLReports.aspx.

The Virginia Department of Environmental Quality will host a public meeting to wrap up the development of a TMDL Implementation Plan for the Little Calfpasture River on Thursday, May 18, 2017, at 7 p.m. at the Goshen Volunteer Fire Hall, 9696 Maury River Road, Goshen, VA.

A 30-day public comment period for the meeting begins May 19, 2017, and ends June 19, 2017. Written comments should include the name, address, and telephone number of the person submitting the comments and should be sent to Nesha McRae, Department of Environmental Quality, P.O. Box 3000, Harrisonburg, VA 22801, telephone (540) 574-7850, or email nesha.mcrae@deq.virginia.gov.

VIRGINIA WASTE MANAGEMENT BOARD

Notice of Periodic Review and Small Business Impact Review

Pursuant to Executive Order 17 (2014) and §§ 2.2-4007.1 and 2.2-4017 of the Code of Virginia, the Department of Environmental Quality, on behalf of the Virginia Waste Management Board, is conducting a periodic review and small business impact review of **9VAC 20-11, Public Participation Guidelines**. The review of this regulation will be guided by the principles in Executive Order 17 (2014).

The purpose of this review is to determine whether this regulation should be repealed, amended, or retained in its current form. Public comment is sought on the review of any issue relating to this regulation, including whether the regulation (i) is necessary for the protection of public health, safety, and welfare or for the economical performance of important governmental functions; (ii) minimizes the economic impact on small businesses in a manner consistent with the stated objectives of applicable law; and (iii) is clearly written and easily understandable.

The comment period begins May 15, 2017, and ends June 5, 2017.

Comments may be submitted online to the Virginia Regulatory Town Hall at http://www.townhall.virginia.gov/L/Forums.cfm. Comments may also be sent to Melissa Porterfield, Office of Regulatory Affairs, Department of Environmental Quality, P.O. Box 1105, Richmond, VA 23218, telephone (804) 698-4238, FAX (804) 698-4019, or email melissa.porterfield@deq.virginia.gov.

Comments must include the commenter's name and address (physical or email) information in order to receive a response to the comment from the agency. Following the close of the public comment period, a report of both reviews will be posted on the Town Hall and a report of the small business impact review will be published in the Virginia Register of Regulations.

VIRGINIA CODE COMMISSION

Notice to State Agencies

Contact Information through Thursday, June 15, 2017: *Mailing Address:* Virginia Code Commission, General Assembly Building, 201 North 9th Street, 2nd Floor, Richmond, VA 23219; *Telephone:* Voice (804) 786-3591; *Email:* varegs@dls.virginia.gov.

New Contact Information beginning Monday, June 19, 2017: *Mailing Address:* Virginia Code Commission, Pocahontas Building, 900 East Main Street, 11th Floor, Richmond, VA 23219; *Telephone:* Voice will be available at a later date.

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 https://commonwealthcalendar.virginia.gov.

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.