VIRGINIA REGISTER OF REGULATIONS

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THE VIRGINIA REGISTER INFORMATION PAGE

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

ADOPTION, AMENDMENT, AND REPEAL OF REGULATIONS

Unless exempted by law, an agency wishing to adopt, amend, or repeal regulations must follow the procedures in the Administrative Process Act (§ 2.2-4000 et seq. of the Code of Virginia). Typically, this includes first publishing 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 proposed regulation 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 of Regulations 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 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 the final regulation contains changes made after publication of the proposed regulation that 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*. Pursuant to § 2.2-4007.06 of the Code of Virginia, any person may request that the agency solicit additional public comment on certain changes made after publication of the proposed regulation. The agency shall suspend the regulatory process for 30 days upon such request from 25 or more individuals, 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 alternative to the standard process set forth in the Administrative Process Act for regulations deemed by the Governor to be noncontroversial. To use this process, the Governor's concurrence is required and advance notice must be provided to certain legislative committees. Fast-track regulations become effective on the date noted in the regulatory action if fewer than 10 persons object to using the process in accordance with § 2.2-4012.1.

EMERGENCY REGULATIONS

Pursuant to § 2.2-4011 of the Code of Virginia, an agency may adopt emergency regulations if necessitated by an emergency situation or when Virginia statutory law or the appropriation act or federal law or federal regulation requires that a regulation be effective in 280 days or fewer from its enactment. In either situation, approval of the Governor is required. The emergency regulation is effective upon its filing with the Registrar of Regulations, unless a later date is specified per § 2.2-4012 of the Code of Virginia. Emergency regulations are limited to no more than 18 months in duration; however, may be extended for six months under the circumstances noted in § 2.2-4011 D. Emergency regulations are published as soon as possible in the *Virginia Register* and are on the Register of Regulations website at register.dls.virgina.gov.

During the time the emergency regulation is in effect, the agency may proceed with the adoption of permanent regulations in accordance with the Administrative Process Act. 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. **34:8 VA.R. 763-832 December 11, 2017,** refers to Volume 34, Issue 8, pages 763 through 832 of the *Virginia Register* issued on December 11, 2017.

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

Members of the Virginia Code Commission: **John S. Edwards, Chair; Ward L. Armstrong; Nicole Cheuk; Richard E. Gardiner; James A. Leftwich, Jr.; Jennifer L. McClellan; Christopher R. Nolen; Steven Popps; Charles S. Sharp; Malfourd W. Trumbo; Amigo R. Wade; Wren M. Williams.**

Staff of the *Virginia Register:* **Holly Trice,** Registrar of Regulations; **Anne Bloomsburg,** Assistant Registrar; **Nikki Clemons,** Regulations Analyst; **Rhonda Dyer,** Publications Assistant; **Terri Edwards,** Senior Operations Staff Assistant.

PUBLICATION SCHEDULE AND DEADLINES

This schedule is available on the Virginia Register of Regulations website (http://register.dls.virginia.gov).

December 2022 through December 2023

Volume: Issue	Material Submitted By Noon*	Will Be Published On
39:9	November 30, 2022	December 19, 2022
39:10	December 13, 2022 **(Tuesday)**	January 2, 2023
39:11	December 27, 2022 **(Tuesday)**	January 16, 2023
39:12	January 11, 2023	January 30, 2023
39:13	January 25, 2023	February 13, 2023
39:14	February 8, 2023	February 27, 2023
39:15	February 22, 2023	March 13, 2023
39:16	March 8, 2023	March 27, 2023
39:17	March 22, 2023	April 10, 2023
39:18	April 5, 2023	April 24, 2023
39:19	April 19, 2023	May 8, 2023
39:20	May 3, 2023	May 22, 2023
39:21	May 17, 2023	June 5, 2023
39:22	May 31, 2023	June 19, 2023
39:23	June 14, 2023	July 3, 2023
39:24	June 28, 2023	July 17, 2023
39:25	July 12, 2023	July 31, 2023
39:26	July 26, 2023	August 14, 2023
40:1	August 9, 2023	August 28, 2023
40:2	August 23, 2023	September 11, 2023
40:3	September 6, 2023	September 25, 2023
40:4	September 20, 2023	October 9, 2023
40:5	October 4, 2023	October 23, 2023
40:6	October 18, 2023	November 6, 2023
40:7	November 1, 2023	November 20, 2023
40:8	November 14, 2023 **(Tuesday)**	December 4, 2023
40:9	November 29, 2023	December 18, 2023

*Filing deadlines are Wednesdays unless otherwise specified.

TITLE 12. HEALTH

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

Initial Agency Notice

Title of Regulation: **12VAC30-20. Administration of Medical Assistance Services.**

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

Name of Petitioner: D. Adam McKelvey, Esq.

Nature of Petitioner's Request: Pursuant to § 2.2-4007 of the Code of Virginia, the petitioner requests a regulation that mandates a firm deadline for the Department of Medical Assistance Services (DMAS) to respond to requests for final lien amounts asserted against personal injury claims proceeds and arising from the Medicaid program or any other DMAS program. The petitioner requests that this regulation contain all contact information and documents necessary to trigger the deadline, and that upon passing of the deadline, the amount owed is deemed zero dollars.

Agency Plan for Disposition of Request: The petition for rulemaking will be published in the Virginia Register of Regulations on December 5, 2022, and on the Virginia Regulatory Town Hall. Public comment will open on December 5, 2022, and will close on December 26, 2022. DMAS will consider the petition and all comments in support or opposition after the close of the public comment period. The agency will issue a written decision within 90 days following the close of the comment period.

Public Comment Deadline: December 26, 2022.

Agency Contact: Meredith Lee, Policy, Regulations, and Manuals Supervisor, Division of Policy, Regulation and Member Engagement, Department of Medical Assistance Services, 600 East Broad Street, Suite 1300, Richmond, VA 23219, telephone (804) 371-0552, or email meredith.lee@dmas.virginia.gov.

VA.R. Doc. No. PFR23-13; Filed November 3, 2022, 7:34 a.m.

TITLE 2. AGRICULTURE

BOARD OF AGRICULTURE AND CONSUMER SERVICES

Agency Notice

Pursuant §§ 2.2-4007.1 and 2.2-4017 of the Code of Virginia, the following regulation is undergoing a periodic review and a small business impact review: **2VAC5-390. Rules and Regulations for the Enforcement of the Virginia Seed Law**.

The Notice of Intended Regulatory Action to amend 2VAC5-390, which is published in this issue of the Virginia Register, serves as the agency notice of announcement.

Contact Information: David Gianino, Program Manager, Office of Plant Industry Services, Department of Agriculture and Consumer Services, P.O. Box 1163, Richmond, VA 23218, telephone (804) 786-3515, FAX (804) 371-7793, TDD (800) 828-1120, or email david.gianino@vdacs.virginia.gov.

TITLE 9. ENVIRONMENT

STATE AIR POLLUTION CONTROL BOARD

Report of Findings

Pursuant to §§ 2.2-4007.1 and 2.2-4017 of the Code of Virginia, the State Air Pollution Control Board conducted a periodic review and a small business impact review of **9VAC5-220, Variance for Rocket Motor Test Operations at Aerojet Rocketdyne Inc. Orange County Facility**, and determined that this regulation should be retained as is. The department is publishing its report of findings dated November 7, 2022, to support this decision.

The regulation is necessary for the protection of public health and welfare, as it is needed to meet the primary goals of the federal Clean Air Act (CAA): the attainment and maintenance of the National Ambient Air Quality Standards (NAAQS), and the prevention of significant deterioration (PSD) of air quality in areas cleaner than the NAAQS.

The NAAQS, developed and promulgated by the U.S. Environmental Protection Agency (EPA), establish the maximum limits of pollutants that are permitted in the outside ambient air in order to protect public health and welfare. EPA requires that each state submit a state implementation plan (SIP), including any laws and regulations necessary to enforce the plan, which shows how the air pollution concentrations will be reduced to levels at or below these attainment standards (attainment). Once the pollution levels are within the standards, the SIP must also demonstrate how the state will maintain the air pollution concentrations at the reduced levels (maintenance).

An SIP is the key to the state's air quality programs. The CAA is specific concerning the elements required for an acceptable SIP. If a state does not prepare such a plan, or EPA does not approve a submitted plan, then EPA itself is empowered to take the necessary actions to attain and maintain the air quality standards, that is, it would have to promulgate and implement an air quality plan for that state. EPA is also, by law, required to impose sanctions in cases where there is no approved plan or the plan is not being implemented. The sanctions consist of loss of federal funds for highways and other projects or more restrictive requirements for new industry. Generally, the plan is revised, as needed, based upon changes in the CAA and its requirements.

The basic approach to developing an SIP is to examine air quality across the state, delineate areas where air quality needs improvement, determine the degree of improvement necessary, inventory the sources contributing to the problem, develop a control strategy to reduce emissions from contributing sources enough to bring about attainment of the air quality standards, implement the strategy, and take the steps necessary to ensure that the air quality standards are not violated in the future. The heart of the SIP is the control strategy. The control strategy describes the emission reduction measures to be used by the state to attain and maintain the air quality standards.

Federal guidance on state approaches to the inclusion of control measures in the SIP has varied considerably over the years, ranging from very general in the early years of the CAA to very specific in more recent years. Many regulatory requirements were adopted in the 1970s when no detailed guidance existed. The legally binding federal mandate for these regulations is general, not specific, consisting of the CAA's broad-based directive to states to attain and maintain the air quality standards. However, in recent years, the CAA, EPA regulations, and EPA policy have become much more specific, thereby removing much of an individual state's discretion to craft its own air quality control programs.

Generally, an SIP is revised, as needed, based upon changes in air quality or statutory requirements. For the most part the SIP has worked, and the standards have been attained for most pollutants in most areas. However, attainment of NAAQS for the pollutant ozone has proven problematic. While ozone is needed at the earth's outer atmospheric layer, excess concentrations at the surface have an adverse effect on human health and welfare. Ozone is formed by a chemical reaction between volatile organic compounds (VOCs), nitrogen oxides (NO_X), and sunlight. When VOC and NO_X emissions are reduced, ozone is reduced.

The CAA establishes a process for evaluating the air quality in each region and identifying and classifying each nonattainment area according to the severity of its air pollution problem. Nonattainment areas are classified as marginal, moderate, serious, severe, or extreme. Marginal areas are subject to the least stringent requirements, and each subsequent classification (or class) is subject to successively more

stringent control measures. Areas in a higher classification of nonattainment must meet the mandates of the lower classifications and the more stringent requirements of their class. In addition to the general SIP-related sanctions, nonattainment areas have unique sanctions. If a particular area fails to attain the federal standard by the legislatively mandated attainment date, EPA is required to reassign it to the next higher classification level (denoting a worse air quality problem), thus subjecting the area to more stringent air pollution control requirements. The CAA includes specific provisions requiring these sanctions to be issued by EPA if so warranted.

Once a nonattainment area is defined, each state is then obligated to submit an SIP demonstrating how it will attain the air quality standards in each nonattainment area. Certain specific control measures and other requirements must be adopted and included in the SIP. In cases where the specific federal control measures are inadequate to achieve the emission reductions or attain the air quality standard, the state is obligated to adopt additional control measures as necessary to achieve this end.

The regulation provides for the control of particulate matter from a facility that cannot meet the opacity standard. Due to the nature of the testing operations, the company had no appropriate method by which it could demonstrate compliance with the board's opacity standards. The board, therefore, granted a variance for the testing facility that enabled it to demonstrate compliance through meeting a particulate matter standard as an alternative to the opacity standard.

The variance for Aerojet Rocketdyne Inc. was adopted by the board in 2002. No significant changes have occurred at the facility that would require a modification to the variance.

The regulation has been effective in protecting public health and welfare with the least possible cost and intrusiveness to the citizens and the facility. The regulation ensures that the owners comply with air pollution emission limits and control technology requirements in order to control levels of particulate matter emitted into the ambient air during rocket testing and prohibiting emissions that would contribute to nonattainment of the national air quality standards or interference with maintenance of those standards.

The department has determined that the regulation is clearly written and easily understandable by the individuals and the facility affected. It is written to permit only one reasonable interpretation, is written to adequately identify the affected entity, and, insofar as possible, is written in nontechnical language. The variance for Aerojet Rocketdyne Inc., is necessary as the facility is still in operation. The variance is required to address the need for control of particulate matter in lieu of the opacity limitations. Therefore, the regulation is being retained as is.

This regulation continues to be needed. It provides sources with the most cost-effective means of fulfilling ongoing state and federal requirements that protect air quality. The regulation's level of complexity is appropriate to ensure that the regulated entity is able to meet its legal mandate as efficiently and cost-effectively as possible. This regulation does not overlap, duplicate, or conflict with any state law or other state regulation.

This regulation was last reviewed in 2018. Over time, it generally becomes less expensive to characterize, measure, and mitigate the regulated pollutants that contribute to poor air quality. This regulation continues to provide the most efficient and cost-effective means to determine the level and impact of excess emissions and to control those excess emissions. The department, through examination of the regulation and relevant public comments, has determined that the regulatory requirements have no impact on small businesses. The affected facility is owned by Aerojet Rocketdyne, which employs 5,000 persons and does not qualify as a small business under Virginia law.

Contact Information: Karen G. Sabasteanski, Department of Environmental Quality, 1111 East Main Street, Suite 1400, P.O. Box 1105, Richmond, VA 23218, telephone (804) 659-1973.

Agency Notice

Pursuant to §§ 2.2-4007.1 and 2.2-4017 of the Code of Virginia, these regulations are undergoing a periodic review and a small business impact review: **9VAC5-520, Biomass Energy Generator General Permit for a Pilot Test Facility,** and **9VAC5-530, Electric Generator Voluntary Demand Response General Permit**. The purpose of a periodic review is to determine whether each regulation should be repealed, amended, or retained in its current form. Public comment is sought on the review of any issue relating to these regulations, including whether each 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.

Public comment period begins December 5, 2022, and ends December 26, 2022.

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 Virginia Regulatory Town Hall and published in the Virginia Register of Regulations.

Contact Information: Karen G. Sabasteanski, Department of Environmental Quality, 1111 East Main Street, Suite 1400, P.O. Box 1105, Richmond, VA 23218, telephone (804) 659-1973.

TITLE 12. HEALTH

STATE BOARD OF HEALTH

Report of Findings

Pursuant to §§ 2.2-4007.1 and 2.2-4017 of the Code of Virginia, the State Board of Health conducted a periodic review and a small business impact review of **12VAC5-191, State Plan for the Children with Special Health Care Needs Program**, and determined that this regulation should be retained as is. The department is publishing its report of findings dated August 3, 2022, to support this decision.

The regulation meets the criteria set out in Executive Order 19 (2022) as the regulation is necessary for the protection of public health, safety, and welfare of infants born in the Commonwealth of Virginia and their families. The regulation is clearly written and understandable.

The Virginia Department of Health is recommending the regulation be retained as is without change. The regulation, in its current form, allows for the ongoing provision of services for children with special health care needs. The regulation is essential to outline program services for children with special health care needs. Program services are provided through available appropriations under federal Title V funds to eligible Virginia residents. No public comments were received. The regulation is clearly written and easily understandable. The regulation does not overlap, duplicate, or conflict with any known federal or state law or regulation. Regulations are evaluated on an ongoing basis, and this regulation was last amended in May 2021. The regulation was amended in response to a 2020 General Assembly legislative mandate to promulgate a new regulation to implement an adult comprehensive sickle cell clinic network. Retaining the regulation in its current form does not appear to cause an adverse economic impact on small businesses in the Commonwealth of Virginia.

Contact Information: Marcus Allen, Program Administrative Specialist, Office of Family Health Services, Virginia Department of Health, 109 Governor Street, Richmond, VA 23219, telephone (804) 864-7716.

Report of Findings

Pursuant to §§ 2.2-4007.1 and 2.2-4017 of the Code of Virginia, the State Board of Health conducted a periodic review and a small business impact review of **12VAC5-200, Regulations Governing Eligibility Standards and Charges for Medical Care Services to Individuals**, and determined that this regulation should be amended. The department is publishing its report of findings dated October 18, 2022, to support this decision.

The regulation is necessary for the protection of public health, safety, and welfare by establishing a means to identify an individual as medically indigent for the purposes of receiving no cost medical services by the Virginia Department of Health. It also establishes a framework of charges and an incremental charge scale based on a person's ability to pay, which will be consistently applied throughout the department and its local offices. In addition, it allows services to reduce vaccine-preventable and other communicable diseases to be provided at low cost or no cost to individuals with limited ability to pay for them. The regulation includes extensive definitions of the most basic terms, references to the Code of Virginia where applicable, and is clearly worded without undefined acronyms or technical terms.

The agency's decision is to amend the regulation to make format and style changes, procedural updates, add reference to a change made to the Code of Virginia, add clarifying language, and remove any unnecessary, duplicative, or nonregulatory language.

The regulation is necessary to provide details to local health department offices on the structure for charging for medical services and assessing a client's ability to pay in a consistent manner statewide. There were no public comments or complaints submitted concerning this regulation. The regulation is not complex. The regulation does not duplicate or conflict with federal or state law or regulation. The regulation is assessed on a continual basis to evaluate if changes in technology, economic conditions, or other factors in the area affected by the regulation indicate a need for an amendment to reflect current state.

Contact Information: Lisa Park, Health Care Reimbursement Manager, Virginia Department of Health, 109 Governor Street, Richmond, VA 23219, telephone (804) 864-7018.

Agency Notice

Pursuant to Executive Order 19 (2022) and §§ 2.2-4007.1 and 2.2-4017 of the Code of Virginia, the following regulations are undergoing a periodic review and a small business impact review: **12VAC5-613, Regulations for Alternative Onsite Sewage Systems** and **12VAC5-650, Schedule of Civil Penalties**. The review of each regulation will be guided by the principles in Executive Order 19 (2022). The purpose of a periodic review is to determine whether each regulation should be repealed, amended, or retained in its current form. Public comment is sought on the review of any issue relating to these regulations, including whether each 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.

Public comment period begins December 5, 2022, and ends January 5, 2023.

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 Virginia Regulatory Town Hall and published in the Virginia Register of Regulations.

Contact Information: Lance Gregory, Division Director, Virginia Department of Health, James Madison Building, 109 Governor Street, Richmond, VA 23219, telephone (804) 864-7491.

TITLE 22. SOCIAL SERVICES

STATE BOARD OF SOCIAL SERVICES

Agency Notice

Pursuant to Executive Order 19 (2022) and §§ 2.2-4007.1 and 2.2-4017 of the Code of Virginia, this regulation is undergoing a periodic review and a small business impact review: **22VAC40-910, General Provisions for Maintaining and Disclosing Confidential Information of Public Assistance, Child Support Enforcement, and Social Services Record**. The review of this regulation will be guided by the principles in Executive Order 19 (2022). The purpose of a periodic 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.

Public comment period begins December 5, 2022, and ends December 26, 2022.

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 Virginia Regulatory Town Hall and published in the Virginia Register of Regulations.

Contact Information: Gail Jennings, PhD, Senior Research Associate, Department of Social Services, 801 East Main Street, Richmond, VA 23219, telephone (804) 615-4000.

TITLE 2. AGRICULTURE

BOARD OF AGRICULTURE AND CONSUMER 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 Agriculture and Consumer Services intends to consider amending **2VAC5-390, Rules and Regulations for the Enforcement of the Virginia Seed Law**. The purpose of the proposed action is to establish an appropriate minimum germination rate for cotton seed sold in Virginia. Section 3.2-4001 of the Virginia Seed Law authorizes the Board of Agriculture and Consumer Services to adopt regulations governing the establishment of standards for agricultural, vegetable, flower, tree and shrub, lawn and turf seeds, mixtures of such seeds, and screenings. 2VAC5-390 provides specific requirements for seeds sold in Virginia, including minimum germination rates for vegetable, flower, and peanut seeds. Currently, cotton seed sold in Virginia has no minimum standard for germination rate.

In addition, pursuant to Executive Order 19 and § 2.2-4007.1 of the Code of Virginia, the agency is conducting a periodic review and small business impact review of this regulation to determine whether this regulation should be terminated, 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; (ii) minimizes the economic impact on small businesses consistent with the stated objectives of applicable law; and (iii) is clearly written and easily understandable.

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

Statutory Authority: §§ 3.2-4001 and 3.2-4002 of the Code of Virginia.

Public Comment Deadline: January 4, 2023.

Agency Contact: David Gianino, Program Manager, Office of Plant Industry Services, Department of Agriculture and Consumer Services, P. O. Box 1163, Richmond, VA 23218, telephone (804) 786-3515, FAX (804) 371-7793, TDD (800) 828-1120, or email david.gianino@vdacs.virginia.gov.

VA.R. Doc. No. R23-7135; Filed November 2, 2022, 1:54 p.m.

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 amending **12VAC5-71, Regulations Governing Virginia Newborn Screening Services**. The purpose of the proposed action is to remove outdated information and reflect recommended national best practices in newborn screening; identify the Newborn Screening Advisory Committee and remove the Virginia Genetics Advisory Committee as the advisory group for this regulation; and clarify reporting requirements following a 2021 periodic review.

Blood spot newborn screening services are provided by the Department of General Services Division of Consolidated Laboratory Services in partnership with the Virginia Department of Health (VDH). On a national level, genetic disorders are included in the Recommended Uniform Screening Panel (RUSP) of the U.S. Secretary of Health and Human Services Advisory Committee on Heritable Disorders in Newborns and Children. Additions of disorders to Virginia's newborn screening panel in alignment with the RUSP are recommended by the Virginia Newborn Screening Advisory Committee. Currently, there are 33 heritable disorders and diseases on the Virginia newborn screening panel. VDH is recommending the regulations be amended to reflect current practices and updated scientific information relevant to newborn screening. This regulatory action seeks to clarify content that may be unclear, inconsistent, or obsolete, and ensure consistency with the RUSP.

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

Statutory Authority: §§ 32.1-12 and 32.1-67 of the Code of Virginia.

Public Comment Deadline: January 4, 2023.

Agency Contact: Vanessa Walker-Harris, Director, Office of Family Health Services, Virginia Department of Health, 109 Governor Street, Richmond, VA 23219, telephone (804) 864-7627, or email vanessa.walkerharris@vdh.virginia.gov.

VA.R. Doc. No. R23-7169; Filed November 4, 2022, 12:13 p.m.

TITLE 18. PROFESSIONAL AND OCCUPATIONAL LICENSING

BOARD FOR CONTRACTORS

Notice of Intended Regulatory Action

Notice is hereby given in accordance with § 2.2-4007.01 of the Code of Virginia that the Board for Contractors intends to consider amending **18VAC50-22, Board for Contractors Regulations**. The purpose of the proposed action is to generally review the regulation to clarify and consolidate requirements, eliminate redundant language, and repeal text that restates statute. The board seeks to amend regulations that are determined to be overly burdensome or no longer

applicable. The action is in response to and in accordance with Governor Youngkin's Executive Directive 1.

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

Statutory Authority: § 54.1-201 of the Code of Virginia.

Public Comment Deadline: January 4, 2023.

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.

VA.R. Doc. No. R23-7412; Filed November 2, 2022, 1:25 p.m.

BOARD OF PHARMACY

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 Pharmacy intends to consider amending **18VAC110-30, Regulations for Practitioners of the Healing Arts to Sell Controlled Substances**. The purpose of the proposed action is to (i) insert requirements for facilities of practitioners of the healing arts who sell controlled substances, similar to other facilities permitted by the Board of Pharmacy, to declare hours of operation a location will be open to service the public; to report changes in the hours of operation expected to last for more than one week to the board and the public at least 14 days prior to the anticipated change; and to include exemptions for emergency circumstances beyond control of the owner or responsible party or expansion of hours; and (ii) prohibit a license or permit from being issued to a private dwelling or residence.

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

Statutory Authority: §§ 54.1-2400 and 54.1-3307 of the Code of Virginia.

Public Comment Deadline: January 4, 2023.

Agency Contact: Caroline Juran, RPh, Executive Director, Board of Pharmacy, 9960 Mayland Drive, Suite 300, Richmond, VA 23233-1463, telephone (804) 527-4456, FAX (804) 527-4472, or email caroline.juran@dhp.virginia.gov.

VA.R. Doc. No. R22-7073; Filed November 4, 2022, 12:52 p.m.

DEPARTMENT OF PROFESSIONAL AND OCCUPATIONAL REGULATION

Notice of Intended Regulatory Action

Notice is hereby given in accordance with § 2.2-4007.01 of the Code of Virginia that the Department of Professional and Occupational Regulation intends to consider amending **18VAC120-30, Regulations Governing Polygraph Examiners**. The purpose of the proposed action is to review and amend the standards of practice and conduct to conform to changes regarding copies of polygraph reports being made available to the public to the Virginia Freedom of Information Act (§ 2.2-3700 et seq. of the Code of Virginia). In the past, law-enforcement agencies were able to withhold polygraph reports from Freedom of Information Act (FOIA) requests because some case files were exempt from FOIA and not accessible to the public. Amendments to the Virginia Freedom of Information Act provided access to some closed law-enforcement cases to the public.

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

Statutory Authority: § 54.1-1802.1 of the Code of Virginia.

Public Comment Deadline: January 4, 2023.

Agency Contact: Marjorie King, Regulatory Boards Administrator, Department of Professional and Occupational Regulation, 9960 Mayland Drive, Suite 400, Richmond, VA 23233, telephone (804) 367-2785, FAX (866) 430-1033, TDD (804) 527-4290, or email contractors@dpor.virginia.gov.

VA.R. Doc. No. R23-7093; Filed November 2, 2022, 1:27 p.m.

TITLE 9. ENVIRONMENT

STATE WATER CONTROL BOARD

Proposed Regulation

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

Title of Regulation: **9VAC25-800. Virginia Pollutant Discharge Elimination System (VPDES) General Permit Regulation for Discharges Resulting from the Application of Pesticides to Surface Waters (amending 9VAC25-800-10 through 9VAC25-800-30, 9VAC25-800-60).**

Statutory Authority: § 62.1-44.15 of the Code of Virginia; § 402 of the federal Clean Water Act.

Public Hearing Information:

January 11, 2023 - 10 a.m. - Department of Environmental Quality, Piedmont Regional Office Training Room, 4949-A Cox Road, Glen Allen, VA 23060

Public Comment Deadline: February 3, 2023.

Agency Contact: Peter Sherman, Department of Environmental Quality, 1111 East Main Street, Suite 1400, P.O. Box 1105, Richmond, VA 23218, telephone (804) 659-2666, FAX (804) 698-4178, or email peter.sherman@deq.virginia.gov.

Summary:

The Virginia Pollutant Discharge Elimination System (VPDES) General Permit Regulation for Discharges Resulting from the Application of Pesticides to Surface Waters contains effluent limitations, monitoring requirements, and special conditions for discharges of pesticides to surface waters. The proposed amendments reissue this general permit to clarify permit conditions and increase consistency with other general permits, including (i) a substantive change for animal pest control, which is the addition of "cultural methods" as a method that must be evaluated when selecting pest management measures; and (ii) changes to effective dates, definitions, and website and physical addresses.

9VAC25-800-10. Definitions.

The words and terms used in this chapter shall have the same meanings as given in the State Water Control Law (§ 62.1-44.2 et seq. of the Code of Virginia) and the VPDES Permit Regulation (9VAC25-31), unless the context clearly indicates otherwise, except that for the purposes of this chapter:

"Action threshold" means the point at which pest populations or environmental conditions necessitate that pest control action be taken based on economic, human health, aesthetic, or other effects. An action threshold may be based on current or past environmental factors that are or have been demonstrated to be conducive to pest emergence or growth, as well as past or current pest presence. Action thresholds are those conditions that indicate both the need for control actions and the proper timing of such actions.

"Active ingredient" means any substance (or group of structurally similar substances if specified by the federal Environmental Protection Agency (EPA) that will prevent, destroy, repel, or mitigate any pest, or that functions as a plant regulator, desiccant, or defoliant within the meaning of § 2(a) of the Federal Insecticide, Fungicide and Rodenticide Act (FIFRA) (40 CFR 152.3). Active ingredient also means a pesticidal substance that is intended to be produced and used in a living plant, or in the produce thereof, and the genetic material necessary for the production of such a pesticidal substance (40 CFR 174.3).

"Adverse incident" means an unusual or unexpected incident that the operator observes upon inspection or of which otherwise becomes aware, in which there is evidence that:

1. A person or nontarget organism has likely been exposed to a pesticide residue; and

2. The person or nontarget organism suffered a toxic or adverse effect.

The phrase "toxic or adverse effects" includes effects that occur within surface waters on nontarget plants, fish, or

wildlife that are unusual or unexpected (e.g., effects are to organisms not described on the pesticide product labels or not expected to be present) as a result of exposure to a pesticide residue and may include:

1. Distressed or dead juvenile and small fishes;

2. Washed up or floating fish;

3. Fish swimming abnormally or erratically;

4. Fish lying lethargically at water surface or in shallow water;

5. Fish that are listless or nonresponsive to disturbance;

6. Stunting, wilting, or desiccation of nontarget submerged or emergent aquatic plants; and

7. Other dead or visibly distressed nontarget aquatic or semi-aquatic organisms (amphibians, turtles, invertebrates, etc.).

The phrase "toxic or adverse effects" also includes any adverse effects to humans (e.g., skin rashes) or domesticated animals (e.g., vomiting, lethargy) that occur either from direct contact with or as a secondary effect from a discharge (e.g., sickness from consumption of plants or animals containing pesticides) to surface waters that are temporally and spatially related to exposure to a pesticide residue.

"Biological control" means organisms that can be introduced to sites, such as herbivores, predators, parasites, and hyperparasites.

"Biological pesticides" or "biopesticides" includes microbial pesticides, biochemical pesticides, and plant-incorporated protectants (PIP).

1. "Microbial pesticide" means a microbial agent intended for preventing, destroying, repelling, or mitigating any pest, or intended for use as a plant regulator, defoliant, or desiccant, that:

a. Is a eukaryotic microorganism, including protozoa, algae, and fungi;

b. Is a prokaryotic microorganism, including Eubacteria and Archaebacteria; or

c. Is a parasitically replicating microscopic element, including viruses.

2. "Biochemical pesticide" means a pesticide that:

a. Is a naturally occurring substance or structurally similar and functionally identical to a naturally occurring substance;

b. Has a history of exposure to humans and the environment demonstrating minimal toxicity, or in the case of a synthetically derived biochemical pesticide, is equivalent to a naturally occurring substance that has such a history; and

c. Has a nontoxic mode of action to the target pests.

3. "Plant-incorporated protectant" means a pesticidal substance that is intended to be produced and used in a living plant, or in the produce thereof, and the genetic material necessary for production of such a pesticidal substance. It also includes any inert ingredient contained in the plant or produce thereof.

"Board" means the State Water Control Board. When used outside the context of the promulgation of regulations, including regulations to establish general permits, "board" means the Department of Environmental Quality.

"Chemical pesticides" means all pesticides not otherwise classified as biological pesticides.

"Cultural methods" means manipulation of the habitat to increase pest mortality by making the habitat less suitable to the pest.

"Declared pest emergency situation" means an event defined by a public declaration by a federal agency, state, or local government of a pest problem determined to require control through application of a pesticide beginning less than 10 days after identification of the need for pest control. This public declaration may be based on:

1. Significant risk to human health;

2. Significant economic loss; or

3. Significant risk to:

a. Endangered species;

b. Threatened species;

c. Beneficial organisms; or

d. The environment.

"DEQ" or "department" means the Virginia Department of Environmental Quality.

"Discharge of a pollutant" means the addition of any "pollutant" or combination of pollutants to surface waters from any point source, or the addition of any pollutant or combination of pollutants to the water of the contiguous zone or the ocean from any point source.

"FIFRA" means the Federal Insecticide, Fungicide and Rodenticide Act (7 USC § 136 et seq.) as amended.

"Impaired water" or "water quality impaired water" or "water quality limited segment" means any stream segment where the water quality does not or will not meet applicable water quality standards, even after the application of technology-based effluent limitations required by §§ 301(b) and 306 of the Clean Water Act (CWA) (33 USC § 1251 et seq. as of 1987). Impaired waters include both impaired waters with approved or established TMDLs, and impaired waters for which a TMDL has not yet been approved or established.

"Inert ingredient" means any substance (or group of structurally similar substances if designated by EPA), other

than an active ingredient, that is intentionally included in a pesticide product. Inert ingredient also means any substance, such as a selectable marker, other than the active ingredient, where the substance is used to confirm or ensure the presence of the active ingredient, and includes the genetic material necessary for the production of the substance, provided that genetic material is intentionally introduced into a living plant in addition to the active ingredient.

"Integrated pest management" or "IPM" means an effective and environmentally sensitive approach to pest management that relies on a combination of common-sense practices. IPM uses current, comprehensive information on the life cycles of pests and their interaction with the environment. This information, in combination with available pest control methods, is used to manage pest damage by the most economical means, and with the least possible hazard to people, property, and the environment.

"Label" means the written, printed, or graphic matter on, or attached to, the pesticide or device, or the immediate container thereof, and the outside container or wrapper of the retail package, if any, of the pesticide or device.

"Labeling" means all labels and other written, printed, or graphic matter:

1. Upon the pesticide or device or any of its containers or wrappers;

2. Accompanying the pesticide or device at any time; or

3. To which reference is made on the label or in literature accompanying the pesticide or device, except when accurate, nonmisleading reference is made to current official publications of the agricultural experiment station, the Virginia Polytechnic Institute and State University, the Virginia Department of Agriculture and Consumer Services, the State Board of Health, or similar federal institutions or other official agencies of the Commonwealth or other states when such states are authorized by law to conduct research in the field of pesticides.

"Mechanical or physical methods" means mechanical tools or physical alterations of the environment for pest prevention or removal.

"Minimize" means to reduce or eliminate pesticide discharges to surface waters through the use of pest management measures to the extent technologically available and economically practicable and achievable.

"Nontarget organisms" means the plant and animal hosts of the target species, the natural enemies of the target species living in the community, and other plants and animals, including vertebrates, living in or near the community that are not the target of the pesticide.

"Operator" means any person involved in the application of a pesticide that results in a discharge to surface waters that meets either or both of the following two criteria:

1. The person who has control over the financing for or the decision to perform pesticide applications that result in discharges, including the ability to modify those decisions; or

2. The person who performs the application of a pesticide or who has day-to-day control of the application (e.g., they are authorized to direct workers to carry out those activities that result in discharges to surface waters).

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

"Pest" means any deleterious organism that is:

1. Any vertebrate animal other than man;

2. Any invertebrate animal excluding any internal parasite of living man or other living animals;

3. Any plant growing where not wanted, and any plant part such as a root; or

4. Any bacterium, virus, or other microorganisms, except for those on or in living man or other living animals and those on or in processed food or processed animal feed, beverages, drugs (as defined by the federal Food, Drug, and Cosmetic Act at 21 USC § 321(g)(1)), and cosmetics (as defined by the federal Food, Drug, and Cosmetic Act at 21 USC § 321(i)).

Any organism classified by state or federal law or regulation as endangered or threatened shall not be deemed a pest for the purposes of this chapter.

"Pest management area" means the area of land, including any water, for which pest management activities covered by this permit are conducted.

"Pest management measure" means any practice used to meet the effluent limitations that comply with manufacturer specifications, industry standards, and recommended industry practices related to the application of pesticides, relevant legal requirements, and other provisions that a prudent operator would implement to reduce or eliminate pesticide discharges to surface waters.

"Pesticide" means:

1. Any substance or mixture of substances intended for preventing, destroying, repelling, or mitigating any insects, rodents, fungi, bacteria, weeds, or other forms of plant or animal life or viruses, except viruses on or in living man or other animals, which the Commissioner of Agriculture and Consumer Services shall declare to be a pest;

2. Any substance or mixture of substances intended for use as a plant regulator, defoliant, or desiccant; and

3. Any substance which is intended to become an active ingredient thereof.

Pesticides that are used or applied shall only be those that are approved and registered for use by the Virginia Department of Agriculture and Consumer Services.

"Pesticide discharges to surface waters from pesticide application" means the discharges that result from the application of biological pesticides and the application of chemical pesticides that leave a residue from point sources to surface waters. In the context of this definition of pesticide discharges to surface waters from pesticide application, this does not include agricultural storm water discharges and return flows from irrigated agriculture, which are excluded by law (33 USC § 1342(l) and 33 USC § 1362(14)).

"Pesticide product" means a pesticide in the particular form (including active and inert ingredients, packaging, and labeling) in which the pesticide is, or is intended to be, distributed or sold. The term includes any physical apparatus used to deliver or apply the pesticide if distributed or sold with the pesticide.

"Pesticide research and development" means activities undertaken on a systematic basis to gain new knowledge (research) or apply research findings or other scientific knowledge for the creation of new or significantly improved products or processes (experimental development).

"Pesticide residue" for the purposes of determining whether an VPDES permit is needed for discharges to surface waters from pesticide application, means that portion of a pesticide application that has been discharged from a point source to surface waters and no longer provides pesticidal benefits. It also includes any degradates of the pesticide.

"Point source" means any discernible, confined, and discrete conveyance including any pipe, ditch, channel, tunnel, conduit, or container from which pollutants are or may be discharged. This includes biological pesticides or chemical pesticides that leave a residue coming from a container or nozzle of a pesticide application device. This term does not include return flows from irrigated agriculture or agricultural stormwater run-off.

"Pollutant" means biological pesticides and any pesticide residue resulting from use of a chemical pesticide.

"Surface waters" means:

1. All waters that are currently used, were used in the past, or may be susceptible to use in interstate or foreign commerce, including all waters that are subject to the ebb and flow of the tide;

2. All interstate waters, including interstate wetlands;

3. All other waters such as intrastate lakes, rivers, streams (including intermittent streams), mudflats, sandflats, wetlands, sloughs, prairie potholes, wet meadows, playa lakes, or natural ponds the use, degradation, or destruction of which would affect or could affect interstate or foreign commerce including any such waters:

a. That are or could be used by interstate or foreign travelers for recreational or other purposes;

b. From which fish or shellfish are or could be taken and sold in interstate or foreign commerce; or

c. That are used or could be used for industrial purposes by industries in interstate commerce;

4. All impoundments of waters otherwise defined as surface waters under this definition;

5. Tributaries of waters identified in subdivisions 1 through 4 of this definition;

6. The territorial sea; and

7. Wetlands adjacent to waters, other than waters that are themselves wetlands, identified in subdivisions 1 through 6 of this definition.

Surface waters do not include wastewater treatment systems, including treatment ponds or lagoons designed to meet the requirements of the Clean Water Act (CWA) and the law. Surface waters do not include prior converted cropland. Notwithstanding the determination of an area's status as prior converted cropland by any other agency, for the purposes of the CWA, the final authority regarding the CWA jurisdiction remains with EPA.

"Target pest" means the organism toward which pest management measures are being directed.

"Total maximum daily load" or "TMDL" means a calculation of the maximum amount of a pollutant that a waterbody can receive and still meet water quality standards, and an allocation of that amount to the pollutant's sources. A TMDL includes wasteload allocations (WLAs) for point source discharges, and load allocations (LAs) for nonpoint sources or natural background or both, and must include a margin of safety (MOS) and account for seasonal variations.

"Treatment area" means the area of land including any waters, or the linear distance along water or water's edge, to which pesticides are being applied. Multiple treatment areas may be located within a single pest management area.

Treatment area includes the entire area, whether over land or water, where the pesticide application is intended to provide pesticidal benefits. In some instances, the treatment area will be larger than the area where pesticides are actually applied. For example, the treatment area for a stationary drip treatment into a canal should be calculated by multiplying the width of the canal by the length over which the pesticide is intended to control weeds. The treatment area for a lake or marine area is

the water surface area where the application is intended to provide pesticidal benefits.

Treatment area calculations for pesticide applications that occur at water's edge, where the discharge of pesticides directly to waters is unavoidable, are determined by the linear distance over which pesticides are applied.

"VDACS" means the Virginia Department of Agriculture and Consumer Services. VDACS administers the provisions of Virginia's pesticide statute, Chapter 39 (§ 3.2-3900 et seq.) of Title 3.2 of the Code of Virginia, as well as the regulations promulgated by the Virginia Pesticide Control Board. VDACS also has delegated authority to enforce the provisions of FIFRA. As such, VDACS is the primary agency for the regulatory oversight of pesticides in the Commonwealth.

"Wetlands" means those areas that are inundated or saturated by surface or groundwater at a frequency and duration sufficient to support, and that under normal circumstances do support, a prevalence of vegetation typically adapted for life in saturated soil conditions. Wetlands generally include swamps, marshes, bogs, and similar areas.

9VAC25-800-15. Applicability of incorporated references based on the dates that they became effective.

Except as noted, when a regulation of the U.S. Environmental Protection Agency set forth in Title 40 of the Code of Federal Regulations (CFR) is referenced and incorporated in this chapter, that regulation shall be as it exists and has been published as of the July 1, ~~2018~~ 2022, CFR update.

9VAC25-800-20. Purpose; effective date of permit.

A. This general permit regulation governs discharges resulting from the application of pesticides to surface waters.

B. This VPDES general permit will become effective on March 1, ~~2019~~ 2024, and expire on February ~~29 , 2024~~ 28, 2029.

9VAC25-800-30. Authorization to discharge.

A. Any operator that meets the eligibility requirements in subsection B of this section is hereby authorized for his discharges resulting from the application of pesticides to surface waters of the Commonwealth of Virginia.

The definition of operator in 9VAC25-800-10 provides that more than one person may be responsible for the same discharge resulting from pesticide application. Any operator authorized to discharge under this general permit is responsible for compliance with the terms of this permit for discharges resulting from the application of pesticides.

B. Eligibility. This permit is available to operators who discharge to surface waters from the application of (i) biological pesticides, or (ii) chemical pesticides that leave a residue (pesticides), when the pesticide application is for one of the following pesticide use patterns:

1. Mosquito and other flying insect pest control - to control public health, nuisance and other flying insect pests that develop or are present during a portion of their life cycle in or above standing or flowing water.

2. Weed and algae pest control - to control weeds, algae, and pathogens that are pests in surface waters.

3. Animal pest control - to control animal pests in surface waters.

4. Forest canopy pest control - application of a pesticide to the forest canopy to control the population of a pest species (e.g., insect or pathogen) where to target the pests effectively, a portion of the pesticide unavoidably will be applied over and deposited to surface water.

5. Intrusive vegetation pest control - to control vegetation along roads, ditches, canals, waterways, and utility rights of way where to target the intrusive pests effectively, a portion of the pesticide unavoidably will be applied over and deposited to surface water.

C. Operators applying pesticides are required to maintain a pesticide discharge management plan (PDMP) if they exceed the annual calendar year treatment area thresholds in Table 1 of this subsection:

Table 1. Annual Treatment Area Thresholds

Pesticide Use	Annual Threshold
Mosquito and Other Flying Insect Pest Control	6400 acres of treatment area[1]
Weed and Algae Pest Control	80 acres of treatment area[1] or 20 linear miles of treatment area[2]
Animal Pest Control	80 acres of treatment area[1] or 20 linear miles of treatment area[2]
Forest Canopy Pest Control	6400 acres of treatment area[1]
Intrusive Vegetation Pest Control	6400 acres of treatment area[1] or 20 linear miles of treatment area[2]

[1]Calculations include the area of the applications made to: (i) surface waters and (ii) conveyances with a hydrologic surface connection to surface waters at the time of pesticide application. For calculating annual treatment area totals, count each pesticide application activity as a separate activity. For example, applying pesticides twice a year to a 10-acre site is counted as 20 acres of treatment area.

[2]Calculations include the extent of the application made to linear features (e.g., roads, ditches, canals, waterways, and utility rights of way) or along the water's edge adjacent to: (i) surface waters and (ii) conveyances with a hydrologic surface connection to surface waters at the time of pesticide application. For calculating annual treatment totals, count each pesticide application activity or area as a separate activity. For example, applying pesticides twice a year to a one mile linear feature (e.g., ditch) equals two miles of treatment area regardless of whether one or both sides of the ditch are treated. Applying pesticides twice a year along one mile of lake shoreline equals two miles of treatment area.

D. An operator's discharge resulting from the application of pesticides is not authorized under this permit in the event of any of the following:

1. The operator is required to obtain an individual VPDES permit in accordance with 9VAC25-31-170 B 3 of the VPDES Permit Regulation.

2. The discharge would violate the antidegradation policy stated in 9VAC25-260-30 of the Virginia Water Quality Standards. Discharges resulting from the application of pesticides are temporary and allowable in exceptional waters (see 9VAC25-260-30 A 3 (b) (3)).

3. The operator is proposing a discharge from a pesticide application to surface waters that have been identified as impaired by that pesticide or its degradates. Impaired waters include both impaired waters with board-adopted, EPA-approved or EPA-imposed TMDLs, and impaired waters for which a TMDL has not yet been approved, established, or imposed.

If the proposed discharge would not be eligible for coverage under this permit because the surface water is listed as impaired for that specific pesticide, but the applicant has evidence that shows the water is no longer impaired, the applicant may submit this information to the ~~board~~ department and request that coverage be allowed under this permit.

E. Discharge authorization date. Operators are not required to submit a registration statement and are authorized to discharge under this permit immediately upon the permit's effective date of March 1, 2019.

F. Compliance with this general permit constitutes compliance, for purposes of enforcement, with §§ 301, 302, 306, 307, 318, 403, and 405(a) through (b) of the federal Clean Water Act (33 USC § 1251 et seq.) and the State Water Control Law with the exceptions stated in 9VAC25-31-60 of the VPDES Permit Regulation. Approval for coverage under this VPDES general permit does not relieve any operator of the responsibility to comply with any other applicable federal, state, or local statute, ordinance, or regulation. For example, this permit does not negate the requirements under FIFRA and its implementing regulations to use registered pesticides consistent with the product's labeling. It also does not negate the requirement to fully comply with applicable state wetland program requirements administered by DEQ and the Virginia Marine Resources Commission.

G. Continuation of permit coverage.

1. ~~This general permit~~ Permit coverage shall expire ~~on February 29, 2024,~~ at the end of the applicable permit term, except that the conditions of the expired pesticides general permit will continue in force for an operator until coverage is granted under a reissued pesticides general permit if the board, through no fault of the operator, does not reissue a pesticides general permit on or before the expiration date of the expiring general permit.

2. General permit coverages continued under this section remain fully effective and enforceable.

3. When the operator that was covered under the expiring or expired pesticides general permit is not in compliance with the conditions of that permit, the ~~board~~ department may choose to do any or all of the following:

a. Initiate enforcement action based upon the pesticides general permit that has been continued;

b. Issue a notice of intent to deny coverage under a reissued pesticides general permit. If the general permit coverage is denied, the operator would then be required to cease the activities authorized by the continued general permit or be subject to enforcement action for operating without a permit;

c. Issue an individual permit with appropriate conditions; or

d. Take other actions authorized by the VPDES Permit Regulation (9VAC25-31).

9VAC25-800-60. General permit.

Any operator who is authorized to discharge shall comply with the requirements contained in this general permit and be subject to all requirements of 9VAC25-31-170.

General Permit No.: VAG87
Effective Date: March 1, ~~2019~~ 2024
Expiration Date: February ~~29, 2024~~ 28, 2029

GENERAL PERMIT FOR DISCHARGES RESULTING FROM THE APPLICATION OF PESTICIDES TO SURFACE WATERS OF VIRGINIA

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

In compliance with the provisions of the Clean Water Act (33 USC § 1251 et seq.), as amended, and pursuant to the State Water Control Law and regulations adopted pursuant thereto,

operators that apply pesticides that result in a discharge to surface waters are authorized to discharge to surface waters within the boundaries of the Commonwealth of Virginia.

The authorized discharge shall be in accordance with this cover page, Part I-Effluent Limitations, Monitoring Requirements, and Special Conditions, and Part II-Conditions Applicable to All VPDES Permits, as set forth in this general permit. Coverage under this VPDES general permit does not relieve any operator of the responsibility to comply with any other applicable federal, state, or local statute, ordinance, or regulation, including the pesticide product label.

A. Effluent limitations.

1. Technology-based effluent limitations. To meet the effluent limitations in this permit, the operator shall implement pest management measures that minimize discharges of pesticides to surface waters.

a. Minimize pesticide discharges to surface waters from pesticide application. All operators who perform the application of pesticides or who have day-to-day control of applications shall minimize the discharge of pollutants resulting from the application of pesticides, and:

(1) Use the lowest effective amount of pesticide product per application and optimum frequency of pesticide applications necessary to control the target pest, consistent with reducing the potential for development of pest resistance without exceeding the maximum allowable rate of the product label;

(2) No person shall apply, dispense, or use any pesticide in or through any equipment or application apparatus unless the equipment or apparatus is in sound mechanical condition and capable of satisfactory operation. All pesticide application equipment shall be properly equipped to dispense the proper amount of material. All pesticide mixing, storage, or holding tanks, whether on application equipment or not, shall be leak proof. All spray distribution systems shall be leak proof, and any pumps that these systems may have shall be capable of operating at sufficient pressure to assure a uniform and adequate rate of pesticide application;

(3) All pesticide application equipment shall be equipped with cut-off valves and discharge orifices to enable the operator to pass over nontarget areas without contaminating them. All hoses, pumps, or other equipment used to fill pesticide handling, storage, or application equipment shall be fitted with an effective valve or device to prevent backflow into water supply systems, streams, lakes, other sources of water, or other materials. However, these backflow devices or valves are not required for separate water storage tanks used to fill pesticide application equipment by gravity systems when the fill spout, tube, or pipe is not allowed to contact or fall below the water level of the application equipment being filled, and no other possible means of establishing a back siphon or backflow exists; and

(4) Assess weather conditions (e.g., temperature, precipitation, and wind speed) in the treatment area to ensure application is consistent with product label requirements.

b. Integrated pest management (IPM) practices. The operator with control over the financing for or the decision to perform pesticide applications that result in discharges, including the ability to modify those decisions, shall to the extent practicable consider integrated pest management practices to ensure that discharges resulting from the application of pesticides to surface waters are minimized. Operators that exceed the annual treatment area thresholds established in 9VAC25-800-30 C are also required to maintain a pesticide discharge management plan (PDMP) in accordance with Part I C of this permit. The PDMP documents the operator's IPM practices.

The operator's IPM practices shall consider the following for each pesticide use pattern:

(Note: If the operator's discharge of pollutants results from the application of a pesticide that is being used solely for the purpose of "pesticide research and development," as defined in 9VAC25-800-10, the operator is only required to fully implement IPM practices to the extent that the requirements do not compromise the research design.)

(1) Mosquito and other flying insect pest control. This subpart applies to discharges resulting from the application of pesticides to control public health, nuisance and other flying insect pests that develop or are present during a portion of their life cycle in or above standing or flowing water.

(a) Identify the problem. Prior to the first pesticide application covered under this permit that will result in a discharge to surface waters, and at least once each calendar year thereafter prior to the first pesticide application for that calendar year, the operator shall consider the following for each pest management area:

(i) Identify target pests;

(ii) Establish densities for pest populations or identify environmental conditions, either current or based on historical data, to serve as action thresholds for implementing pest management measures;

(iii) Identify known breeding sites for source reduction, larval control program, and habitat management;

(iv) Analyze existing surveillance data to identify new or unidentified sources of pest problems as well as sites that have recurring pest problems; and

(v) In the event there are no data for the pest management area in the past calendar year, use other available data as appropriate to meet the conditions in Part I A 1 b (1) (a).

(b) Pest management options. Prior to the first pesticide application covered under this permit that will result in a discharge to surface waters, and at least once each calendar year thereafter prior to the first pesticide application for that calendar year, the operator shall select and implement for each pest management area efficient and effective pest management measures that minimize discharges resulting from application of pesticides to control mosquitoes or other flying insect pests. In developing these pest management measures, the operator shall evaluate the following management options, including a combination of these options, considering impact to water quality, impact to nontarget organisms, pest resistance, feasibility, and cost effectiveness:

(i) No action;

(ii) Prevention;

(iii) Mechanical or physical methods;

(iv) Cultural methods;

(v) Biological control; and

(vi) Pesticides.

(c) Pesticide use. If a pesticide is selected to manage mosquitoes or flying insect pests and application of the pesticide will result in a discharge to surface waters, the operator shall:

(i) Conduct larval or adult surveillance in an area that is representative of the pest problem or evaluate existing larval surveillance data, environmental conditions, or data from adjacent areas prior to each pesticide application to assess the pest management area and to determine when the action threshold is met;

(ii) Reduce the impact on the environment and on nontarget organisms by applying the pesticide only when the action threshold has been met;

(iii) In situations or locations where practicable and feasible for efficacious control, use larvicides as a preferred pesticide for mosquito or flying insect pest control when larval action thresholds have been met; and

(iv) In situations or locations where larvicide use is not practicable or feasible for efficacious control, use adulticides for mosquito or flying insect pest control when adult action thresholds have been met.

(2) Weed and algae pest control. This subpart applies to discharges resulting from the application of pesticides to control weeds, algae, and pathogens that are pests in surface waters.

(a) Identify the problem. Prior to the first pesticide application covered under this permit that will result in a discharge to surface waters, and at least once each calendar year thereafter prior to the first pesticide application for that calendar year, the operator shall consider the following for each pest management area:

(i) Identify target pests;

(ii) Identify areas with pest problems and characterize the extent of the problems, including, for example, water use goals not attained (e.g., wildlife habitat, fisheries, vegetation, and recreation);

(iii) Identify possible factors causing or contributing to the pest problem (e.g., nutrients, invasive species, etc.);

(iv) Establish past or present pest densities to serve as action thresholds for implementing pest management strategies; and

(v) In the event there are no data for the pest management area in the past calendar year, use other available data as appropriate to meet the conditions in Part I A 1 b (2) (a).

(b) Pest management options. Prior to the first pesticide application covered under this permit that will result in a discharge to surface waters, and at least once each calendar year thereafter prior to the first pesticide application for that calendar year, the operator shall select and implement, for each pest management area, efficient and effective pest management measures that minimize discharges resulting from application of pesticides to control pests. In developing these pest management measures, the operator shall evaluate the following management options, including a combination of these options, considering impact to water quality, impact to nontarget organisms, pest resistance, feasibility, and cost effectiveness:

(i) No action;

(ii) Prevention;

(iii) Mechanical or physical methods;

(iv) Cultural methods;

(v) Biological control; and

(vi) Pesticides.

(c) Pesticide use. If a pesticide is selected to manage pests and application of the pesticide will result in a discharge to surface waters, the operator shall:

(i) Conduct surveillance in an area that is representative of the pest problem prior to each pesticide application to assess the pest management area and to determine when the action threshold is met that necessitates the need for pest management; and

(ii) Reduce the impact on the environment and nontarget organisms by applying the pesticide only when the action threshold has been met.

(3) Animal pest control. This subpart applies to discharges resulting from the application of pesticides to control animal pests in surface waters.

(a) Identify the problem. Prior to the first pesticide application covered under this permit that will result in a discharge to surface waters, and at least once each calendar year thereafter prior to the first pesticide application for that calendar year, the operator shall consider the following for each pest management area:

(i) Identify target pests;

(ii) Identify areas with pest problems and characterize the extent of the problems, including, for example, water use goals not attained (e.g., wildlife habitat, fisheries, vegetation, and recreation);

(iii) Identify possible factors causing or contributing to the problem (e.g., nutrients and invasive species);

(iv) Establish past or present pest densities to serve as action thresholds for implementing pest management strategies; and

(v) In the event there are no data for the pest management area in the past calendar year, use other available data as appropriate to meet the conditions in Part I A 1 b (3) (a).

(b) Pest management options. Prior to the first pesticide application covered under this permit that will result in a discharge to surface waters, and at least once each year thereafter prior to the first pesticide application during that calendar year, the operator shall select and implement, for each pest management area, efficient and effective pest management measures that minimize discharges resulting from application of pesticides to control animal pests. In developing these pest management measures, the operator shall evaluate the following management options, including a combination of these options, considering impact to water quality, impact to nontarget organisms, pest resistance, feasibility, and cost effectiveness:

(i) No action;

(ii) Prevention;

(iii) Mechanical or physical methods;

(iv) Cultural methods;

(v) Biological control; and

~~(v)~~ (vi) Pesticides.

(c) Pesticide use. If a pesticide is selected to manage animal pests and application of the pesticide will result in a discharge to surface waters, the operator shall:

(i) Conduct surveillance prior to each application to assess the pest management area and to determine when the action threshold is met that necessitates the need for pest management; and

(ii) Reduce the impact on the environment and nontarget organisms by evaluating site restrictions, application timing, and application method in addition to applying the pesticide only when the action threshold has been met.

(4) Forest canopy pest control. This subpart applies to discharges resulting from the application of pesticides to the forest canopy to control the population of a pest species where, to target the pests effectively, a portion of the pesticide unavoidably will be applied over and deposited to surface waters.

(a) Identify the problem. Prior to the first pesticide application covered under this permit that will result in a discharge to surface waters, and at least once each calendar year thereafter prior to the first pesticide application in that calendar year, the operator shall consider the following for each pest management area:

(i) Identify target pests;

(ii) Establish target pest densities to serve as action thresholds for implementing pest management measures;

(iii) Identify current distribution of the target pest and assess potential distribution in the absence of pest management measures; and

(iv) In the event there are no data for the pest management area in the past calendar year, use other available data as appropriate to meet the conditions in Part I A 1 (b) (4) (a).

(b) Pest management options. Prior to the first pesticide application covered under this permit that will result in a discharge to surface waters, and at least once each calendar year thereafter prior to the first pesticide application for that calendar year, the operator shall select and implement for each pest management area efficient and effective pest management measures that minimize discharges resulting from application of pesticides to control forestry pests. In developing these pest management measures, the operator shall evaluate the following management options, including a combination of these options, considering impact to water quality, impact to nontarget organisms, pest resistance, feasibility, and cost effectiveness:

(i) No action;

(ii) Prevention;

(iii) Mechanical or physical methods;

(iv) Cultural methods;

(v) Biological control; and

(vi) Pesticides.

(c) Pesticide use. If a pesticide is selected to manage forestry pests and application of the pesticide will result in a discharge to surface waters, the operator shall:

(i) Conduct surveillance prior to each application to assess the pest management area and to determine when the pest action threshold is met that necessitates the need for pest management;

(ii) Assess environmental conditions (e.g., temperature, precipitation, and wind speed) in the treatment area to identify conditions that support target pest development and are conducive for treatment activities;

(iii) Reduce the impact on the environment and nontarget organisms by evaluating the restrictions, application timing, and application methods in addition to applying the pesticide only when the action thresholds have been met; and

(iv) Evaluate using pesticides against the most susceptible developmental stage.

(5) Intrusive vegetation pest control. This subpart applies to discharges resulting from the application of pesticides along roads, ditches, canals, waterways, and utility rights of way where, to target the intrusive pests effectively, a portion of the pesticide will unavoidably be applied over and deposited to surface waters.

(a) Identify the problem. Prior to the first pesticide application covered under this permit that will result in a discharge to surface waters, and at least once each calendar year thereafter prior to the first pesticide application in that calendar year, the operator shall consider the following for each pest management area:

(i) Identify target pests;

(ii) Establish target pest densities to serve as action thresholds for implementing pest management measures;

(iii) Identify current distribution of the target pest and assess potential distribution in the absence of pest management measures; and

(iv) In the event there are no data for the pest management area in the past calendar year, use other available data as appropriate to meet the conditions in Part I A 1 (b) (5) (a).

(b) Pest management options. Prior to the first pesticide application covered under this permit that will result in a discharge to surface waters, and at least once each calendar year thereafter prior to the first pesticide application for that calendar year, the operator shall select and implement for each pest management area efficient and effective pest management measures that minimize discharges resulting from application of pesticides to intrusive vegetation pests. In developing these pest management measures, the operator shall evaluate the following management options, including a combination of these options, considering impact to water quality, impact to nontarget organisms, pest resistance, feasibility, and cost effectiveness:

(i) No action;

(ii) Prevention;

(iii) Mechanical or physical methods;

(iv) Cultural methods;

(v) Biological control; and

(vi) Pesticides.

(c) Pesticide use. If a pesticide is selected to manage intrusive vegetation pests and application of the pesticide will result in a discharge to surface waters, the operator shall:

(i) Conduct surveillance prior to each application to assess the pest management area and to determine when the pest action threshold is met that necessitates the need for pest management;

(ii) Assess environmental conditions (e.g., temperature, precipitation, and wind speed) in the treatment area to identify conditions that support target pest development and are conducive for treatment activities;

(iii) Reduce the impact on the environment and nontarget organisms by evaluating the restrictions, application timing, and application methods in addition to applying the pesticide only when the action thresholds have been met; and

(iv) Evaluate using pesticides against the most susceptible developmental stage.

2. Water quality-based effluent limitations. The operator's discharge of pollutants must be controlled as necessary to meet applicable numeric and narrative water quality standards for any discharges authorized under this permit, with compliance required upon beginning such discharge.

If at any time the operator become aware, or the ~~board~~ department determines, that the operator's discharge of pollutants causes or contributes to an excursion of applicable water quality standards, corrective action must be taken as required in Part I D 1 of this permit.

B. Monitoring requirements.

All operators covered under this permit must conduct a visual monitoring assessment (i.e., spot checks in the area to and around where pesticides are applied) for possible and observable adverse incidents caused by application of pesticides, including the unanticipated death or distress of nontarget organisms and disruption of wildlife habitat, recreational, or municipal water use.

A visual monitoring assessment is only required during the pesticide application when feasibility and safety allow. For example, visual monitoring assessment is not required during the course of treatment when that treatment is performed in darkness as it would be infeasible to note adverse effects under these circumstances. Visual monitoring assessments of the application site must be performed:

1. During any post-application surveillance or efficacy check that the operator conducts, if surveillance or an efficacy check is conducted.

2. During any pesticide application, when considerations for safety and feasibility allow.

C. Pesticide discharge management plan (PDMP). Any operator applying pesticides and exceeding the annual application thresholds established in 9VAC25-800-30 C must prepare a PDMP for the pest management area. The plan must be kept up-to-date thereafter for the duration of coverage under this general permit, even if discharges subsequently fall below the annual application threshold levels. The operator applying pesticides shall develop a PDMP consistent with the deadline outlined in Table I-1 below.

Table I-1. Pesticide Discharge Management Plan Deadline	
Category	PDMP Deadline
Operators who know prior to commencement of discharge that they will exceed an annual treatment area threshold identified in 9VAC25-800-30 C for that year.	Prior to first pesticide application covered under this permit.
Operators who do not know until after commencement of discharge that they will exceed an annual treatment area threshold identified in 9VAC25-800-30 C for that year.	Prior to exceeding an annual treatment area threshold.
Operators commencing discharge in response to a declared pest emergency situation as defined in 9VAC25-800-10 that will cause the operator to exceed an annual treatment area threshold.	No later than 90 days after responding to declared pest emergency situation.

The PDMP does not contain effluent limitations; the limitations are contained in Parts I A 1 and I A 2 of the permit. The PDMP documents how the operator will implement the effluent limitations in Parts I A 1 and I A 2 of the permit, including the evaluation and selection of pest management measures to meet those effluent limitations and minimize discharges. In the PDMP, the operator may incorporate by reference any procedures or plans in other documents that meet the requirements of this permit. If other documents are being relied upon by the operator to describe how compliance with the effluent limitations in this permit will be achieved, such as a pre-existing integrated pest management (IPM) plan, a copy of the portions of any documents that are being used to document the implementation of the effluent limitations shall be attached to the PDMP. The pest management measures implemented must be documented and the documentation must be kept up to date.

1. Contents of the pesticide discharge management plan. The PDMP must include the following elements:

a. Pesticide discharge management team;

b. Problem identification;

c. Pest management options evaluation;

d. Response procedures:

(1) Spill response procedures;

(2) Adverse incident response procedures; and

e. Signature requirements.

2. PDMP team. The operator shall identify all the persons (by name and contact information) who compose the team as well as each person's individual responsibilities, including:

a. Persons responsible for managing pests in relation to the pest management area;

b. Persons responsible for developing and revising the PDMP; and

c. Persons responsible for developing, revising, and implementing corrective actions and other effluent limitation requirements.

3. Problem identification. The operator shall document the following:

a. Pest problem description. Describe the pest problem at the pest management area, including identification of the target pests, sources of the pest problem, and sources of data used to identify the problem in Part I A 1 b (1) through b (5).

b. Action thresholds. Describe the action thresholds for the pest management area, including how they were determined.

c. General location map. Include a general location map that identifies the geographic boundaries of the area to which the plan applies and location of major surface waters.

4. Integrated pest management options evaluation. Operators shall document the evaluation of the pest management options, including a combination of the pest management options, to control the target pests. Pest management options include the following: no action, prevention, mechanical or physical methods, cultural methods, biological control agents, and pesticides. In the evaluation, decision makers shall consider the impact to water quality, impact to nontarget organisms, feasibility, cost effectiveness, and any relevant previous pest management measures.

5. Response procedures. Document the following procedures in the PDMP:

a. Spill response procedures. At a minimum the PDMP must have:

(1) Procedures for expeditiously stopping, containing, and cleaning up leaks, spills, and other releases to surface waters. Employees who may cause, detect, or respond to a spill or leak must be trained in these procedures and have necessary spill response equipment available. If possible, one of these individuals should be a member of the PDMP team.

(2) Procedures for notification of appropriate facility personnel, emergency response agencies, and regulatory agencies.

b. Adverse incident response procedures. At a minimum the PDMP must have:

(1) Procedures for responding to any incident resulting from pesticide applications; and

(2) Procedures for notification of the incident, both internal to the operator's agency or organization and external. Contact information for DEQ, nearest emergency medical facility, and nearest hazardous chemical responder must be in locations that are readily accessible and available.

6. PDMP signature requirements.

a. The PDMP, including changes to the PDMP to document any corrective actions taken as required by Part I D 1, and all reports submitted to the department must be signed by a person described in Part II G 1 or by a duly authorized representative of that person described in Part II G 2.

b. All other changes to the PDMP, and other compliance documentation required under this permit, must be signed and dated by the person preparing the change or documentation.

c. Any person signing documents in accordance with Part I C 6 a must include the certification from Part II G 4.

7. PDMP modifications and availability.

a. PDMP modifications. The operator shall modify the PDMP whenever necessary to address any of the triggering conditions for corrective action in Part I D 1 a, or when a change in pest control activities significantly changes the type or quantity of pollutants discharged. Changes to the PDMP must be made before the next pesticide application that results in a discharge, if practicable, or if not, as soon as possible thereafter. The revised PDMP must be signed and dated in accordance with Part II G.

The operator shall review the PDMP at a minimum once per calendar year and whenever necessary to update the pest problem identified and pest management strategies evaluated for the pest management area.

b. PDMP availability. The operator shall retain a copy of the current PDMP, along with all supporting maps and documents. The operator shall make the PDMP and supporting information available to the department upon request. The PDMP is subject to the provisions and exclusions of the Virginia Freedom of Information Act (§ 2.2-3700 et seq. of the Code of Virginia).

D. Special conditions.

1. Corrective action.

a. Situations requiring revision of pest management measures. If any of the following situations occur, the operator shall review and, as necessary, revise the evaluation and selection of pest management measures to ensure that the situation is eliminated and will not be repeated in the future:

(1) An unauthorized release or discharge associated with the application of pesticides occurs (e.g., spill, leak, or discharge not authorized by this or another VPDES permit);

(2) The operator becomes aware, or the ~~board~~ department concludes, that the pest management measures are not adequate or sufficient for the discharge of pollutants to meet applicable water quality standards;

(3) Any monitoring activities indicate that the operator failed to meet the technology-based effluent limitations in Part I A 1 a of this permit;

(4) An inspection or evaluation of the operator's activities by DEQ, VDACS, EPA, or a locality reveals that modifications to the pest management measures are necessary to meet the non-numeric effluent limits in this permit; or

(5) The operator observes (e.g., during visual monitoring that is required in Part I B) or is otherwise made aware of an adverse incident.

b. Corrective action deadlines. If the operator determines that changes to the pest management measures are necessary to eliminate any situation identified in Part I D 1 a, such changes must be made before the next pesticide application that results in a discharge if practicable, or if not, as soon as possible thereafter.

2. Adverse incident documentation and reporting.

a. Twenty-four-hour adverse incident notification. If the operator observes or is otherwise made aware of an adverse incident that may have resulted from a discharge from the operator's pesticide application, the operator shall immediately notify the department (see Part I D 5). This notification must be made within 24 hours of when the operator becomes aware of the adverse incident and must include at least the following information:

(1) The caller's name and telephone number;

(2) Operator's name and mailing address;

(3) The name and telephone number of a contact person if different than the person providing the 24-hour notice;

(4) How and when the operator became aware of the adverse incident;

(5) Description of the location of the adverse incident;

(6) Description of the adverse incident identified and the EPA pesticide registration number for each product that was applied in the area of the adverse incident; and

(7) Description of any steps the operator has taken or will take to correct, repair, remedy, cleanup, or otherwise address any adverse effects.

If the operator is unable to notify the department within 24 hours, notification shall be made as soon as possible and

the rationale for why the notification was not possible within 24 hours shall be provided.

The adverse incident notification and reporting requirements are in addition to what the registrant is required to submit under FIFRA § 6(a)(2) and its implementing regulations at 40 CFR Part 159.

b. Reporting of adverse incidents is not required under this permit in the following situations:

(1) The operator is aware of facts that clearly establish that the adverse incident was not related to toxic effects or exposure from the pesticide application.

(2) The operator has been notified in writing by the ~~board~~ department that the reporting requirement has been waived for this incident or category of incidents.

(3) The operator receives notification of a potential adverse incident but that notification and supporting information are clearly erroneous.

(4) An adverse incident occurs to pests that are similar in kind to pests identified as potential targets.

c. Five-day adverse incident written report. Within five days of a reportable adverse incident pursuant to Part I D 2 a, the operator shall provide a written report of the adverse incident to the appropriate DEQ regional office at the address listed in Part I D 5. The adverse incident report must include at least the following information:

(1) Information required to be provided in Part I D 2 a;

(2) Date and time the operator contacted DEQ notifying the department of the adverse incident, and with whom the operator spoke at DEQ, and any instructions the operator received from DEQ;

(3) Location of incident, including the names of any waters affected and appearance of those waters (sheen, color, clarity, etc.);

(4) A description of the circumstances of the adverse incident including species affected, estimated number of individuals, and approximate size of dead or distressed organisms;

(5) Magnitude and scope of the affected area (e.g., aquatic square area or total stream distance affected);

(6) Pesticide application rate, intended use site, method of application, and name of pesticide product, description of pesticide ingredients, and EPA registration number;

(7) Description of the habitat and the circumstances under which the adverse incident occurred (including any available ambient water data for pesticides applied);

(8) If laboratory tests were performed, indicate what tests were performed, and when, and provide a summary of the test results within five days after they become available;

(9) If applicable, explain why it is believed the adverse incident could not have been caused by exposure to the pesticide;

(10) Actions to be taken to prevent recurrence of adverse incidents; and

(11) Signed and dated in accordance with Part II G.

The operator shall report adverse incidents even for those instances when the pesticide labeling states that adverse effects may occur.

d. Adverse incident to threatened or endangered species or critical habitat.

(1) Notwithstanding any of the other adverse incident notification requirements of this section, if the operator becomes aware of an adverse incident to threatened or endangered species or critical habitat that may have resulted from a discharge from the operator's pesticide application, the operator shall immediately notify the:

(a) National Marine Fisheries Service (NMFS) and the Virginia Department of Game and Inland Fisheries (DGIF) in the case of an anadromous or marine species;

(b) U.S. Fish and Wildlife Service (FWS) and the DGIF in the case of an animal or invertebrate species; or

(c) FWS and the Virginia Department of Agriculture and Consumer Services in the case of plants or insects.

(2) Threatened or endangered species or critical habitats include the following:

(a) Federally listed threatened or endangered species;

(b) Federally designated critical habitat;

(c) State-listed threatened or endangered species; and

(d) Tier I (critical conservation need) or Tier II (very high conservation need) species of greatest conservation need (SGCN) as defined in Virginia's Wildlife Action Plan ~~(www.bewildvirginia.org)~~ (http://bewildvirginia.org/wildlife-action-plan/).

(3) This notification must be made by telephone immediately upon the operator becoming aware of the adverse incident and must include at least the following information:

(a) The caller's name and telephone number;

(b) Operator's name and mailing address;

(c) The name of the affected species, size of area impacted, and if applicable, the approximate number of animals affected;

(d) How and when the operator became aware of the adverse incident;

(e) Description of the location of the adverse incident;

(f) Description of the adverse incident, including the EPA pesticide registration number for each product the operator applied in the area of the adverse incident;

(g) Description of any steps the operator has taken or will take to alleviate the adverse impact to the species; and

(h) Date and time of application. Additional information on federally listed threatened or endangered species and

federally designated critical habitat is available from NMFS ~~(www.nmfs.noaa.gov)~~ (https://www.fisheries.noaa.gov/species-directory/threatened-endangered) for anadromous or marine species or FWS ~~(www.fws.gov)~~ (https://www.fws.gov/species/search) for terrestrial or freshwater species. Additional information on state-listed threatened or endangered wildlife species is available through the Virginia Fish and Wildlife Information Service ~~(www.dgif.virginia.gov)~~ (https://dwr.virginia.gov/wildlife/wildlife-information/). Listing of state threatened or endangered plants and insects can be found in §§ 3.2-1000 through 3.2-1011 of the Code of Virginia and 2VAC5-320-10 of the Virginia Administrative Code (both the Code of Virginia and the Virginia Administrative Code must be referenced in order to obtain the complete plant and insect list). (Contact information for these agencies can be found on the contact information form or through the DEQ website.)

3. Reportable spills and leaks.

a. Spill, leak, or other unauthorized discharge notification. Where a leak, spill, or other release containing a hazardous substance or oil in an amount equal to or in excess of a reportable quantity established under either 40 CFR Part 110, 117, or 302 occurs in any 24-hour period, the operator shall notify the department (see Part I D 2) as soon as the operator has knowledge of the release. Department contact information must be kept in locations that are readily accessible and available in the area where a spill, leak, or other unpermitted discharge may occur.

b. Five-day spill, leak, or other unauthorized discharge report. Within five days of the operator becoming aware of a spill, leak, or other unauthorized discharge triggering the notification in subdivision 3 of this subsection, the operator shall submit a written report to the appropriate DEQ regional office at the address listed in Part I D 5. The report shall contain the following information:

(1) A description of the nature and location of the spill, leak, or discharge;

(2) The cause of the spill, leak, or discharge;

(3) The date on which the spill, leak, or discharge occurred;

(4) The length of time that the spill, leak, or discharge continued;

(5) The volume of the spill, leak, or discharge;

(6) If the discharge is continuing, how long it is expected to continue and what the expected total volume of the discharge will be;

(7) A summary of corrective action taken or to be taken including date initiated and date completed or expected to be completed; and

(8) Any steps planned or taken to prevent recurrence of such a spill, leak, or other discharge, including notice of whether PDMP modifications are required as a result of the spill or leak.

Discharges reportable to the department under the immediate reporting requirements of other regulations are exempted from this requirement.

The ~~board~~ department may waive the written report on a case-by-case basis for reports of noncompliance if the oral report has been received within 24 hours and no adverse impact on state waters has been reported.

4. Recordkeeping and annual reporting. The operator shall keep records as required in this permit. These records must be accurate, complete, and sufficient to demonstrate compliance with the conditions of this permit. The operator can rely on records and documents developed for other obligations, such as requirements under FIFRA and state or local pesticide programs, provided all requirements of this permit are satisfied. The ~~board~~ department recommends that all operators covered under this permit keep records of acres or linear miles treated for all applicable use patterns covered under this general permit.

a. All operators must keep the following records:

(1) A copy of any adverse incident reports (see Part I D 2 c).

(2) The operator's rationale for any determination that reporting of an identified adverse incident is not required consistent with allowances identified in Part I D 2 b.

b. Any operator performing the application of a pesticide or who has day-to-day control of the application and exceeding the annual application thresholds established in 9VAC25-800-30 C must also maintain a record of each pesticide applied. This shall apply to both general use and restricted use pesticides. Each record shall contain the:

(1) Name, address, and telephone number of customer and address or location, if different, of site of application;

(2) Name and VDACS certification number of the person making the application or certification number of the supervising certified applicator;

(3) Day, month, and year of application;

(4) Type of plants, crop, animals, or sites treated and principal pests to be controlled;

(5) Acreage, area, or number of plants or animals treated;

(6) Brand name or common product name;

(7) EPA registration number;

(8) Amount of pesticide concentrate and amount of diluting used, by weight or volume, in mixture applied; and

(9) Type of application equipment used.

c. All required records must be assembled as soon as possible but no later than 30 days following completion of such activity. The operator shall retain any records required under this permit for at least three years from the

date of the pesticide application. The operator shall make available to the ~~board~~ department, including an authorized representative of the ~~board~~ department, all records kept under this permit upon request and provide copies of such records, upon request.

d. Annual reporting.

(1) Any operator applying pesticides that reports an adverse incident as described in Part I D 2 must submit an annual report to the department no later than February 10 of the following year (and retain a copy for the operator's records).

(2) The annual report must contain the following information:

(a) Operator's name;

(b) Contact person's name, title, email address (where available), and phone number;

(c) A summary report of all adverse incidents that occurred during the previous calendar year; and

(d) A summary of any corrective actions, including spill responses, in response to adverse incidents, and the rationale for such actions.

5. DEQ contact information and mailing addresses.

a. All incident reports under Part I D 2 must be sent to the appropriate DEQ regional office within five days of the operator becoming aware of the adverse incident.

b. All other written correspondence concerning discharges must be sent to the address of the appropriate DEQ regional office listed in Part I D 5 ~~c~~ d.

~~NOTE:~~ c. The immediate (within 24 hours) reports required in Part I D 2 ~~may~~ shall be made to the department's regional office. Reports may be made by telephone, fax, or online ~~(http://www.deq.virginia.gov/Programs/PollutionResponsePreparedness/MakingaReport.aspx)~~ (https://www.deq.virginia.gov/get-involved/pollution-response) (online reporting preferred).

For reports outside normal working hours, ~~leave a message, and this shall fulfill the immediate reporting requirement~~ the online portal shall be used. For emergencies, call the Virginia Department of Emergency Management ~~maintains a 24 hour telephone service at~~ Emergency Operations Center (24-hours) 1-800-468-8892.

c. DEQ regional office addresses.

(1) Blue Ridge Regional Office (BRRO)

~~3019 Peters Creek Road~~ 901 Russell Drive

~~Roanoke~~ Salem, VA ~~24019~~ 24153

(540) 562-6700

(fax - for all regional offices) (804) 698-4178

(2) Northern ~~Virginia~~ Regional Office (NVRO)

13901 Crown Court

Woodbridge, VA 22193

(703) 583-3800

(3) Piedmont Regional Office (PRO)

4949-A Cox Road

Glen Allen, VA 23060

(804) 527-5020

(4) Southwest Regional Office (SWRO)

355 Deadmore St.

P.O. Box 1688

Abingdon, VA 24212

(276) 676-4800

(5) Tidewater Regional Office (TRO)

5636 Southern Blvd.

Virginia Beach, VA 23462

(757) 518-2000

(6) Valley Regional Office (VRO)

4411 Early Road

Mailing address: P.O. Box 3000

Harrisonburg, VA 22801

(540) 574-7800

Part II

Conditions Applicable to all VPDES Permits

A. Monitoring.

1. Samples and measurements taken as required by this permit shall be representative of the monitored activity.

2. Monitoring shall be conducted according to procedures approved under 40 CFR Part 136 or alternative methods approved by the U.S. Environmental Protection Agency, unless other procedures have been specified in this permit.

3. The operator shall periodically calibrate and perform maintenance procedures on all monitoring and analytical instrumentation at intervals that will ensure accuracy of measurements.

B. Records.

1. Records of monitoring information shall include:

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

b. The individuals who performed the sampling or measurements;

c. The dates and times analyses were performed;

d. The individuals who performed the analyses;

e. The analytical techniques or methods used; and

f. The results of such analyses.

2. The operator shall retain records of all monitoring information, including all calibration and maintenance records and copies of all reports required by this permit for a period of at least three years from the date that coverage under this permit expires. This period of retention shall be extended automatically during the course of any unresolved litigation regarding the regulated activity or regarding control standards applicable to the operator, or as requested by the ~~board~~ department.

C. Reporting monitoring results. Monitoring results under this permit are not required to be submitted to the department. However, should the department request that the operator submit monitoring results, the following subdivisions would apply.

1. The operator shall submit the results of the monitoring required by this permit not later than the 10th day of the month after monitoring takes place, unless another reporting schedule is specified elsewhere in this permit. Monitoring results shall be submitted to the department's regional office.

2. Monitoring results shall be reported on a discharge monitoring report (DMR) or on forms provided, approved, or specified by the department.

3. If the operator monitors any pollutant specifically addressed by this permit more frequently than required by this permit using test procedures approved under 40 CFR Part 136 or using other test procedures approved by the U.S. Environmental Protection Agency or using procedures specified in this permit, the results of this monitoring shall be included in the calculation and reporting of the data submitted on the DMR or reporting form specified by the department.

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

D. Duty to provide information. The operator shall furnish to the department, within a reasonable time, any information that the ~~board~~ department may request to determine whether cause exists for terminating coverage under this permit or to determine compliance with this permit. The ~~board~~ department may require the operator to furnish, upon request, such plans, specifications, and other pertinent information as may be necessary to determine the effect of the wastes from the permittee's discharge on the quality of state waters, or such other information as may be necessary to accomplish the purposes of the State Water Control Law. The operator shall also furnish to the department, upon request, copies of records required to be kept by this permit.

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

F. Unauthorized discharges. Except in compliance with this permit, or another permit issued by the department or general permit regulation adopted by the board, it shall be unlawful for any person to:

1. Discharge into state waters sewage, industrial wastes, other wastes, or any noxious or deleterious substances; or

2. Otherwise alter the physical, chemical, or biological properties of such state waters and make them detrimental to the public health, to animal or aquatic life, or to the use of such waters for domestic or industrial consumption, recreation, or other uses.

G. Signature requirements.

1. The PDMP, including changes to the PDMP to document any corrective actions taken as required by Part I D 1, and all reports submitted to the department must be signed by a person described in this subsection or by a duly authorized representative of that person described in subdivision 2 of this subsection.

a. For a corporation: by a responsible corporate officer. For the purpose of this subsection, a responsible corporate officer means: (i) a president, secretary, treasurer, or vice-president of the corporation in charge of a principal business function, or any other person who performs similar policy-making or decision-making functions for the corporation, or (ii) the manager of one or more manufacturing, production, or operating facilities, provided the manager is authorized to make management decisions that govern the operation of the regulated activity including having the explicit or implicit duty of making major capital investment recommendations and initiating and directing other comprehensive measures to assure long-term environmental compliance with environmental laws and regulations; the manager can ensure that the necessary systems are established or actions taken to gather complete and accurate information for permit application requirements; and authority to sign documents has been assigned or delegated to the manager in accordance with corporate procedures;

b. For a partnership or sole proprietorship: by a general partner or the proprietor, respectively; or

c. For a municipality, state, federal, or other public agency: by either a principal executive officer or ranking elected official. For purposes of this subsection, a principal executive officer of a federal agency includes (i) the chief executive officer of the agency or (ii) a senior executive officer having responsibility for the overall operations of a principal geographic unit or the agency.

2. A person is a duly authorized representative only if:

a. The authorization is made in writing by a person described in subdivision 1 of this subsection;

b. The authorization specifies either an individual or a position having responsibility for the overall operation of

the regulated activity such as the position of superintendent, position of equivalent responsibility, or an individual or position having overall responsibility for environmental matters for the company. A duly authorized representative may thus be either a named individual or any individual occupying a named position; and

c. The signed and dated written authorization is included in the PDMP. A copy of this authorization must be submitted to the department if requested.

3. All other changes to the PDMP, and other compliance documentation required under this permit, must be signed and dated by the person preparing the change or documentation.

4. Any person signing documents in accordance with subdivision 1 or 2 of this subsection must include the following certification:

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

H. Duty to comply. The operator shall comply with all conditions of this permit. Any permit noncompliance constitutes a violation of the State Water Control Law and the federal Clean Water Act, except that noncompliance with certain provisions of this permit may constitute a violation of the State Water Control Law but not the Clean Water Act. Permit noncompliance is grounds for enforcement action, for permit coverage termination, or denial of permit coverage renewal.

The operator shall comply with effluent standards or prohibitions established under § 307(a) of the Clean Water Act for toxic pollutants within the time provided in the regulations that establish these standards or prohibitions, even if this permit has not yet been modified to incorporate the requirement.

I. Duty to reapply. If the operator wishes to continue an activity regulated by this permit after the expiration date of this permit, the operator must have coverage under a new permit.

J. Effect of a permit. This permit does not convey any property rights in either real or personal property or any exclusive privileges, nor does it authorize any injury to private property or invasion of personal rights, or any infringement of federal, state, or local law or regulations.

K. State law. Nothing in this permit shall be construed to preclude the institution of any legal action under, or relieve the operator from any responsibilities, liabilities, or penalties established pursuant to any other state law or regulation or under authority preserved by § 510 of the Clean Water Act. Nothing in this permit shall be construed to relieve the operator from civil and criminal penalties for noncompliance.

L. Oil and hazardous substance liability. Nothing in this permit shall be construed to preclude the institution of any legal action or relieve the operator from any responsibilities, liabilities, or penalties to which the operator is or may be subject under §§ 62.1-44.34:14 through 62.1-44.34:23 of the State Water Control Law.

M. Proper operation and maintenance. The operator shall at all times properly operate and maintain all facilities and systems of treatment and control (and related appurtenances) that are installed or used by the operator to achieve compliance with the conditions of this permit. Proper operation and maintenance also include effective plant performance, adequate funding, adequate staffing, and adequate laboratory and process controls, including appropriate quality assurance procedures. This provision requires the operation of backup or auxiliary facilities or similar systems that are installed by the operator only when the operation is necessary to achieve compliance with the conditions of this permit.

N. Disposal of solids or sludges. Solids, sludges, or other pollutants removed in the course of treatment or management of pollutants shall be disposed of in a manner so as to prevent any pollutant from such materials from entering state waters.

O. Duty to mitigate. The operator shall take all reasonable steps to minimize or prevent any discharge or sludge use or disposal in violation of this permit that has a reasonable likelihood of adversely affecting human health or the environment.

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

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

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

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

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

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

For purposes of this section, the time for inspection shall be deemed reasonable during regular business hours or whenever the facility is discharging. Nothing contained herein shall make an inspection unreasonable during an emergency.

R. Permit actions. Permit coverage may be terminated for cause. The filing of a request by the operator for a permit termination or a notification of planned changes or anticipated noncompliance does not stay any permit condition.

S. Transfer of permit coverage. Permits are not transferable to any person except after notice to the department. The transfer of permit coverage under this pesticide general permit is not anticipated since coverage is automatic where an operator meets the permit eligibility requirements.

T. Severability. The provisions of this permit are severable, and if any provision of this permit or the application of any provision of this permit to any circumstance is held invalid, the application of such provision to other circumstances, and the remainder of this permit, shall not be affected thereby.

VA.R. Doc. No. R22-6928; Filed November 2, 2022, 3:51 p.m.

TITLE 12. HEALTH

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

Proposed Regulation

Title of Regulation: **12VAC30-120. Waivered Services (amending 12VAC30-120-900 through 12VAC30-120-925, 12VAC30-120-927, 12VAC30-120-930, 12VAC30-120-935, 12VAC30-120-945; repealing 12VAC30-120-1700 through 12VAC30-120-1770).**

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

Public Hearing Information: No public hearing is currently scheduled.

Public Comment Deadline: February 3, 2023.

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 the Board of Medical Assistance Services the authority to administer and amend the Plan for Medical Assistance and to promulgate regulations. Section 32.1-324 of the Code of Virginia grants the Director of the Department of Medical Assistance Services (DMAS) the authority of the board when it is not in session.

Item 306 JJJ(3) of the 2016 Appropriations Act directs the agency to seek reforms to include all remaining Medicaid populations and services, including long-term care and home-based and community-based waiver services into cost-effective, managed, and coordinated delivery systems, which was carried forward in Item 306 JJJ(3) of the 2017 Appropriations Act, Item 303 SS(3) of the 2018 Appropriations Act, and Item 303 SS(3) of the 2019 Appropriations Act.

Virginia was granted authority by the Centers for Medicare and Medicaid Services (CMS) to mandate the enrollment of eligible individuals into selected managed care plans using a §1915(b) waiver to run concurrently with this waiver authority. CMS granted authority to DMAS on July 1, 2017, to allow individuals previously served under the Elderly or Disabled with Consumer Direction or Technology Assisted Waiver to be covered under the Commonwealth Coordinated Care Plus Waiver.

Purpose: DMAS created a new § 1915(c) waiver, the Commonwealth Coordinated Care Plus (CCC) Waiver. This waiver will permit individuals previously served under the Elderly or Disabled with Consumer Direction (EDCD) Waiver and Technology Assisted (Tech) Waiver to receive home and community-based services to prevent institutionalization while supporting the health, safety, and welfare of individuals. Individuals older than 65 years of age or younger than 65 years of age with a physical disability are the targeted audience for this waiver. Individuals on the CCC Waiver may receive services either through the fee-for-service model or as members of the CCC managed care program as part of a fully integrated model across the full continuum of care that includes physical health, behavioral health, the Program for All-Inclusive Care for the Elderly, and institutional services.

Substance: The proposed amendments repeal the Tech Waiver and combines the EDCD and Tech Waivers into one home and community-based waiver to provide access for both populations to additional services to utilize. New regulation include definitions, waiver description and legal authority for the waiver, individual eligibility requirements, covered services, respite coverage in children's residential facilities, general requirements for home and community-based participating providers, participation standards, and payment for services.

Issues: The primary advantages of this regulatory action for the public and the agency are that the rules guiding the CCC Waiver, which have been approved by CMS, will be included in the Virginia Administrative Code for Medicaid providers,

Medicaid members, and other stakeholders. There are no disadvantages to the public, the agency, or the Commonwealth as a result of this regulatory action.

Department of Planning and Budget's Economic Impact Analysis: The Department of Planning and Budget (DPB) has analyzed the economic impact of this proposed regulation in accordance with § 2.2-4007.04 of the Code of Virginia (Code) and Executive Order 14 (as amended, July 16, 2018). The analysis presented represents DPB's best estimate of these economic impacts.[1]

Summary of the Proposed Amendments to Regulation. Pursuant to the 2016 Appropriations Act, Item 306.JJJ(3), the Board of Medical Assistance Services (Board) proposes to create the Commonwealth Coordinated Care Plus (CCC Plus) waiver as a replacement for the Elderly or Disabled with Consumer Direction Waiver (12VAC30-120-900 et seq.) and the Technology Assisted Waiver (12VAC30-120-1700 et seq.). This action also incorporates 1) language for overtime for Consumer-Directed attendants as required by Item 313 ZZZZ of the 2021 Appropriation Act, 2) a reduction from eight to four hours for the employment earnings disregard criteria as required by Item 313 QQQQ of the 2021 Appropriation Act, 3) a limit of 16 hours per day for a single aide, attendant, or nurse to provide care (personal care or respite services) to an individual, and 4) changes from a state fiscal year to a calendar year regarding respite, assistive technology, and environmental modification services.

Background. The 2016 Appropriations Act, Item 306 JJJ(3)[2] directed the Department of Medical Assistance Services (DMAS) to "seek reforms to include all remaining Medicaid populations and services, including long-term care and home- and community-based waiver services into cost-effective, managed and coordinated delivery systems."[3] Pursuant to the legislative mandate, DMAS created a new § 1915(c) waiver known as the Commonwealth Coordinated Care Plus (CCC Plus) waiver[4] and the Centers for Medicare and Medicaid Services (CMS) granted authority to DMAS on July 1, 2017. CCC Plus waiver combines the populations of the Elderly or Disabled with Consumer Direction (EDCD) waiver and Technology Assisted (TECH) waiver into a single waiver.

The CCC Plus waiver permits individuals previously served under the EDCD and TECH waivers to receive home and community-based services to prevent institutionalization while supporting the health, safety, and welfare of individuals. Individuals over the age of 65 or under the age of 65 with a physical disability are the targeted audience for this waiver. Individuals on the CCC Plus waiver may receive services either through the fee for service model or as members of the CCC Plus managed care program as part of a fully integrated model across the full continuum of care that includes physical health, behavioral health, the program for all-inclusive care for the elderly, and institutional services. In Fiscal Year (FY) 2019, there were 43,344 individuals enrolled in the waiver with expenditures totaling $967 million.

Estimated Benefits and Costs. This action primarily combines the EDCD waiver (12VAC30-120-900 et seq.) and the TECH waiver (12VAC30-120-1700 et seq.) into a single waiver without changing eligibility rules, coverage of services, reimbursement rates, etc. except as discussed. This combined waiver was approved by CMS effective July 1, 2017 and has been in effect since then. Thus the main impact of this action is providing clarity to Medicaid providers, Medicaid members, and stakeholders by revising the regulatory text to reflect the approved waiver. The CCC Plus waiver was designed to be budget neutral. DMAS does not project costs, savings, fees, or revenues from this regulatory change except as discussed below.

One of the proposed changes represents a departure from the original ECDC or TECH waivers because it was recently mandated by Item 313 ZZZZ of the 2021 Appropriation Act[5] and was not part of the old waivers. The mandate required DMAS to authorize effective July 1, 2021, time and a half "up to 16 hours for a single attendant who works more than 40 hours per week for attendants providing Medicaid-reimbursed consumer-directed personal assistance, respite and companion services." This change provided overtime for consumer directed attendants. These are service providers hired by the member/their representative to provide personal care, respite, or companion care. The General Assembly provided $9.6 million in general funds and $9.6 million in federal funds for FY 2022 to implement this mandate. There are approximately 23,000 attendants who provide this service who became eligible for overtime pay if they worked more than 40 hours in a week. In addition to benefiting attendants directly, the use of federal funds for the higher pay rate represents an injection of new resources into Virginia's economy with an expected expansionary effect.

Another change that was not in the original waivers is a reduction from eight to four hours for the employment earnings disregard criteria per Item 313 QQQQ of the 2021 Appropriation Act.[6] The earnings disregard allows a certain amount of money to be disregarded during the eligibility review when the member has a job. With this change individuals who work at least four hours will have their earnings disregarded when eligibility is calculated. Previously, an individual would have to work at least eight hours to have any earnings disregarded. The General Assembly has provided no funding for this change, perhaps because it affected only a few persons that DMAS is aware of.

This action also adds a limit of 16 hours per day for a single aide, attendant, registered nurse (RN), or licensed practical nurse (LPN) to provide care (personal care or respite services) to an individual. According to DMAS, this is to allow the aide/attendant/RN/LPN to take breaks to avoid possible health, safety, and welfare issues due to the provider's exhaustion. The members still have the same number of service hours authorized. Similarly, agency providers are not expected to be financially affected because the same number of hours will be authorized. Typically, agencies already provide more than one

caregiver if the number of authorized hours per day are more than 16. However, attendants who currently work more than 16 hours in a day will be affected as they will no longer be able to provide more than 16 hours of care per day.

Finally, the action changes respite, assistive technology, and environmental modifications approvals from a state fiscal year base to a calendar year base. The purpose of this change is to move the approval base to the calendar year to be in line with the managed care enrollment. The service limits are unchanged and no fiscal impact is expected from this particular change.

Businesses and Other Entities Affected. Approximately 4,000 providers are enrolled to provide services through this waiver to approximately 43,344 Medicaid members.

The Code of Virginia requires DPB to assess whether an adverse impact may result from the proposed regulation.[7] An adverse impact is indicated if there is any increase in net cost or reduction in net revenue for any entity, even if the benefits exceed the costs for all entities combined. The only adverse impact from this change appears to be on attendants, RNs, and LPNs who currently work more than 16 hours in a day as they will no longer be allowed to provide more than 16 hours of care per day.

Small Businesses[8] Affected:[9] The proposed action does not appear to adversely affect small businesses.

Localities[10] Affected.[11] The proposed changes do not disproportionately affect particular localities or introduce costs for local governments.

Projected Impact on Employment. The legislatively mandated overtime pay for attendants may incentivize attendants to work more than 40 hours a week, but without the need for attendants willing to work overtime the impact on total employment would not be significant.

Effects on the Use and Value of Private Property. The proposed amendments do not appear to affect the use and value of private property or real estate development costs.

[1]Section 2.2-4007.04 of the Code of Virginia requires that such economic impact analyses determine the public benefits and costs of the proposed amendments. Further the analysis should include but not be limited to: (1) the projected number of businesses or other entities to whom the proposed regulatory action would apply, (2) the identity of any localities and types of businesses or other entities particularly affected, (3) the projected number of persons and employment positions to be affected, (4) the projected costs to affected businesses or entities to implement or comply with the regulation, and (5) the impact on the use and value of private property.

[2]https://budget.lis.virginia.gov/item/2016/1/HB30/Chapter/1/306/

[3]This mandate was carried forward in the 2017 Appropriations Act, Item 306.JJJ(3), the 2018 Appropriations Act, Item 303.SS(3), and the 2019 Appropriations Act, Item 303.SS(3).

[4]CCC Plus waiver is often confused with CCC Plus managed care program, but they are separate and distinct. CCC Plus program is the managed long term services and supports system. The CCC Plus waiver is the specific home and community based service that supports individuals in the community in lieu of institutional care (nursing facilities). The CCC Plus waiver serves individuals in the CCC Plus program and individuals in fee for service.

[5]https://budget.lis.virginia.gov/item/2021/2/HB1800/Chapter/1/313/

[6]Ibid.

[7]Pursuant to § 2.2-4007.04 D: In the event this economic impact analysis reveals that the proposed regulation would have an adverse economic impact on businesses or would impose a significant adverse economic impact on a locality, business, or entity particularly affected, the Department of Planning and Budget shall advise the Joint Commission on Administrative Rules, the House Committee on Appropriations, and the Senate Committee on Finance. Statute does not define "adverse impact," state whether only Virginia entities should be considered, nor indicate whether an adverse impact results from regulatory requirements mandated by legislation.

[8]Pursuant to § 2.2-4007.04, 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."

[9]If the proposed regulatory action may have an adverse effect on small businesses, § 2.2-4007.04 requires that such economic impact analyses include: (1) an identification and estimate of the number of small businesses subject to the proposed regulation, (2) the projected reporting, recordkeeping, and other administrative costs required for small businesses to comply with the proposed regulation, including the type of professional skills necessary for preparing required reports and other documents, (3) a statement of the probable effect of the proposed regulation on affected small businesses, and (4) a description of any less intrusive or less costly alternative methods of achieving the purpose of the proposed regulation. Additionally, pursuant to § 2.2-4007.1 of the Code of Virginia, if there is a finding that a proposed regulation may have an adverse impact on small business, the Joint Commission on Administrative Rules shall be notified.

[10]"Locality" can refer to either local governments or the locations in the Commonwealth where the activities relevant to the regulatory change are most likely to occur.

[11]Section 2.2-4007.04 defines "particularly affected" as bearing disproportionate material impact.

Agency's Response to the 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 proposed amendments repeal the Technology Assisted Waiver and establish Commonwealth Coordinated Care Plus (CCC Plus) for individuals previously served under the Elderly and Disabled with Consumer Direction and the Technology Assistance Waivers. CCC Plus will operate under a fully integrated model across the full continuum of care that includes physical health, behavioral health, and community-based and institutional services and have very few carved out services. The proposed new waiver includes definitions, waiver description and legal authority for the waiver, individual eligibility requirements, covered services, respite coverage in children's residential facilities, general requirements for home and community-based participating providers, participation standards, and payment for services. Some specific proposed provisions include (i) language for overtime for consumer-directed attendants as required by Item 313 ZZZZ of the 2021 Appropriation Act; (ii) a reduction to four hours for the employment earnings disregard criteria as required by Item 313 QQQQ of the 2021 Appropriation Act; (iii) a limit of 16 hours per day for a single aide, attendant, or nurse to provide personal care or respite services to an

individual; and (iv) changes from a state fiscal year to a calendar year regarding respite, assistive technology, and environmental modification services.

Part IX

~~Elderly or Disabled with Consumer Direction~~ Commonwealth Coordinated Care Plus 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~~ eating or feeding. An individual's degree of independence in performing these activities is a part of determining appropriate level of care and service needs.

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

"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 program licensed by the Virginia Department of Social Services (VDSS) as an adult day care center (ADCC) and authorized as a Medicaid-enrolled provider meeting home and community-based services (HCBS) settings rules that provides 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.

"Adult protective services" or "APS" means the same as defined in § 63.2-100 of the Code of Virginia.

"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.~~

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

"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 et seq. and 12VAC30-20-500 through ~~12VAC30-20-560~~ 12VAC30-20-570.

"Applicant" means an individual or representative on the individual's behalf who has applied for or is in the process of applying for and is awaiting a determination of eligibility for admission to the CCC Plus Program Waiver.

"Assess" means to evaluate an applicant's or an individual's condition, including functional status (i.e., an individual's degree of dependence in performing ADLs or IADLs), current medical status, psycho-social history, and environment. Information is collected from the applicant or individual, applicant's or individual's representative, family, and medical professionals as well as the assessor's observation of the applicant or individual.

"Assessment" means one or more processes that are used to obtain information about an individual, including the individual's condition, personal goals and preferences, functional limitations, health status, financial status, and other factors that are relevant to the determination of eligibility for service. An assessment is required for the authorization of and provision of services and for the development of the plan of care.

"Assistive technology" or "AT" means specialized medical equipment and supplies including those devices, controls, or appliances specified in the plan of care but not available under the State Plan for Medical Assistance that (i) enable ~~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~~ ADLs or IADLs and to perceive, control, or communicate with the environment in which ~~they~~ the individuals live~~,~~ or ~~that~~ (ii) are necessary to the proper functioning of the specialized equipment.

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

"Backup plan" means a secondary network of supports to perform the duties needed by the waiver individual to ensure the individual's health, safety, and welfare should the paid caregiver be unable to provide such services. All waiver individuals are required to have a backup plan prior to initiation of services and ongoing, which shall be documented in the waiver individual's records. Those listed in the backup

plan shall be trained in the skilled needs and technologies required by the waiver individual.

"Barrier crime" means those crimes as defined at ~~§ 32.1-162.9:1~~ § 19.2-392.02 of the Code of Virginia that would prohibit either the employment or the continuation of employment if a person is found, through a Virginia State Police criminal record check, to have been convicted of such a crime.

"Care coordinator" means a professional from one of the state's contracted managed care organizations who assists assigned individuals enrolled in the CCC Plus integrated care initiative by performing care management as defined in 12VAC30-121-20.

"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.

"Child protective services" or "CPS" means the same as defined in § 63.2-100 of the Code of Virginia.

"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.

"Commonwealth Coordinated Care Plus Program" or "CCC Plus" means the DMAS mandatory integrated care initiative for certain qualifying Medicaid members, including members who are dually eligible for Medicare and Medicaid and members receiving long-term services and supports (LTSS). The CCC Plus Program includes members who receive services through nursing facility (NF) care, specialized care NF, or long-stay hospitals, or from one of the four DMAS home and community-based services (HCBS) § 1915(c) waivers. Not all individuals in the CCC Plus Program will qualify for the CCC Plus Waiver.

"Community-based team" or "CBT" means the same as defined in 12VAC30-60-301.

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

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

"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~~ two services, and who is also exempt from workers' compensation.

"Consumer-directed ~~(CD) model of service~~" or "CD" means the model of service delivery for which the individual ~~enrolled in the waiver~~ or the individual's employer of record, as appropriate, is responsible for hiring, training, supervising, and firing of the attendant or attendants who 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.~~

"Critical incident" means any incident that threatens or impacts the well-being of a waiver individual. Critical incidents shall include the following incidents: medication errors, severe injury or fall, theft, suspected mental or physical abuse or neglect, financial exploitation, and death.

"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~~, family, or caregivers as inducements to use a provider's services; (v) providing continuous, periodic marketing activities to the same prospective individual ~~or family/caregiver~~, family, or caregiver, for example, monthly, quarterly, or annual giveaways as inducements to use a provider's services; or (vi) engaging in marketing activities that offer potential customers rebates or discounts in conjunction with the use of a provider's services or other benefits as a means of influencing the individual's ~~or family/caregiver's~~, family's, or caregiver's use of a provider's services.

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

"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.~~

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

"Early periodic screening, diagnosis and treatment" or "EPSDT" means the benefit program administered by DMAS for individuals younger than 21 years of age in accordance with the definition set forth at 42 CFR 440.40 (b) and the requirements of 42 CFR 441, Subpart B.

"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.

"Enrollment" means the process where an individual has been determined to meet the financial and categorical eligibility requirements for a Medicaid program or service, and the approving entity has verified the availability of services for the individual requesting waiver enrollment and services.

"Environmental modifications" or "EM" means physical adaptations to an individual's primary ~~home~~ residence 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~~ that are necessary to ensure the individual's health ~~and~~, safety ~~or~~, and welfare or that enable ~~functioning~~ the individual to function 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.)~~ the individual. 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" or "F/EA" 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~~ a CCC Plus 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.~~

"Institution" means a nursing facility, specialized care nursing facility, or long-stay hospital. Individuals who receive enrollment in the CCC Plus Waiver are deemed to meet the level of care necessary for residence in one of these institutions or are anticipated to need to be in one of these institutions within the next 30 days without the services of the waiver.

"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.~~

"Local department of social services" or "LDSS" means the entity established under § 63.2-324 of the Code of Virginia by the governing city or county in the Commonwealth.

"Long-term ~~care~~ services and supports" or ~~"LTC"~~ "LTSS" 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.

"LTSS screening" means the process to (i) evaluate the functional, nursing, and social supports of individuals referred for screening for certain long-term care services and supports requiring nursing facility eligibility; (ii) assist individuals in determining what specific services the individual needs; (iii) evaluate whether a service or a combination of existing community services are available to meet an individual's 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.

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

"Managed care organization" or "MCO" means the same as the definition of this term in 42 CFR 438.2

"Medicaid Long-Term ~~Care (LTC)~~ Services and Supports 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.

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

"Medication monitoring" means an electronic device, which is only available in conjunction with ~~Personal Emergency Response Systems~~ personal emergency response systems, that ~~enables certain waiver individuals who are at risk of institutionalization to be reminded~~ reminds an individual 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.~~

"Minor child" means an individual who is younger than 18 years of age.

"Monitoring" means the ongoing oversight of the provision of waiver and other services to determine that they are furnished according to the waiver individual's plan of care and effectively meet the individual's needs, thereby assuring the individual's health, safety, and welfare. Monitoring activities may include telephone contact; observation; interviewing the individual or the trained individual representative, as appropriate, in person or by telephone; or interviewing service providers.

"Nurse supervisor" means a registered nurse (RN) or licensed professional nurse (LPN) hired or contracted by an agency to provide the supervisory responsibilities as outlined in the waiver to the agency's staff who perform personal care or respite care services to waiver individuals.

"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 or a managed care organization that has a signed contract with DMAS.

"Patient pay amount" means the portion of the individual's income that must be paid as ~~his~~ the individual's share of the long-term ~~care~~ services and supports 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.~~

"Person-centered planning" means a fundamental process that focuses on what is important to and for an individual and the needs and preferences of the individual to create a plan of care.

"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 issued by the training entity, which is provided to DMAS during provider audits~~, issued by the training entity~~.

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

"Personal care services" or "PC 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)~~ ADLs or 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~~ through the agency-directed ~~model~~ or ~~by personal care attendants under the CD~~ consumer-directed model of service ~~delivery~~. Personal

care services shall be provided by aides or attendants within the scope of their licenses or certifications, as appropriate.

"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~~,~~ and 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~~ family or caregiver, as appropriate, and the provider related solely to the specific services necessary for the individual to remain in the community while ensuring ~~his~~ the individual's 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 individual needs; (iii) evaluate whether a service or a combination of existing community services are available to meet 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.~~

"Private duty nursing services" or "PDN" means skilled in-home nursing services listed in the POC that are (i) not otherwise covered under the State Plan for Medical Assistance home health benefit; (ii) required to prevent institutionalization; or (iii) provided within the scope of the Commonwealth's Nurse Practice Act (Chapter 30 (§ 54.1-3000 et seq.) of Title 54.1 of the Code of Virginia) and Drug Control Act (Chapter 34 (§ 54.1-3400 et seq.) of Title 54.1 of the Code of Virginia).

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

"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~~ a service for the individual. The process of approving is done 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~~ an MCO.

"Service authorization contractor" means DMAS or the entity that has been contracted by DMAS, including an MCO, 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~~ family, caregiver, or EOR, 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, 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 private duty nursing services" or "skilled PDN" means skilled in-home nursing services listed in the POC that are (i) not otherwise covered under the State Plan for Medical Assistance home health benefit; (ii) required to prevent institutionalization; and (iii) provided within the scope of the Commonwealth's Nurse Practice Act (Chapter 30 (§ 54.1-3000 et seq.) of Title 54.1 of the Code of Virginia) and Drug Control

Act (Chapter 34 (§ 54.1-3400 et seq.) of Title 54.1 of the Code of Virginia).

"Skilled respite services" means temporary skilled nursing services that are provided to waiver individuals ~~who need such services~~ and that are performed by ~~a~~ an LPN or RN 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.

"Unpaid primary caregiver" means the primary 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.

"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~~ screening entity that assesses an individual's physical health, mental health, and ~~psycho/social~~ psychosocial and functional abilities to determine if the individual meets the nursing facility level of care.

"Waiver individual" or "individual" means the person who has applied for and been approved to receive these waiver services.

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

12VAC30-120-905. Waiver description and legal authority.

A. The ~~Elderly or Disabled with Consumer Direction (EDCD)~~ Commonwealth Coordinated Care Plus (CCC Plus) Waiver operates under the authority of § 1915 (c) of the Social Security Act and 42 CFR 430.25(b), which permit the waiver of certain State Plan requirements. These federal statutory and regulatory provisions permit the establishment of Medicaid waivers to afford the states with greater flexibility to devise different approaches to the provision of long-term ~~care (LTC)~~ services and supports. Under this § 1915(c) waiver, DMAS waives § 1902(a)(10)(B) and (C) of the Social Security Act related to comparability of services.

B. ~~This waiver provides Medicaid individuals who are elderly or who have a disability with supportive services to enable such individuals to remain in their communities thereby avoiding institutionalization.~~ CCC Plus Waiver services shall be covered only for Medicaid-eligible individuals who have been determined eligible to require the level of care provided in either a nursing facility, specialized care nursing facility, or long-stay hospital. These services shall be the critical service necessary to delay or avoid the individual's placement in an appropriate facility.

C. Federal waiver requirements provide that the current aggregate average cost of care fiscal year expenditures under this waiver shall not exceed the average per capita expenditures in the aggregate for the level of care (LOC) provided in a nursing facility (NF), specialized care nursing facility, or long-stay hospital under the State Plan that would have been provided had the waiver not been granted.

D. DMAS shall be the single state agency authority, pursuant to 42 CFR 431.10, responsible for the processing and payment of claims for the services covered in this waiver and for obtaining federal financial participation from CMS.

E. Payments for ~~EDCD~~ CCC Plus Waiver services shall not be provided to any financial institution or entity located outside of the United States pursuant to § 1902(a)(80) of the Social Security Act. Payments for ~~EDCD~~ CCC Plus Waiver services furnished in another state shall be (i) provided for an individual who meets the requirements of 42 CFR 431.52 and (ii) limited to the same service limitations that exist when services are rendered within the Commonwealth's political boundaries. Waiver services shall not be ~~furnished to~~ covered for Medicaid-eligible individuals who are inpatients of a hospital, nursing facility (NF), intermediate care facility for individuals with intellectual disabilities (ICF/IID), ~~inpatient rehabilitation facility~~ rehabilitation hospitals, assisted living facility licensed by VDSS that serves five or more ~~individuals~~ persons, long-stay hospitals, specialized care nursing facilities, adult foster homes, or ~~a~~ group ~~home~~ homes licensed by DBHDS.

F. An individual shall not be simultaneously enrolled in more than one waiver program but may be listed on the waiting list for another waiver program as long as criteria are met for both waiver programs.

G. DMAS shall be responsible for ~~assuring appropriate placement of the individual in home and community based waiver services and shall have the authority to terminate such services for the individual for the reasons set out below.~~ the following:

1. ~~Waiver services shall not be reimbursed until the provider is enrolled and the individual eligibility process is complete.~~ Placing individuals in appropriate services that are home and community based;

2. ~~DMAS payment for services under this waiver shall be considered payment in full and no balance billing by the~~

~~provider to the waiver individual, family/caregiver, employer of record (EOR), or any other family member of the waiver individual shall be permitted.~~ Providing reimbursement for waiver services only after the provider is enrolled and the individual's eligibility process is complete;

3. ~~Additional voluntary payments or gifts from family members shall not be accepted by providers of services. 4. DMAS shall not duplicate~~ Not duplicating services that are required as a reasonable accommodation as a part of the Americans with Disabilities Act (42 USC §§ 12131 through 12165) or the Rehabilitation Act of 1973 (29 USC § 794). ~~EDCD services shall not be authorized if another entity is required to provide the services, (e.g., schools, insurance) because these waiver services shall not duplicate payment for services available through other programs or funding streams~~ CCC Plus Waiver services shall not be authorized if another entity is required to provide the services (e.g., schools, insurance) because these waiver services shall not duplicate payment for services available through other programs or funding streams; and

4. Ensuring providers meet the following requirements:

a. Providers shall consider DMAS payment for services under this waiver as payment in full and no balance billing from the provider to the individual, any family member, caregiver, or the employer of record (EOR) of the waiver individual shall be permitted; and

b. Additional voluntary payments or gifts from family members shall not be accepted by providers of services.

H. ~~In the case of termination of home and community-based waiver services by DMAS, individuals shall be notified of their appeal rights pursuant to 12VAC30-110.~~ DMAS~~,~~ or the designated ~~Srv Auth~~ service authorization contractor~~,~~ or managed care organization shall have the responsibility and the authority to terminate the receipt of home and community-based ~~care services by~~ waiver enrollment for the waiver individual for any of the following reasons. Individuals shall be notified of their appeal rights pursuant to 12VAC30-110:

1. The home and community-based ~~care~~ waiver services are no longer the critical alternative to prevent or delay institutional placement within 30 days;

2. The waiver individual is no longer eligible for Medicaid;

3. The waiver individual no longer meets the ~~NF~~ LOC criteria required for the waiver;

4. The waiver individual's environment in the community does not provide for ~~his~~ the individual's health, safety, or welfare;

5. The waiver individual does not have a backup plan for services in the event the provider is unable to provide services; or

6. Any other circumstances ~~(including hospitalization)~~ that cause services to cease or be interrupted for more than 30 consecutive calendar days. ~~In such cases, such individuals shall be referred back to the local department of social services for redetermination of their Medicaid eligibility.~~

12VAC30-120-920. Individual eligibility requirements.

A. Home and community-based waiver services shall be available through a § 1915(c) waiver of the Social Security Act ~~waiver~~ for the following Medicaid-eligible individuals who have been determined to be eligible for waiver services and to require the level of care provided in a nursing facility (NF), long-stay hospital, or specialized care nursing facility:

1. Individuals who are elderly as defined by § 1614 of the Social Security Act; or

2. Individuals who have a disability as defined by § 1614 of the Social Security Act.

B. The Commonwealth has elected to cover low-income families with children as described in § 1931 of the Social Security Act; aged, blind, or disabled individuals who are eligible under 42 CFR 435.121; optional categorically needy individuals who are aged and disabled who have incomes at 80% of the federal poverty level; the special home and community-based waiver group under 42 CFR 435.217; and the medically needy groups specified in 42 CFR 435.320, 435.322, 435.324, and 435.330.

1. Under this waiver, the coverage groups authorized under § 1902(a)(10)(A)(ii)(VI) of the Social Security Act shall be considered as if ~~they~~ the individual were institutionalized in a NF, specialized care NF, or long-stay hospital for the purpose of applying institutional deeming rules. All individuals in the waiver must meet the financial and nonfinancial Medicaid eligibility criteria and meet the institutional level of care (LOC) criteria. The deeming rules are applied to waiver eligible individuals as if the individual were residing in an institution or would require that level of care.

2. Virginia shall reduce its payment for home and community-based services provided to an individual who is eligible for Medicaid services under 42 CFR 435.217 by that amount of the waiver individual's total income (including amounts disregarded in determining financial eligibility) that remains after allowable deductions for personal maintenance needs, deductions for other dependents, and medical needs have been made, according to the guidelines in 42 CFR 435.735 and § 1915(c)(3) of the Social Security Act as amended by the Consolidated Omnibus Budget Reconciliation Act of 1986. DMAS shall reduce its payment for home and community-based waiver services by the amount that remains after the following deductions:

a. For waiver individuals to whom § 1924(d) applies (Virginia waives the requirement for comparability

pursuant to § 1902(a)(10)(B)), deduct the following in the respective order:

(1) An amount for the maintenance needs of the waiver individual that is equal to 165% of the SSI income limit for one individual. Working individuals have a greater need due to expenses of employment; therefore, an additional amount of income shall be deducted. Earned income shall be deducted within the following limits: (i) for waiver individuals employed 20 hours or more per week, earned income shall be disregarded up to a maximum of both earned and unearned income up to 300% of SSI and (ii) for waiver individuals employed at least ~~eight~~ four but less than 20 hours per week, earned income shall be disregarded up to a maximum of both earned and unearned income up to 200% of SSI. However, in no case shall the total amount of income (both earned and unearned) that is disregarded for maintenance exceed 300% of SSI. If the waiver individual requires a guardian or conservator who charges a fee, the fee, not to exceed an amount greater than 5.0% of the waiver individual's total monthly income, is added to the maintenance needs allowance. However, in no case shall the total amount of the maintenance needs allowance (basic allowance plus earned income allowance plus guardianship fees) for the individual exceed 300% of SSI;

(2) For a waiver individual with only a spouse at home, the community spousal income allowance is determined in accordance with § 1924(d) of the Social Security Act;

(3) For an individual with a family at home, an additional amount for the maintenance needs of the family is determined in accordance with § 1924(d) of the Social Security Act; and

(4) Amounts for incurred expenses for medical or remedial care that are not subject to payment by a third party, including Medicare and other health insurance premiums, deductibles, or coinsurance charges and necessary medical or remedial care recognized under the state law but not covered under the State Plan.

b. For waiver individuals to whom § 1924(d) of the Social Security Act does not apply, deduct the following in the respective order:

(1) An amount for the maintenance needs of the waiver individual that is equal to 165% of the SSI income limit for one individual. Working individuals have a greater need due to expenses of employment; therefore, an additional amount of income shall be deducted. Earned income shall be deducted within the following limits: (i) for waiver individuals employed 20 hours or more, earned income shall be disregarded up to a maximum of 300% of SSI and (ii) for waiver individuals employed at least ~~eight~~ four but less than 20 hours, earned income shall be disregarded up to a maximum of 200% of SSI. However, in no case shall the total amount of income (both earned and unearned) that is disregarded for maintenance exceed 300% of SSI. If the individual requires a guardian or conservator who charges a fee, the fee, not to exceed an amount greater than 5.0% of the individual's total monthly income, is added to the maintenance needs allowance. However, in no case shall the total amount of the maintenance needs allowance (basic allowance plus earned income allowance plus guardianship fees) for the individual exceed 300% of SSI;

(2) For an individual with a family at home, an additional amount for the maintenance needs of the family that shall be equal to the medically needy income standard for a family of the same size; and

(3) Amounts for incurred expenses for medical or remedial care that are not subject to payment by a third party including Medicare and other health insurance premiums, deductibles, or coinsurance charges and necessary medical or remedial care recognized under state law but not covered under the State Plan.

C. Assessment and authorization of home and community-based waiver services.

1. To ensure that Virginia's home and community-based waiver programs serve only Medicaid eligible individuals who would otherwise be ~~placed~~ supported in a NF, specialized care NF, or long-stay hospital, home and community-based waiver services shall be considered only for individuals who are eligible for admission within 30 calendar days to ~~a NF~~ one of these institutions. Home and community-based waiver services shall be the critical service to enable the individual to remain at home and in the community rather than being placed in ~~a NF~~ an institution.

2. The individual's eligibility for home and community-based waiver services shall be determined by the ~~Preadmission Screening Team or DMAS enrolled hospital provider~~ LTSS screening team after completion of a thorough assessment of the individual's needs and available support. If ~~an individual meets NF criteria and in the absence of community based services, is at risk of NF placement within 30 days,~~ the individual is determined eligible based on the procedures outlined in 12VAC30-60-303, the ~~Preadmission Screening Team or DMAS enrolled hospital provider~~ LTSS screening team shall provide the individual and ~~family/caregiver~~ family or caregiver with the choice of ~~EDCD~~ CCC Plus Waiver services, other appropriate services, ~~NF~~ institutional placement, or Program of All Inclusive Care for the Elderly (PACE) enrollment for people 55 years of age or older~~, where available~~.

3. The ~~Preadmission Screening Team or DMAS enrolled hospital provider~~ LTSS screening team shall explore alternative settings or services to provide the care needed by the individual. If Medicaid-funded home and community-based ~~care~~ waiver services are selected by the individual ~~and when such services are determined to be the critical services necessary to delay or avoid NF placement~~, the ~~Preadmission~~

~~Screening Team or DMAS-enrolled hospital provider~~ LTSS screening team shall initiate referrals for such services.

4. Medicaid shall not pay for any home and community-based ~~care~~ waiver services delivered prior to the date the individual ~~establishing~~ establishes Medicaid financial eligibility and ~~prior to~~ the date of the ~~preadmission~~ LTSS screening ~~by the Preadmission Screening Team or DMAS-enrolled hospital provider and~~ with the ~~physician~~ physician's signature on the Medicaid Funded Long-Term Care Services Authorization Form (DMAS-96).

5. Before Medicaid shall assume payment responsibility of home and community-based services, service authorization must be obtained from DMAS or the DMAS designated ~~Srv Auth contractor, in accordance with DMAS policy,~~ service authorization contractor for all services requiring service authorization. Providers shall submit all required information to DMAS or the designated ~~Srv Auth contractor~~ service authorization contractor within 10 business days of initiating care or within 10 business days of receiving verification of Medicaid financial eligibility from the local department of social services. If the provider submits all required information to DMAS or the designated ~~Srv Auth contractor~~ service authorization contractor within 10 business days of initiating care, services may be authorized beginning from the date the provider initiated services but not preceding the date of the physician's signature on the DMAS 96 form. If the provider does not submit all required information to DMAS or the designated ~~Srv Auth contractor~~ service authorization contractor within 10 business days of initiating care, the services may be authorized beginning with the date all required information was received by DMAS or the designated ~~Srv Auth contractor~~ service authorization contractor, but in no event preceding the date of the physician's signature on the DMAS-96 form.

6. Once waiver eligibility has been determined by the ~~Preadmission Screening Team or DMAS-enrolled hospital provider~~ LTSS screening team and referrals have been initiated, the provider or MCO shall submit a Medicaid ~~LTC~~ LTSS Communication Form (DMAS-225) to the local department of social services to determine financial eligibility for the waiver program and any patient pay responsibilities. If the waiver individual ~~who is receiving EDCD Waiver services~~ has a patient pay amount, a provider shall use the electronic patient pay process for the required monthly monitoring of relevant changes. Local departments of social services shall enter data regarding a waiver individual's patient pay amount obligation into the ~~Medicaid Management Information System (MMIS)~~ DMAS system of record at the time action is taken on behalf of the individual either as a result of an application for ~~LTC services~~ LTSS, redetermination of financial eligibility, or reported change or changes in a waiver individual's situation. Procedures for the verification of a waiver individual's patient pay obligation are available in the appropriate Medicaid provider manual.

7. After the provider or MCO has received notification via the DMAS-225 process by the local department of social services and enrollment confirmation from DMAS or the designated ~~Srv Auth contractor~~ service authorization contractor, the provider shall inform the individual ~~or family/caregiver~~, family, or caregiver so that services may be initiated.

8. The provider or MCO shall be responsible for notifying the local department of social services via the DMAS-225 when there is an interruption of services for 30 consecutive calendar days or upon discharge or transfer from the provider's services.

~~9. Home and community-based care services shall not be offered or provided to any individual who resides in a NF, an ICF/IID, a hospital, an assisted living facility licensed by VDSS that serves five or more individuals, or a group home licensed by DBHDS. Transition coordination and transition services may be available to individuals residing in some settings as approved by CMS through the Money Follows the Person demonstration program.~~

~~10.~~ 9. Certain home and community-based services shall not be available to individuals residing in an assisted living facility licensed by VDSS that serves four or fewer individuals. These services are: respite, PERS, ADHC, environmental modifications and transition services. Personal care services shall be covered for individuals living in these facilities but shall ~~be limited to personal care~~ not ~~to~~ exceed five hours per day. Personal care services shall be authorized based on the waiver individual's documented need for care over and above that which is provided by the assisted living facility.

~~11.~~ 10. Individuals who are receiving Auxiliary Grants shall not be eligible for ~~EDCD~~ CCC Plus Waiver enrollment or services.

11. All individuals shall have a backup plan prior to initiating services and ongoing in cases of emergency or should the provider be unable to render services as needed. This backup plan shall be shared with the provider at the onset of services and updated with the provider as necessary.

12. Individuals who are receiving PDN waiver services shall have a trained primary caregiver who accepts responsibility for the individual's health, safety, and welfare. This primary caregiver shall be responsible for all hours not provided by an RN or an LPN. The name of the trained primary caregiver shall be documented in the provider's records.

D. Waiver individual responsibilities under the consumer-directed (CD) model.

1. The individual shall be authorized for CD services and the ~~EOR~~ employer of record (EOR) shall successfully complete

consumer employee management training performed by the ~~CD~~ services facilitator before the waiver ~~individual/EOR~~ individual or EOR shall be permitted to hire a personal care attendant for Medicaid reimbursement. Any services rendered by an attendant prior to dates authorized by Medicaid shall not be eligible for reimbursement ~~by Medicaid~~. Individuals who are eligible for CD services shall have the capability to hire and train their own personal care attendants and supervise the attendants' performance including~~, but not limited to,~~ creating and maintaining complete and accurate ~~timesheets~~ work shift entries. ~~Individuals may have~~ The EOR may be the individual or a family member, caregiver, or another person ~~serve as the EOR~~ designated by the individual to serve on ~~their~~ the individual's behalf.

2. The person who serves as the EOR ~~on behalf of the waiver individual~~ shall not be permitted to be (i) the paid attendant for respite services or personal care services or (ii) the services facilitator.

3. Individuals ~~will acknowledge that they will~~ shall not knowingly continue to accept CD personal care services when the service is no longer appropriate or necessary for their care needs and shall inform the services facilitator. If CD services continue after services have been terminated by DMAS or the designated ~~Srv Auth contractor~~ service authorization contractor, the waiver individual shall be held liable for attendant compensation.

4. ~~Individuals~~ The individual or EOR, as appropriate, shall notify the ~~CD~~ services facilitator of all hospitalizations and admission to any rehabilitation ~~facility, rehabilitation~~ hospital unit, ~~or~~ NF, specialized care NF, or long-stay hospital as soon as possible. Failure to do so may result in the waiver individual being liable for employee compensation.

E. Waiver individuals' rights and responsibilities. DMAS shall ensure that:

1. Each waiver individual shall receive, and the provider shall provide, the necessary care and services, to the extent of provider availability, to attain or maintain the highest practicable physical, mental, and psycho-social well-being, in accordance with the person-centered planning of the individual's comprehensive assessment and plan of care (POC).

2. Waiver individuals shall have the right to participate in the development of the plan of care and to receive services from the provider with reasonable accommodation of the individual's needs and preferences except when DMAS makes a determination that the health, safety, or welfare of the waiver individual or other individuals would be endangered.

3. All waiver individuals shall have the right to:

a. Voice grievances to the provider or provider staff without discrimination or reprisal. Such grievances include those with respect to treatment that has or has not been furnished;

b. Prompt efforts by the provider or staff, as appropriate, to resolve any grievances the waiver individual may have;

c. Be free from verbal, sexual, physical, and mental abuse, neglect, exploitation, and misappropriation of property;

d. Be treated with respect and with due consideration for the individual's dignity and privacy;

e. Be free from any physical or chemical restraints or seclusion of any form that may be used as a means of coercion, discipline, convenience, or retaliation and that are not required to treat the individual's medical symptoms;

f. The privacy and confidentiality of the individual's medical and clinical records; and

g. Receive information, such as a handbook or provider directory, in a manner and format that may be easily understood (i.e., in prevalent non-English languages and using translation services) and that is readily accessible in accordance with the standards specified in 42 CFR 438.10.

4. The waiver individual if legally competent, the waiver individual's legal guardian, or the parent of the minor child shall have the right to:

a. Choose whether the individual wishes to receive home and community-based care waiver services instead of institutionalization in accordance with the assessed needs of the individual. The LTSS screening team or MCO shall inform the individual of all available waiver service providers in the community in which the waiver individual resides. The waiver individual shall have the option of selecting the provider and services of the individual's choice. Individuals enrolled in the CCC Plus Program shall have the option of selecting a provider in the MCO's contracted network and services of the individual's choice. This choice must be documented in the individual's medical record;

b. Choose a primary care physician in the community in which the individual resides;

c. Be fully informed in advance about the waiver POC and treatment needs as well as any changes in that care or treatment that may affect the individual's well-being;

d. Participate in the care planning process, choice, and scheduling of providers and services; and

e. Be provided care with privacy, dignity, and respect at all times.

12VAC30-120-924. Covered services; limits on covered services.

A. Covered services in the ~~EDCD~~ CCC Plus Waiver ~~shall include~~ are as follows: adult day health care~~,~~; personal care (both consumer-directed and agency-directed)~~,~~; respite services (both consumer-directed and agency-directed)~~,~~; PERS services, ~~PERS~~ including medication monitoring~~, limited~~; services facilitation; private duty nursing; assistive technology~~, limited~~; environmental modifications~~, transition coordination,~~; and transition services.

1. The services covered in this waiver shall be appropriate and medically necessary to maintain the individual in the community in order to prevent institutionalization and shall be cost effective in the aggregate as compared to the alternative ~~NF~~ institutional placement.

2. ~~EDCD~~ CCC Plus Waiver services shall not be authorized if another entity is required to provide the services (e.g., schools, insurance). Waiver services shall not duplicate services available through other programs or funding streams.

~~3. Assistive technology and environmental modification services shall be available only to those EDCD Waiver individuals who are also participants in the Money Follows the Person (MFP) demonstration program pursuant to Part XX (12VAC30-120-2000 et seq.).~~

~~4.~~ 3. An individual receiving ~~EDCD~~ CCC Plus Waiver services who is also getting hospice care may receive Medicaid-covered personal care (agency-directed and consumer-directed), respite care (agency-directed and consumer-directed), services facilitation, private duty nursing, adult day health care, transition services, ~~transition coordination,~~ and PERS services, regardless of whether the hospice provider receives reimbursement from Medicare or Medicaid for the services covered under the hospice benefit. ~~Such dual waiver/hospice individuals shall only be able to receive assistive technology and environmental modifications if they are also participants in the MFP demonstration program.~~

~~5.~~ 4. Agency-directed and consumer-directed personal care services and respite care services shall be subject to the electronic visit verification requirements set out in 12VAC30-60-65.

B. ~~Voluntary or involuntary disenrollment~~ Disenrollment from consumer-directed services. In ~~either voluntary or involuntary~~ disenrollment situations, the waiver individual shall be ~~permitted to select an agency from which to receive his~~ offered agency-directed personal care and respite services from a provider of the waiver individual's choice.

1. A waiver individual may be found to be ineligible for CD services by either the ~~Preadmission Screening Team, DMAS enrolled hospital provider~~ LTSS screening team, DMAS, its designated agent, or the ~~CD~~ services facilitator. An individual may not begin or continue to receive CD services if there are circumstances where the waiver individual's health, safety, or welfare cannot be assured, including:

a. It is determined that the waiver individual cannot ~~be~~ complete the duties of the EOR and no one else is able to assume this role;

b. The waiver individual cannot ensure his own health, safety, or welfare or develop an emergency backup plan that will ensure his health, safety, or welfare; or

c. The waiver individual has medication or skilled nursing needs or medical or behavioral conditions that cannot be met through CD services or other services.

2. The waiver individual may be involuntarily disenrolled from consumer direction if ~~he~~ the individual or the EOR, as appropriate, is consistently unable to retain or manage the attendant as may be demonstrated by, but not necessarily limited to, a pattern of serious discrepancies with the attendant's ~~timesheets~~ work shift entries or noncompliance with CD EOR requirements.

3. In situations where either (i) the waiver individual's health, safety, or welfare cannot be assured or (ii) attendant ~~timesheet~~ work shift entry discrepancies are known, the services facilitator shall assist as requested with the waiver individual's transfer to agency-directed services as follows:

a. Verify that essential training has been provided to the waiver individual or EOR;

b. Document, in the waiver individual's ~~case~~ record, the conditions creating the necessity for the involuntary disenrollment and actions taken by the services facilitator;

c. Discuss with the waiver individual or the EOR, as appropriate, the agency-directed option that is available and the actions needed to arrange for such services and offer choice of potential providers, and

d. Provide written notice to the waiver individual of the right to appeal such involuntary termination of consumer direction. Such notice shall be given at least 10 calendar days prior to the effective date of this change. In cases when the individual's or the provider personnel's safety may be in jeopardy, the 10 calendar ~~days~~ days' notice shall not apply.

C. Adult day health care (ADHC) services. ADHC services shall only be offered to waiver individuals who meet ~~preadmission~~ LTSS screening criteria as established in 12VAC30-60-303 and ~~12VAC30-60-307~~ 12VAC30-60-313 and for whom ADHC services shall be an appropriate and medically necessary alternative to institutional care. ADHC services may be offered to individuals in a VDSS-licensed adult day care center (ADCC) congregate setting. ADHC may be offered either as the sole home and community-based ~~care~~ waiver service or in conjunction with personal care (either

agency-directed or consumer-directed), respite care (either agency-directed or consumer-directed), or ~~PERS~~ personal emergency response system (PERS). A multi-disciplinary approach to developing, implementing, and evaluating each waiver individual's POC shall be essential to quality ADHC services.

1. ADHC services shall be designed to prevent institutionalization by providing waiver individuals with health care services, maintenance of ~~their~~ the individual's physical and mental conditions, and coordination of rehabilitation services in a congregate daytime setting and shall be tailored to ~~their~~ each individual's unique needs. The minimum range of services that shall be made available to every waiver individual shall be: assistance with ADLs, nursing services, coordination of rehabilitation services, nutrition, social services, recreation, and socialization services.

a. Assistance with ADLs shall include supervision of the waiver individual and assistance with management of the individual's POC.

b. Nursing services shall include the periodic evaluation, at least every 90 days, of the waiver individual's nursing needs; provision of indicated nursing care and treatment; responsibility for monitoring, recording, and administering prescribed medications; supervision of the waiver individual in self-administered medication; support of families in their home care efforts for the waiver individuals through education and counseling; and helping families identify and appropriately utilize health care resources. Periodic evaluations may occur more frequently than every 90 days if indicated by the individual's changing condition. Nursing services shall also include the general supervision of provider staff, who are certified through the Board of Nursing, in medication management and administering medications.

c. Coordination and implementation of rehabilitation services to ensure the waiver individual receives all rehabilitative services deemed necessary to improve or maintain independent functioning, to include physical therapy, occupational therapy, and speech therapy.

d. Nutrition services shall be provided to include one ~~meal~~ or more meals per day that meets the daily nutritional requirements pursuant to 22VAC40-60-800. Special diets and nutrition counseling shall be provided as required or requested by the waiver ~~individuals~~ individual.

e. Recreation and social activities shall be provided that are suited to the needs of the waiver individuals and shall be designed to encourage physical exercise, prevent physical and mental deterioration, and stimulate social interaction.

f. ADHC coordination shall involve implementing the waiver individuals' POCs, updating such plans, recording 30-day progress notes, and reviewing the waiver individuals' daily logs each week.

2. Limits on covered ADHC services.

a. A day of ADHC services shall be defined as a minimum of six hours.

b. ~~ADCCs~~ ADHCs that do not employ professional nursing staff on site shall not be permitted to admit waiver individuals who require skilled nursing care to their centers. Examples of skilled nursing care may include: (i) tube feedings; (ii) Foley catheter irrigations; (iii) sterile dressing changing; or (iv) any other procedures that require sterile technique. The ADCC shall not permit its aide employees to perform skilled nursing procedures.

c. At any time that the center is no longer able to provide reliable, continuous care to any of the center's waiver individuals for the number of hours per day or days per week as contained in the individuals' POCs, then the center shall contact the waiver individuals ~~or their family or caregivers~~, family, caregivers, or MCO care coordinators, as appropriate, to initiate other care arrangements for these individuals. The center may either subcontract with another ADCC or may transfer the waiver individual to another ADCC. The center may discharge waiver individuals from the center's services but not from the waiver. Written notice of discharge shall be provided, with the specific reason or reasons for discharge, at least 10 calendar days prior to the effective date of the discharge. In cases when the individual's or the center personnel's safety may be jeopardy, the 10 calendar days notice shall not apply.

d. ADHC services shall not be provided, for the purpose of Medicaid reimbursement, to individuals who reside in ~~NFs, ICFs/IID~~ nursing facilities, intermediate care facilities for individuals with intellectual disabilities, hospitals, assisted living facilities that are licensed by VDSS, or group homes that are licensed by DBHDS.

D. Agency-directed personal care services. Agency-directed personal care services shall ~~only~~ be offered to persons who meet the ~~preadmission~~ LTSS screening criteria at 12VAC30-60-303 and ~~12VAC30-60-307~~ 12VAC30-60-313 and for whom it shall be an appropriate alternative to institutional care. Agency-directed personal care services shall be comprised of hands-on care of either a supportive or health-related nature and shall include assistance with ADLs, access to the community, assistance with medications in accordance with VDH licensing requirements or other medical needs, supervision, and the monitoring of health status and physical condition. Where the individual requires assistance with ADLs, and when specified in the POC, such supportive services may include assistance with IADLs. This service shall not include skilled nursing services with the exception of skilled nursing tasks (e.g., catheterization) that may be delegated pursuant to Part ~~VIII (18VAC90-20-420~~ VI

(18VAC90-19-240 through ~~18VAC90-20-460)~~ 18VAC90-19-280) of ~~18VAC90-20~~ 18VAC90-19. Agency-directed personal care services may be provided in a home or community setting to enable an individual to maintain the health status and functional skills necessary to live in the community or participate in community activities. Personal care may be offered either as the sole home and community-based ~~care~~ waiver service or in conjunction with adult day health care, respite care (agency-directed or consumer-directed), or PERS. The provider shall document, in the individual's medical record, the waiver individual's choice of the agency-directed model.

1. Criteria. In order to qualify for this service, the waiver individual shall have met the ~~NF~~ LOC criteria as set out in 12VAC30-60-303 and ~~12VAC30-60-307~~ 12VAC30-60-313 as documented on the UAI assessment form, and for whom it shall be an appropriate alternative to institutional care.

a. A waiver individual may receive both CD and agency-directed personal care services if the individual meets the criteria. Hours received by the individual who is receiving both CD and agency-directed services shall not exceed the total number of hours that would be needed if the waiver individual were receiving personal care services through a single delivery model.

b. CD and agency-directed services shall not be simultaneously provided but may be provided sequentially or alternately from each other.

c. The individual ~~or family or caregiver~~, family, or caregiver shall have a backup plan or caregiver for the provision of services in the event the agency is unable to provide an aide.

2. Limits on covered agency-directed personal care services.

a. DMAS shall not duplicate services that are required as a reasonable accommodation as a part of the Americans with Disabilities Act (42 USC §§ 12131 through 12165) or the Rehabilitation Act of 1973 (29 USC § 794).

b. DMAS or its contractor shall reimburse for services delivered, consistent with the approved POC, for personal care that the personal care aide provides to the waiver individual to assist ~~him~~ while ~~he is~~ at work or postsecondary school or both.

(1) DMAS or the designated ~~Srv Auth~~ service authorization contractor shall review the waiver individual's needs and the complexity of the disability, as applicable, when determining the services that are provided to ~~him~~ the individual in the workplace or postsecondary school or both.

(2) DMAS shall not pay for the personal care aide to assist the ~~enrolled~~ waiver individual with any functions or tasks related to the individual completing ~~his~~ a job or postsecondary school functions or for supervision time during either work or postsecondary school or both.

c. Supervision services shall ~~only~~ be authorized to ensure the health, safety, or welfare of the waiver individual who cannot be left alone at any time or is unable to call for help in case of an emergency, and when there is no ~~one else~~ competent adult in the home ~~competent and~~ able to call for help in case of an emergency.

d. There shall be a maximum limit of eight hours per ~~24-hour~~ day for supervision services. Supervision services shall be documented in the POC as needed by the individual.

e. Agency-directed personal care services shall be limited to 56 hours of services per week for 52 weeks per year. ~~Individual exceptions~~ Exceptions may be granted based on criteria ~~established by DMAS~~ set forth in 12VAC30-120-927.

f. Electronic visit verification requirements set out in 12VAC30-60-65 shall apply to these agency-directed respite care services.

g. Due to the complex medical needs of waiver individuals requiring PDN services and the need for 24-hour supervision, the trained primary caregiver shall be present in the home and shall render the required skilled services during the entire time that the aide is providing unskilled care.

E. Agency-directed respite care services. Agency-directed respite care services shall ~~only~~ be offered to waiver individuals who meet the ~~preadmission~~ LTSS screening criteria at 12VAC30-60-303 and ~~12VAC30-60-307~~ 12VAC30-60-313 and for whom it shall be an appropriate alternative to institutional care. Agency-directed respite care services may be either skilled ~~nursing~~ respite or unskilled care and shall be comprised of hands-on care of either a supportive or health-related nature and may include assistance with ADLs, access to the community, assistance with medications in accordance with VDH licensing requirements or other medical needs, supervision, and monitoring health status and physical condition. Skilled respite care shall include skilled nursing care ordered on the physician-certified POC.

1. Respite care shall only be offered to individuals who have an unpaid primary caregiver who requires temporary relief to avoid institutionalization of the waiver individual. Respite care services may be provided in the individual's home or other community settings. Respite shall also be provided in children's residential facilities in accordance with 12VAC30-120-925.

2. When the individual requires assistance with ADLs, and where such assistance is specified in the waiver individual's POC, such supportive services may also include assistance with IADLs.

3. ~~The unskilled care portion of this~~ Unskilled respite service shall not include skilled nursing services with the exception of skilled nursing tasks (e.g., catheterization) that may be

delegated pursuant to Part ~~VIII (18VAC90-20-420~~ VI (18VAC90-19-240 through ~~18VAC90-20-460)~~ 18VAC90-19-280) of ~~18VAC90-20~~ 18VAC90-19.

4. Skilled respite care services.

a. This service shall be provided by skilled nursing staff licensed to practice in the Commonwealth under the direct supervision of a licensed, certified, or accredited home health agency with which DMAS has a provider agreement to provide PDN. Direct supervision means that the supervising RN is immediately accessible by telephone to the RN, LPN, or personal care aide who is delivering waiver-covered services to individuals.

b. Skilled respite care services shall be comprised of both skilled and hands-on care of either a supportive or health-related nature and may include all skilled nursing care as ordered on the physician-certified POC, assistance with ADLs or IADLs, administration of medications or other medical needs, and monitoring of the health status and physical condition of individuals.

c. When skilled respite services are offered in conjunction with PDN, the same individual record may be used with a separate section for skilled respite services documentation. This documentation must be clearly labeled as distinct from PDN services.

d. Individuals who reside in the same house shall be permitted to share skilled respite care service providers. The same limits on this service in the congregate setting (480 hours per calendar year per household) shall apply regardless of the type of waiver.

5. Limits on service.

a. The unit of service shall be one hour. Respite care services shall be limited to 480 hours per individual per ~~state fiscal~~ calendar year, to be service authorized. ~~If an individual changes waiver programs, this same maximum number of respite hours shall apply.~~ No additional respite hours beyond the ~~480~~ maximum limit shall be approved for payment for individuals, even those who change waiver programs. Additionally, individuals who are receiving respite services in this waiver through both the agency-directed and CD models shall not exceed 480 hours per ~~state fiscal~~ calendar year combined.

b. If agency-directed respite care service is the only service received by the waiver individual, it must be received at least as often as every 30 days. If this service is not required at this minimal level of frequency, then the provider ~~agency~~ or MCO shall notify the local department of social services for its redetermination of eligibility for the waiver individual.

c. The individual ~~or,~~ family, or caregiver shall have a backup plan or caregiver for the provision of services in the event the agency is unable to provide an aide.

d. Electronic visit verification requirements set out in 12VAC30-60-65 shall apply to these agency-directed respite care services.

F. Services facilitation for consumer-directed services. Consumer-directed personal care and respite care services shall only be offered to ~~persons~~ waiver individuals who meet the ~~preadmission~~ LTSS screening criteria at 12VAC30-60-303 and ~~12VAC30-60-307~~ 12VAC30-60-313 and for whom there shall be appropriate alternatives to institutional care.

1. Individuals who choose CD services shall receive support from a DMAS-enrolled ~~CD~~ services facilitator or a provider designated by the managed care organization as required in conjunction with CD services. The services facilitator shall document the waiver individual's choice of the CD model and whether there is a need for another person to serve as the EOR on behalf of the individual. The ~~CD~~ services facilitator shall be responsible for assessing the waiver individual's particular needs for a requested CD service, assisting in the development of the POC, providing training to the EOR on ~~his~~ the EOR's responsibilities as an employer, and for providing ongoing support of the CD services.

2. Individuals who are eligible for CD services shall have~~, or have~~ an EOR who has~~,~~ the capability to hire ~~and~~, to train, and to fire the personal care attendant ~~or attendants~~ and supervise the attendant's performance, including approving the attendant's ~~timesheets~~ work shift entries.

a. If a waiver individual is unwilling or unable to direct ~~his~~ the individual's own care or is younger than 18 years of age, family, a caregiver, or a designated person shall serve as the EOR on behalf of the waiver individual in order to perform these supervisory and work shift entry approval functions.

b. Specific employer duties shall include checking references of personal care attendants and determining that personal care attendants meet qualifications.

3. The individual ~~or family or caregiver~~, family, or caregiver shall have a backup plan or caregiver for the provision of services in case the attendant does not show up for work as scheduled or terminates employment without prior notice.

4. The ~~CD~~ services facilitator shall not be the waiver individual, a CD attendant, a provider of other Medicaid-covered services, the spouse of the waiver individual, the natural, adoptive, step, or foster parent or other legal guardian of the waiver individual who is a minor ~~child~~, or the EOR who is employing the CD attendant.

5. DMAS or the MCO shall either provide for ~~fiscal employer/agent~~ fiscal/employer agent services or contract for the services of a ~~fiscal employer/agent~~ fiscal/employer agent for CD services. The ~~fiscal employer/agent~~ fiscal/employer agent shall be reimbursed by DMAS or the DMAS contractor ~~(if the fiscal/employer agent service is contracted)~~ to perform certain tasks as an agent for the EOR.

The ~~fiscal employer/agent~~ fiscal/employer agent shall handle responsibilities for the waiver individual, including payroll, employment taxes, and background checks for attendants. The ~~fiscal employer/agent~~ fiscal/employer agent shall seek and obtain all necessary authorizations and approvals of the Internal Revenue Service in order to fulfill all of these duties.

G. Consumer-directed personal care services. CD personal care services shall be comprised of hands-on care of either a supportive or health-related nature and shall include ~~assistance with ADLs and may include~~ assistance with ADLs, access to the community, monitoring of self-administered medications or other medical needs, supervision, and the monitoring of health status and physical condition. Where the waiver individual requires assistance with ADLs, and when specified in the POC, such supportive services may include assistance with IADLs. This service shall not include skilled nursing services with the exception of skilled nursing tasks (e.g., catheterization) that may be delegated pursuant to Part ~~VIII (18VAC90-20-420 through 18VAC90-20-460) of 18VAC 90-20~~ VI (18VAC90-19-240 through 18VAC90-19-280) of 18VAC90-19 and as permitted by Chapter 30 (§ 54.1-3000 et seq.) of Title 54.1 of the Code of Virginia. CD personal care services may be provided in a home or community setting to enable an individual to maintain the health status and functional skills necessary to live in the community or participate in community activities. Personal care may be offered either as the sole home and community-based waiver service or in conjunction with adult day health care, respite care (agency-directed or consumer-directed), or PERS.

1. In order to qualify for this service, the waiver individual shall have met the ~~NF~~ LOC criteria as set out in 12VAC30-60-303 and ~~12VAC30-60-307~~ 12VAC30-60-313 as documented on the UAI assessment instrument, and for whom it shall be an appropriate alternative to institutional care.

a. A waiver individual may receive both CD and agency-directed personal care services if the individual meets the criteria. Hours received by the waiver individual who is receiving both CD and agency-directed services shall not exceed the total number of hours that would be otherwise authorized had the individual chosen to receive personal care services through a single delivery model.

b. CD and agency-directed services shall not be simultaneously provided but may be provided sequentially or alternately from each other.

2. Limits on covered CD personal care services.

a. DMAS shall not duplicate services that are required as a reasonable accommodation as a part of the Americans with Disabilities Act (42 USC §§ 12131 through 12165) or the Rehabilitation Act of 1973 (29 USC § 794).

b. There shall be a limit of eight hours per ~~24-hour~~ day for supervision services included in the POC. Supervision services shall be authorized to ensure the health, safety, or welfare of the waiver individual who cannot be left alone at any time or is unable to call for help in case of an emergency, and when there is no ~~one else in the home who is competent and~~ other competent adult able to call for help in case of an emergency.

c. Consumer-directed personal care services shall be limited to 56 hours of services per week for 52 weeks per year. ~~Individual exceptions~~ Exceptions may be granted based on criteria ~~established by DMAS~~ set forth in 12VAC30-120-927.

d. Electronic visit verification requirements as set out in 12VAC30-60-65 shall apply to these CD personal care services.

e. Due to the complex medical needs of waiver individuals requiring PDN services and the need for 24-hour supervision, the trained primary caregiver shall be present in the home and shall render the required skilled services during the entire time that the attendant is providing unskilled care.

3. CD personal care services at work or school shall be limited as follows:

a. DMAS or its contractor shall reimburse for services delivered, consistent with the approved POC, for CD personal care that the attendant provides to the waiver individual to assist ~~him~~ while ~~he is~~ at work or postsecondary school or both.

b. DMAS or the designated ~~Srv Auth contractor~~ service authorization contractor shall review the waiver individual's needs and the complexity of the disability, as applicable, when determining the services that will be provided to ~~him~~ the individual in the workplace or postsecondary school or both.

c. DMAS shall not pay for the personal care attendant to assist the waiver individual with any functions or tasks related to the individual completing ~~his~~ a job or postsecondary school functions or for supervision time during work or postsecondary school or both.

H. Consumer-directed respite care services. CD respite care services are unskilled care and shall be comprised of hands-on care of either a supportive or health-related nature and may include assistance with ADLs, access to the community, monitoring of self-administration of medications or other medical needs, supervision, monitoring health status and physical condition, and personal care services in a work environment.

1. In order to qualify for this service, the waiver individual shall have met the ~~NF~~ LOC criteria as set out in 12VAC30-60-303 and ~~12VAC30-60-307~~ 12VAC30-60-313 as documented on the UAI ~~assessment instrument~~ form, and for whom it shall be an appropriate alternative to institutional care.

2. CD respite care services shall only be offered to individuals who have an unpaid primary caregiver who requires temporary relief to avoid institutionalization of the waiver individual. This service shall be provided in the waiver individual's home or other community settings.

3. When the waiver individual requires assistance with ADLs, and where such assistance is specified in the individual's POC, such supportive services may also include assistance with IADLs.

4. Electronic visit verification requirements as set out in 12VAC30-60-65 shall apply to these CD respite care services.

5. Limits on covered CD respite care services.

a. The unit of service shall be one hour. Respite care services shall be limited to 480 hours per waiver individual per ~~state fiscal~~ calendar year. If a waiver individual changes waiver programs, this same maximum number of respite hours shall apply. No additional respite hours beyond the 480 maximum limit shall be approved for payment. Individuals who are receiving respite care services in this waiver through both the agency-directed and CD models shall not exceed 480 hours per ~~state fiscal~~ calendar year combined.

b. CD respite care services shall not include skilled nursing services with the exception of skilled nursing tasks (e.g., catheterization) that may be delegated pursuant to Part ~~VIII (18VAC90-20-420~~ VI (18VAC90-19-240 through ~~18VAC90-20-460)~~ 18VAC90-19-280) of ~~18VAC90-20~~ 18VAC90-19 and as permitted by Chapter 30 (§ 54.1-3000 et seq.) of Title 54.1 of the Code of Virginia).

c. If consumer-directed respite care service is the only service received by the waiver individual, it shall be received at least as often as every 30 days. If this service is not required at this minimal level of frequency, then the services facilitator or MCO shall refer the waiver individual to the local department of social services for its redetermination of Medicaid eligibility for the waiver individual.

I. Personal emergency response system (PERS).

1. Service description. PERS is a service that monitors ~~waiver individual~~ the individual's safety in the home and provides access to emergency assistance for medical or environmental emergencies through the provision of a two-way voice communication system that dials a 24-hour response or monitoring center upon activation and via the individual's home telephone line or system. PERS may also include medication monitoring devices.

a. PERS ~~may~~ shall be authorized only when there is no ~~one else~~ other competent adult in the home ~~with the waiver individual~~ who is ~~competent or continuously~~ available to call for help in an emergency or when the ~~individual is in imminent danger~~ individual's health, safety, and welfare cannot be ensured.

b. The use of PERS equipment shall not relieve the primary or backup caregiver of ~~his~~ the caregiver's responsibilities.

c. Service units and service limitations.

(1) PERS shall be limited to waiver individuals who are ages 14 years and older who also either live alone or are alone for significant parts of the day and who have no regular caregiver for extended periods of time. PERS shall only be provided in conjunction with receipt of personal care services (either agency-directed or consumer-directed), respite services (either agency-directed or consumer-directed), or adult day health care. A waiver individual shall not receive PERS if ~~he~~ the individual has a cognitive impairment as defined in 12VAC30-120-900.

(2) A unit of service shall include administrative costs, time, labor, and supplies associated with the installation, maintenance, monitoring, and adjustments of the PERS. A unit of service shall be the one-month rental price set by DMAS in its fee schedule. The one-time installation of the unit shall include installation, account activation, individual and family or caregiver instruction, and subsequent removal of PERS equipment when it is no longer needed.

(3) PERS services shall be capable of being activated by a remote wireless device and shall be connected to the waiver individual's telephone line or system. The PERS console unit must provide hands-free voice-to-voice communication with the response center. The activating device must be (i) waterproof, (ii) able to automatically transmit to the response center an activator low battery alert signal prior to the battery losing power, (iii) able to be worn by the waiver individual, and (iv) automatically reset by the response center after each activation, thereby ensuring that subsequent signals can be transmitted without requiring manual resetting by the waiver individual.

(4) All PERS equipment shall be approved by the Federal Communications Commission and meet the Underwriters' Laboratories, Inc. (UL) safety standard.

(5) Medication monitoring units shall be physician ordered. In order to be approved to receive the medication monitoring service, a waiver individual shall also receive PERS services. Physician orders shall be maintained in the waiver individual's record. In cases where the medical monitoring unit must be filled by the provider, the person who is filling the unit shall be either an RN or an LPN. The units may be filled as frequently as a minimum of every 14 days. There must be documentation of this action in the waiver individual's record.

J. Transition ~~coordination and transition~~ services. Transition ~~coordination and transition~~ services, as defined at ~~12VAC30-~~

~~120-2000 and~~ 12VAC30-120-2010, provide for ~~applicants~~ individuals to move from institutional placements or licensed or certified provider-operated living arrangements to private homes or other qualified settings. The ~~applicant's~~ individual's transition from an institution to the community shall be coordinated by the facility's discharge planning team. The discharge planner shall ~~coordinate with the transition coordinator to~~ ensure that ~~EDCD~~ CCC Plus Waiver eligibility criteria shall be met.

1. Transition ~~coordination and transition~~ services shall be authorized by DMAS or its designated agent in order for reimbursement to occur.

2. ~~For the purposes of transition services, an institution must meet the requirements as specified by CMS in the Money Follows the Person demonstration program at http://www.ssa.gov/OP_Home/comp2/F109-171.html#ft262~~ To qualify for the service, the waiver individual shall be discharged after 90 consecutive days of residence from an institution, intermediate care facility for individuals with intellectual disabilities, institution for mental disease, or psychiatric residential treatment facility.

~~3. Transition coordination shall be authorized for a maximum of 12 consecutive months upon discharge from an institutional placement and shall be initiated within 30 days of discharge from the institution.~~

~~4.~~ 3. Transition ~~coordination and transition~~ services shall be provided in conjunction with personal care (agency-directed or consumer-directed), respite care (agency-directed or consumer-directed), private duty nursing, or adult day health care services.

4. Transition services may be provided by DMAS enrolled area agencies on aging, centers for independent living, and local departments of social services.

K. Assistive technology (AT).

1. ~~Service description.~~ Assistive technology (AT)~~, as defined in 12VAC30-120-900,~~ shall ~~only be available to waiver individuals who are participating in the MFP program pursuant to Part XX (12VAC30-120-2000 et seq.)~~ be portable and shall be authorized per calendar year. AT services are the specialized medical equipment and supplies, including those devices, controls, or appliances, specified in the individual's plan of care, but that are not available under the State Plan for Medical Assistance, that enable a waiver individual to increase the individual's ability to perform ADLs or IADLs or to perceive, control, or communicate with the environment in which the individual lives.

2. In order to qualify for these services, the individual shall have a demonstrated need for specialized medical equipment and supplies for remedial or direct medical benefit primarily in an individual's primary home, primary vehicle used by the individual, community activity setting, or day program to specifically serve to improve the individual's personal functioning. This shall encompass those items not otherwise covered under the State Plan for Medical Assistance. AT shall be covered in the least expensive~~, most cost-effective~~ manner.

3. AT services shall be available for a waiver individual who has a demonstrated need for equipment for remedial or direct medical benefit. This service includes ancillary supplies and equipment necessary for the proper functioning of such items.

4. Service units and service limitations.

a. ~~All requests for AT shall be made by the transition coordinator to DMAS or the Srv Auth contractor.~~ The cost for AT shall not be carried over from one calendar year to the next. Each item must be service authorized by either DMAS or the DMAS designated service authorization contractor for each calendar year.

b. The maximum funded expenditure per individual for all AT covered procedure codes (combined total of AT items and labor related to these items) shall be $5,000 per calendar year for ~~individuals~~ an individual regardless of waiver, or regardless of whether the individual changes waiver programs, for which AT is approved. The service unit shall always be one, for the total cost of all AT being requested for a specific timeframe.

c. AT may be provided in the individual's home or community setting.

d. AT shall not be approved for purposes of convenience of the caregiver or provider or restraint of the individual, recreation or leisure, educational purposes, or diversion activities.

e. AT shall be carried out in the least expensive manner possible to achieve the goal required for the individual's health, safety, and welfare. AT shall be reimbursed in a manner that is reasonable and customary not to exceed the provider's usual and customary charges to the general public.

~~e.~~ f. An independent, professional consultation shall be obtained from a qualified professional who is knowledgeable of that item for each AT request prior to approval by the ~~Srv Auth~~ service authorization contractor or managed care organization and may include training on such AT by the qualified professional. The consultation shall not be performed by the provider of AT to the individual.

~~f.~~ g. All AT shall be ~~prior~~ authorized by DMAS, the ~~Srv Auth~~ designated service authorization contractor, or managed care organization prior to billing or providing services to the individual.

~~g. Excluded shall be items~~ h. Items that are reasonable accommodation requirements~~, for example,~~ of the Americans with Disabilities Act, the Virginians with

Disabilities Act (§ 51.5-1 et seq. of the Code of Virginia), or the Rehabilitation Act (20 USC § 794) or ~~that~~ are required to be provided through other funding sources shall be excluded from Medicaid coverage. DMAS shall not duplicate services that are required as a reasonable accommodation as a part of the Americans with Disabilities Act (42 USC §§ 12131 through 12165), Virginians with Disabilities Act (§ 51.5-1 et seq. of the Code of Virginia), or the Rehabilitation Act of 1973 (29 USC § 794).

~~h.~~ i. AT services or equipment shall not be rented but shall be purchased.

j. Shipping, freight, or delivery charges shall not be billable to DMAS or the waiver individual, as such charges are considered noncovered items.

(1) All products shall be delivered, demonstrated, and installed and in working order prior to submitting any claim for them to Medicaid.

(2) The date of service on the claim shall be within the service authorization approval dates, which may be prior to the delivery date as long as the initiation of services commenced during the approved dates.

(3) The service authorization shall not be modified to accommodate delays in product deliveries. In such situations, the provider must seek a new service authorization.

(4) When two or more waiver individuals live in the same home or congregate living arrangement, the AT shall be shared to the extent practicable consistent with the type of AT and the needs of the individuals as documented in their POCs. There shall be no duplication of AT in the same house when such product can be used for a communal purpose.

k. Assistive technology shall not be available to individuals younger than 21 years of age through the CCC Plus Waiver. Assistive technology for individuals younger than 21 shall be accessed through the EPSDT benefit.

l. AT exclusions.

(1) Medicaid shall not reimburse for any AT devices or services that may have been rendered prior to authorization from DMAS or the designated service authorization contractor.

(2) Providers that supply AT for the waiver individual may not perform assessments, consultations, or write specifications for that individual. Any request for a change in cost (either an increase or a decrease) requires justification and supporting documentation of medical need and service authorization by DMAS or the designated service authorization contractor. The vendor shall receive a copy of the professional evaluation in order to purchase the items recommended by the professional. If a change is necessary, the vendor shall notify the assessor to ensure the changed items meet the individual's needs.

(3) All equipment or supplies already covered by a service provided for in the State Plan shall not be purchased under the waiver as AT. Such examples include:

(a) Specialized medical equipment, durable or nondurable medical equipment, ancillary equipment, and supplies necessary for life support;

(b) Adaptive devices, appliances, and controls that enable an individual to be more independent in areas of personal care and ADLs or IADLs; and

(c) Equipment and devices that enable an individual to communicate more effectively.

L. Environmental modifications (EM).

1. ~~Service description.~~ Environmental modifications (EM)~~, as defined herein, shall only be available to waiver individuals who are participating in the MFP program pursuant to Part XX (12VAC30-120-2000 et seq.). Adaptations~~ shall ~~be~~ consist of adaptations documented in the waiver individual's POC and may include the installation of nonportable ramps and grab-bars, widening of doorways, modification of bathroom facilities, or installation of specialized electrical and plumbing systems that are necessary to accommodate the medical equipment and supplies that are necessary for the health, safety, and welfare of the waiver individual. Excluded are those adaptations or improvements to the home that are of general utility and are not of direct medical or remedial benefit to the individual, such as carpeting, flooring, roof repairs, central air conditioning, or decks. Adaptations that add to the total square footage of the home shall be excluded from this benefit, except when necessary to complete an authorized adaptation, as determined by DMAS or its designated agent. All services shall be provided in the individual's primary home in accordance with applicable state or local building codes. All modifications ~~must~~ shall be prior authorized by the ~~Srv Auth~~ service authorization contractor or managed care organization. Modifications may only be made to a vehicle if it is the primary vehicle being used by the waiver individual. This service does not include the purchase or lease of vehicles. This service shall not include general repairs to a residence or vehicle.

2. In order to qualify for these services, the waiver individual shall have a demonstrated need for modifications of a remedial or direct medical benefit offered in ~~his~~ the individual's primary home or primary vehicle ~~used by the waiver individual~~ to ensure ~~his~~ the individual's health, welfare, or safety or specifically to improve the individual's personal functioning. Modifications may include a generator for a waiver individual who is dependent on mechanical ventilation for 24 hours a day and when the generator is used to support the medical equipment and supplies necessary for the individual's welfare. This service shall encompass those items not otherwise covered in the State Plan for Medical

Assistance or through another program. EM shall be covered in the least expensive~~, most cost-effective~~ manner.

3. Service units and service limitations.

~~a. All requests for EM shall be made by the MFP transition coordinator to DMAS or the Srv Auth contractor.~~

~~b.~~ a. The maximum funded expenditure per individual for all EM covered procedure codes (combined total of EM items and labor related to these items) shall be $5,000 per calendar year for ~~individuals~~ an individual regardless of waiver, or regardless of whether the individual changes waiver programs, for which EM is approved. Unexpended portions of this maximum amount shall not be accumulated across one or more years to be expended in a later year. The service unit shall always be one, for the total cost of all EM being requested for a specific timeframe.

~~c.~~ b. All EM shall be authorized by ~~the Srv Auth contractor~~ DMAS or the DMAS designated service authorization contractor prior to billing or providing services to the individual.

~~d.~~ c. Modifications shall not be used to bring a substandard dwelling up to minimum habitation standards. ~~Also excluded shall be modifications that are reasonable accommodation requirements of the Americans with Disabilities Act, the Virginians with Disabilities Act (§ 51.5-1 et seq. of the Code of Virginia), and the Rehabilitation Act (20 USC§ § 794).~~

~~e. Transition coordinators shall, upon completion of each modification, meet face-to-face with the waiver individual and his family or caregiver, as appropriate, to ensure that the modification is completed satisfactorily and is able to be used by the individual.~~

~~f.~~ d. EM shall not be approved for purposes of convenience of the caregiver or provider or restraint of the waiver individual.

e. Only the actual cost of material and labor is reimbursed. There shall be no additional markup.

f. EM shall be carried out in the least expensive manner possible to achieve the goal required for the individual's health, safety, and welfare.

g. All services shall be provided in the individual's primary residence in accordance with applicable state or local building codes and appropriate permits or building inspections, which shall be provided to DMAS or the DMAS contractor.

h. Proposed modifications that are to be made to rental properties shall have prior written approval of the property's owner. Modifications to rental properties shall only be valid if it is an independently operated rental facility with no direct or indirect ties to any other Medicaid service provider.

i. Modifications may be made to a vehicle if it is the primary vehicle used by the individual. This service shall not include the purchase of, lease of, or the general repair of vehicles. Repairs of modifications that have been reimbursed by DMAS shall be covered.

j. The EM provider shall ensure that all work and products are delivered, installed, and in good working order prior to seeking reimbursement from DMAS. The date of service on this provider's claim shall be within the service authorization approval dates, which may be prior to the completion date as long as the work commenced during the approval dates. The service authorization shall not be modified to accommodate installation delays. All requests for cost changes (either increases or decreases) shall be submitted to DMAS or the DMAS-designated service authorization contractor for revision to the previously issued service authorization and shall include justification and supporting documentation of medical needs.

k. DMAS shall not duplicate services that are required as a reasonable accommodation as a part of the Americans with Disabilities Act (42 USC §§ 12131 through 12165), the Virginians with Disabilities Act (§ 51.5-1 et seq. of the Code of Virginia), or the Rehabilitation Act of 1973 (29 USC § 794).

4. EM exclusions.

a. There shall be no duplication of previous EM services within the same residence such as multiple nonportable wheelchair ramps or previous modifications to the same room.

b. Adaptations or improvements to the primary home that shall be excluded are of general utility and are not of direct medical or remedial benefit to the waiver individual, such as, but not limited to, carpeting; flooring; roof repairs; central air conditioning or heating; general maintenance and repairs to a home; additions or maintenance of decks or fences; maintenance, replacement, or addition of sidewalks, driveways, or carports; or adaptations that only increase the total square footage of the home.

c. EM shall not be covered by Medicaid for general leisure or diversion items, items that are recreational in nature, items for educational purposes, or items that may be used as an outlet for adaptive or maladaptive behavioral issues. Such noncovered items may include swing sets, playhouses, climbing walls, trampolines, protective matting or ground cover, sporting equipment, hot tubs, or exercise equipment, such as special bicycles or tricycles.

d. EM shall not be covered by Medicaid if payment for such modifications can be made through the Fair Housing Act (42 USC § 3601 et seq.), the Virginia Fair Housing Law (§ 36-96.1 et seq. of the Code of Virginia) or the Americans with Disabilities Act (42 USC § 12101 et seq.).

e. EM shall not include the costs of removal or disposal, or any other costs, of previously installed modifications, whether paid for by DMAS or any other source.

f. Providers who supply EM to a waiver individual shall not perform assessments, consultations, or write EM specifications for such individuals

g. EM shall not cover payment for modifications or items that can be made through other Medicaid services, such as durable medical equipment.

M. Private duty nursing. PDN, for a single individual and individuals residing in the same home, as defined in 12VAC30-120-900, shall be provided for individuals who have serious medical conditions or complex health care needs. To receive this service, an individual must require specific skilled and continuous nursing care on a regularly scheduled or intermittent basis performed by an RN or an LPN. Once waiver eligibility has been determined by the LTSS screening team and a determination that the individual requires ongoing skilled nursing care has been made, then the PDN hours shall be authorized by DMAS or the DMAS designated service authorization contractor.

1. PDN services shall be rendered according to a POC authorized by DMAS or the DMAS designated service authorization contractor and shall have been certified by a physician as medically necessary to enable the individual to remain at home.

2. No reimbursement shall be provided by DMAS for either RN or LPN services without signed physician orders that specifically identify skilled nursing tasks to be performed for the individual.

3. Limits placed on the amount of PDN that will be approved for reimbursement shall be consistent with the individual's support needs and medical necessity but shall not exceed 112 hours per week. The maximum PDN hours authorized per week for individuals shall be based on their technology and documented medical necessity justification.

4. For individuals, whether living separately or in a congregate setting, PDN shall be reimbursed up to a maximum 112 hours per week (Sunday through Saturday) per waiver individual living in the household.

5. The individual shall be determined to need a medical device and ongoing skilled nursing care when such individual meets Category A or all eight criteria in Category B:

a. Category A. Individuals who depend on mechanical ventilators; or

b. Category B. Individuals who have a complex tracheostomy as defined by:

(1) Tracheostomy with the potential for weaning off of it, or documentation of attempts to wean, with subsequent inability to wean;

(2) Nebulizer treatments ordered at least four times a day or nebulizer treatments followed by chest physiotherapy provided by a nurse or respiratory therapist at least four times a day;

(3) Pulse oximetry monitoring at least every shift due to unstable oxygen saturation levels;

(4) Respiratory assessment and documentation every shift by a licensed respiratory therapist or nurse;

(5) Oxygen therapy with documented usage under a physician's order;

(6) Daily tracheostomy care;

(7) Tracheostomy suctioning under a physician's order; and

(8) At risk of requiring subsequent mechanical ventilation.

6. PDN shall not be available to individuals younger than 21 years of age as a waiver service. PDN for individuals younger than 21 shall be accessed through the EPSDT benefit.

7. PDN services may include consultation and training for the primary caregiver.

8. The provider shall be responsible for notifying the LDSS, the service authorization contractor, and the managed care organization should the primary residence of the individual be changed, should the individual be hospitalized, should the individual die, or should the individual be absent from the Commonwealth for 48 hours or more.

9. Exclusions from DMAS coverage of PDN:

a. PDN hours shall not be reimbursed while the individual is receiving emergency care or during emergency transport of the individual to emergency care facilities. The RN or LPN shall not transport the waiver individual to emergency care facilities.

b. PDN services may be ordered but shall not be provided simultaneously with skilled respite care or personal care services. These services may be provided sequentially or alternately from each other.

c. Providers shall not bill prior to receiving the physician's dated signature on the individual's POC for services provided and DMAS or DMAS designated service authorization contractor's authorization or determination of PDN hours.

d. Time spent transporting the waiver individual shall not be reimbursed by DMAS.

e. DMAS shall not reimburse for PDN services through the CCC Plus Waiver and PDN services through the EPSDT benefit at the same time.

10. Congregate PDN.

a. If more than one waiver individual resides in the home, the same waiver provider shall be chosen to provide all PDN services for all waiver individuals in the home.

b. Only one nurse shall be authorized to care for no more than two waiver individuals in such arrangements. In instances when three waiver individuals share a home, nursing ratios shall be determined by DMAS or its designated agent based on the needs of all the individuals who are living together. These congregate PDN hours shall be at the same scheduled shifts.

c. The unpaid primary caregiver shall be shared and shall be responsible for providing all care needs when a private duty nurse is not available.

12VAC30-120-925. Respite coverage in children's residential facilities.

A. Individuals ~~with special needs who are enrolled in the EDCD Waiver and~~ who have a diagnosis of intellectual disability (ID) or developmental disability (DD) shall be eligible to receive respite services in children's residential facilities that are licensed for respite services for children with ID or DD.

B. These respite services shall be covered consistent with the requirements of 12VAC30-120-924, 12VAC30-120-930, and 12VAC30-120-935, whichever is in effect at the time of service delivery~~.~~ with the following exceptions:

1. An assessment by the nurse supervisor shall be conducted at the onset of each use of respite in the children's residential facility;

2. Documentation of each utilization of respite in a children's residential facility will document the arrival and departure times of the individual instead of the arrival and departure times of each staff member; and

3. The nurse supervisor shall review the utilization of respite services in the children's residential facility. The nurse supervisor shall not be required to conduct the supervisory visit in the home of the waiver individual.

12VAC30-120-927. Exception criteria for personal care services.

DMAS shall apply the following criteria to individuals who request approval of personal care hours in excess of the maximum allowed 56 hours per week. In order to qualify for personal care hours in excess of 56 hours per week, the waiver individual shall:

1. Presently have a minimum level of care of B (the waiver individual has a composite activities of daily living (ADL) score between seven and 12 and has a medical nursing need) or C (the waiver individual has a composite ADL score of nine or higher and has a skilled medical nursing need).

2. In addition to meeting the requirements set out in subdivision 1 of this section, the individual shall have at least one of the following:

a. Documentation of dependencies in all of the following activities of daily living: bathing, dressing, transferring, toileting, and ~~eating/feeding~~ eating or feeding, as defined by the current ~~preadmission~~ LTSS screening criteria (12VAC30-60-303) ~~(~~submitted to the service authorization contractor via DMAS-99~~)~~;

b. Documentation of dependencies in both behavior and orientation as defined by the current ~~preadmission~~ LTSS screening criteria (12VAC30-60-303) ~~(~~submitted to the service authorization contractor via DMAS-99~~)~~; or

c. Documentation from the local department of social services that the individual has an open case (as described in subdivisions 2 c (1) and 2 c (2) of this ~~subdivision 2~~ section) with either ~~Adult Protective Services~~ adult protective services (APS) or ~~Child Protective Services~~ child protective services (CPS) and is therefore in need of additional services beyond the maximum allowed 56 hours per week. Documentation can be in the form of a phone log contact or any other documentation supplied (submitted to the service authorization contractor via attestation).

(1) For APS, an open case is defined as a substantiated APS case with a disposition of needs protective services and the adult accepts the needed services.

(2) For CPS, an open case is defined as being open to CPS investigation if it is both founded by the investigation and the completed family assessment documents the case with moderate or high risk.

12VAC30-120-930. General requirements for home and community-based participating providers.

A. The following agency-directed services shall be provided through an agency that is either (i) licensed by VDH, (ii) certified by VDH under provisions of Title XVIII or Title XIX of the Social Security Act, or (iii) accredited either by the Joint Commission on Accreditation of Health Care Organizations (JCAHO) or by the Community Health Accreditation Program (CHAP) established by the National League of Nursing for Medicaid participation: personal care, respite care, PDN, skilled respite care, and congregate PDN. The provider shall make available verification of its license, certification, or accreditation upon request.

B. Requests for participation shall be screened by DMAS or the designated DMAS contractor to determine whether the provider applicant meets the requirements for participation, as set ~~out~~ forth in the provider agreement, and demonstrates the abilities to perform, at a minimum, the following activities:

1. Screen all new and existing employees and contractors to determine whether any are excluded from eligibility for payment from federal health care programs, including Medicaid (i.e., via the United States Department of Health and Human Services Office of Inspector General List of Excluded Individuals or Entities (LEIE) website). Immediately report in writing to DMAS any exclusion information discovered to: DMAS, ATTN: Program

Integrity/Exclusions, 600 East Broad Street, Suite 1300, Richmond, VA 23219, or email to providerexclusions@dmas.virginia.gov;

2. Immediately notify DMAS in writing of any change in the information that the provider previously submitted to DMAS;

3. ~~Except for waiver individuals who are subject to the DMAS Client Medical Management program Part VIII (12VAC30-130-800 et seq.) of 12VAC30-130 or are enrolled in a Medicaid managed care program, ensure~~ Ensure freedom of choice to individuals in seeking services from any institution, pharmacy, practitioner, or other provider qualified and enrolled in Medicaid at the time of delivery to perform the ~~services~~ service required ~~and participating in the Medicaid Program at the time the services are performed~~, except for waiver individuals who are subject to the DMAS Client Medical Management program as set out in Part VIII of 12VAC30 or are enrolled in a Medicaid managed care organization;

4. Ensure the individual's freedom to refuse medical care, treatment, and services;

5. Accept referrals for services only when staff is available to initiate and perform such services on an ongoing basis;

6. Provide services and supplies to individuals in full compliance with Title VI (42 USC § 2000d et seq.) of the Civil Rights Act of 1964 which prohibits discrimination on the grounds of race, color, religion, or national origin; the Virginians with Disabilities Act (§ 51.5-1 et seq. of the Code of Virginia); § 504 of the Rehabilitation Act of 1973 (29 USC § 794), which prohibits discrimination on the basis of a disability; and the Americans with Disabilities Act of 1990 (42 USC § 12101 et seq.), which provides comprehensive civil rights protections to individuals with disabilities in the areas of employment, public accommodations, state and local government services, and telecommunications;

7. Provide services and supplies to individuals of the same quality and in the same mode of delivery as are provided to the general public;

8. Submit charges to DMAS, the MCO, or the DMAS-designated service authorization contractor for the provision of services and supplies to individuals in amounts not to exceed the provider's usual and customary charges to the general public and accept as payment in full the amount established by DMAS payment methodology beginning with the individual's authorization date for the waiver services;

9. Use only DMAS-designated forms for service documentation, except when otherwise permitted. The provider shall not alter the DMAS forms in any manner without prior written approval from DMAS;

10. Use DMAS-designated billing forms for submission of charges;

11. Perform no type of direct marketing activities to Medicaid individuals;

12. Maintain and retain business and professional records sufficient to document fully and accurately the nature, scope, and details of the services provided.

a. In all instances of forms required to be in records, all documents shall have original notes, dates, and signatures. Copied, re-dated, and photocopied forms, notes and signatures are prohibited. Signatures shall not be dated prior to the last date of rendered services for the appropriate form being used.

b. In general, such records shall be retained for a period of at least six years from the last date of service or as provided by applicable federal and state laws, whichever period is longer. However, if an audit is initiated within the required retention period, the records shall be retained until the audit is completed and every exception resolved. Records of minors shall be kept for a period of at least six years after such minor has reached 18 years of age.

~~b.~~ c. Policies regarding retention of records shall apply even if the provider discontinues operation. DMAS shall be notified in writing of the storage location and procedures for obtaining records for review should the need arise. The location, agent, or trustee shall be within the Commonwealth;

13. Furnish information on the request of and in the form requested to DMAS, or its contractors, the Attorney General of Virginia or their authorized representatives, federal personnel, and the state Medicaid Fraud Control Unit. The Commonwealth's right of access to provider agencies and records shall survive any termination of the provider agreement;

14. Disclose, as requested by DMAS, all financial, beneficial, ownership, equity, surety, or other interests in any and all firms, corporations, partnerships, associations, business enterprises, joint ventures, agencies, institutions, or other legal entities providing any form of health care services to recipients of Medicaid;

15. Pursuant to 42 CFR 431.300 et seq., § 32.1-325.3 of the Code of Virginia, and the Health Insurance Portability and Accountability Act (HIPAA), safeguard and hold confidential all information associated with an applicant or enrollee or individual that could disclose the ~~applicant's, enrollee's, or individual's~~ identity of the applicant, enrollee, or individual. Access to information concerning the applicant, enrollee, or individual shall be restricted to persons or agency representatives who are subject to the standards of confidentiality that are consistent with that of the agency and any such access must be in accordance with

the provisions found in 42 CFR 431.306 and 12VAC30-20-90;

16. When ownership of the provider changes, notify DMAS in writing at least 15 calendar days before the date of change;

17. Pursuant to §§ 63.2-100, 63.2-1509, and 63.2-1606 of the Code of Virginia, if a participating provider or the provider's staff knows or suspects that a home and community-based waiver services individual is being abused, neglected, or exploited, the party having knowledge or suspicion of the abuse, neglect, or exploitation shall report this immediately ~~from first knowledge or suspicion of such knowledge~~ to the local department of social services adult or child protective services ~~worker~~ department as applicable or to the toll-free, 24-hour hotline as described on the local department of social services' website. Employers shall ensure and document that their staff is aware of this requirement;

a. The party having knowledge or suspicion of abuse, neglect, or exploitation shall also report this immediately to DMAS, or its authorized contractor separately as a critical incident. The provider shall ensure that in such instances of suspected or known abuse, neglect, and exploitation that DMAS, or its authorized contractor are informed after notifying adult or child protective services and will document the date and time of report.

b. If a participating provider or the provider's staff knows or suspects that a waiver individual has incurred a critical incident that does not include suspected or known abuse, neglect, or exploitation, the party having knowledge or suspicion of the critical incident shall report this immediately to DMAS or the DMAS-designated contractor. Employers shall ensure and document that their staff is aware of this requirement and maintain copies of all records of reported critical incidents in the individual's file.

18. In addition to compliance with the general conditions and requirements, adhere to the conditions of participation outlined in the ~~individual~~ provider's participation agreements, in the applicable DMAS provider manual, and in other DMAS laws, regulations, and policies. DMAS shall conduct ongoing monitoring of compliance with provider participation standards and DMAS policies. A provider's noncompliance with DMAS policies and procedures may result in a retraction of Medicaid payment or termination of the provider agreement, or both;

19. Meet minimum qualifications of staff.

a. For reasons of Medicaid individuals' safety and welfare, all employees shall have a satisfactory work record, as evidenced by at least two references from prior job experience, including no evidence of abuse, neglect, or exploitation of incapacitated or older adults or children. In instances of employees who have worked for only one employer, such employees shall be permitted to provide one appropriate employment reference and one appropriate personal reference including no evidence of abuse, neglect, or exploitation of incapacitated or older adults or children.

b. ~~Criminal record checks for both employees and volunteers conducted by the Virginia State Police. Proof that these checks were performed with satisfactory results shall be available for review by DMAS staff or its designated agent who are authorized by the agency to review these files. DMAS shall not reimburse the provider for any services provided by an employee or volunteer who has been convicted of committing a barrier crime as defined in § 32.1-162.9:1 of the Code of Virginia. Providers shall be responsible for complying with § 32.1-162.9:1 of the Code of Virginia regarding criminal record checks. Provider staff shall not be reimbursed for services provided to the waiver individual effective on the date and thereafter that the criminal record check confirms the provider's staff person or volunteer was convicted of a barrier crime.~~ Pursuant to 42 CFR 441.302 and 42 CFR 441.352, within 30 calendar days of employment, the staff or volunteer shall obtain an original criminal record clearance with respect to convictions for offenses specified in § 19.2-392.02 of the Code of Virginia or an original criminal history record from the Central Criminal Records Exchange.

(1) DMAS shall not reimburse a provider for services provided by a staff member or volunteer who works in a position that involves direct contact with a waiver individual until an original criminal record clearance or original criminal history record has been received. DMAS shall reimburse services provided by such staff member or volunteer during only the first 30 calendar days of employment if the provider can produce documented evidence that such person worked only under the direct supervision of another staff member or volunteer for whom a background check was completed in accordance with the requirements of this section. If an original criminal record clearance or original criminal history record is not received within the first 30 calendar days of employment, DMAS shall not reimburse the provider for services provided by such employee on the 31st calendar day through the date on which the provider receives an original criminal record clearance or an original criminal history record.

(2) DMAS shall not reimburse a provider for services provided by a staff member or volunteer who has been convicted of any offense set forth in clause (i) of the definition of barrier crime in § 19.2-392.02 of the Code of Virginia unless all of the following conditions are met: (i) the offense was punishable as a misdemeanor; (ii) the staff member or volunteer has been convicted of only one such offense; (iii) the offense did not involve abuse or neglect; and (iv) at least five years have elapsed since the conviction.

c. The staff or volunteer shall provide the hiring facility with a sworn statement or affirmation disclosing any criminal convictions or any pending criminal charges, whether within or outside of the Commonwealth.

d. Provider staff and volunteers shall 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 https://oig.hhs.gov.

~~c.~~ e. Provider staff and volunteers who serve waiver individuals who are minor children shall ~~also~~ be screened through the VDSS Child Protective Services (CPS) Central Registry. Provider staff and volunteers shall not be reimbursed for services provided to the waiver individual effective on the date and thereafter that the VDSS CPS Central Registry check confirms the provider's staff person or volunteer has a finding.

20. Comply with the electronic visit verification requirements set out in 12VAC30-60-65.

21. Providers shall comply with requirements for person-centered planning and home and community-based settings as described in 42 CFR 441.301. As part of the person-centered planning process, providers shall discuss the available services to the individual to meet the individual's needs and shall not perform services that are not identified or agreed upon in the person-centered plan.

~~B.~~ C. DMAS shall terminate the provider's Medicaid provider agreement pursuant to § 32.1-325 of the Code of Virginia and as may be required for federal financial participation. A provider who has been convicted of a felony, or who has otherwise pled guilty to a felony, in Virginia or in any other of the 50 states, the District of Columbia, or the U.S. territories shall within 30 days of such conviction notify DMAS of this conviction and relinquish its provider agreement. Such provider agreement terminations, subject to applicable appeal rights, shall conform to § 32.1-325 D and E of the Code of Virginia and Part XII (12VAC30-20-500 et seq.) of 12VAC30-20.

~~C. For DMAS to approve provider agreements with home~~ D. Home and community-based waiver services providers~~,~~ shall meet the following standards ~~shall be met~~:

1. Staffing, financial solvency, disclosure of ownership, and ensuring comparability of services requirements as specified in the applicable provider manual;

2. The ability to document and to maintain waiver individuals' case records in accordance with state and federal requirements;

3. Compliance with all applicable laws, regulations, and policies pertaining to ~~EDCD~~ CCC Plus Waiver services.

~~D.~~ E. The waiver individual shall have the option of selecting ~~the~~ a Medicaid-enrolled provider ~~of his choice from among those providers who are approved and who~~ that can appropriately meet ~~his~~ the individual's needs.

~~E.~~ F. A participating provider may voluntarily terminate ~~his~~ its participation in Medicaid by providing 30 days' written notification to DMAS.

~~F.~~ G. Except as otherwise provided by state or federal law, DMAS may terminate at will a provider's participation agreement on 30 days' written notice as specified in the DMAS participation agreement. DMAS may immediately terminate a provider's participation agreement if the provider is no longer eligible to participate in the Medicaid program. Such action precludes further payment by DMAS for services provided to individuals on or after the date specified in the termination notice.

~~G.~~ H. The provider or the managed care organization shall be responsible for completing the DMAS-225 form. ~~The provider shall~~ to notify the designated ~~Srv Auth~~ service authorization contractor~~, as appropriate,~~ and the local department of social services~~, in writing,~~ when any of the following events occur. ~~Furthermore, it shall be the responsibility of the designated Srv Auth contractor to also update DMAS, as requested, when any of the following events occur~~:

1. Home and community-based waiver services are ~~implemented~~ started;

2. A waiver individual dies;

3. A waiver individual is discharged from the provider's ~~EDCD~~ CCC Plus Waiver services;

4. Any other events (including hospitalization) that cause home and community-based waiver services to cease or be interrupted for more than 30 consecutive calendar days; or

5. ~~The initial selection by the waiver individual or family or caregiver of a provider to provide services, or a change by the waiver individual or family or caregiver of a provider, if it affects the individual's patient pay amount~~ Changes in the individual's status that may affect the individual's patient pay amount or financial Medicaid eligibility.

~~H.~~ I. Changes or termination of services.

1. The provider may decrease the amount of authorized care if the revised POC is appropriate and based on the medical needs of the waiver individual. The participating provider shall collaborate with the waiver individual or the family, caregiver, or EOR, ~~or both~~ as appropriate, to develop the new POC and calculate the new hours of service delivery. The provider shall discuss the decrease in care with the waiver individual or family, caregiver, or EOR, document the conversation in the waiver individual's record, and notify the designated ~~Srv Auth~~ service authorization contractor. The ~~Srv Auth~~ service authorization contractor shall process the decrease request and the waiver individual shall be

notified of the change by letter. This letter shall clearly state the waiver individual's right to appeal this change.

2. If a change in the waiver individual's condition necessitates an increase in care, the participating provider shall assess the need for the increase and~~,~~ collaborate with the waiver individual and family, caregiver, or EOR, and MCO care coordinator as appropriate, to develop a POC for services to meet the changed needs. The provider may implement the increase in personal care ~~or respite~~ care hours ~~without~~ prior to approval from DMAS, or the designated ~~Srv Auth~~ service authorization contractor, if the amount of services does not exceed the total amount established by DMAS as the maximum for the level of care designated for that individual on the plan of care.

3. Any increase to a waiver individual's POC that exceeds the number of hours allowed for that individual's level of care or any change in the waiver individual's level of care shall be authorized by DMAS or the designated ~~Srv Auth~~ service authorization contractor prior to the increase and be accompanied by adequate documentation justifying the increase.

4. In an emergency situation when either the health, safety, or welfare of the waiver individual or provider personnel is endangered, or both, the provider shall notify DMAS, or the designated ~~Srv Auth contractor, shall be notified~~ service authorization contractor in writing prior to discontinuing services. The provider shall give written notification to the waiver individual discontinuing services. An advance written notification period ~~set out below~~ shall not be required. If appropriate, local department of social services adult or child protective services~~, as may be appropriate,~~ shall be notified immediately. ~~Appeal rights shall be afforded to the waiver individual.~~

5. In a nonemergency situation, when neither the health, safety, nor welfare of the waiver individual or provider personnel is endangered, the participating provider shall give the waiver individual at least 10 calendar days' written notification (plus three days for mail transit for a total of 13 calendar days from the letter's date) of the intent to discontinue services. The notification letter shall provide the reasons for and the effective date the provider will be discontinuing services. ~~Appeal rights shall be afforded to the waiver individual.~~

~~I.~~ J. Staff education and training requirements.

1. RNs shall (i) be currently licensed to practice in the Commonwealth as an RN, or shall hold multi-state licensure privilege pursuant to Chapter 30 (§ 54.1-3000 et seq.) of Title 54.1 of the Code of Virginia; (ii) have at least one year of related clinical nursing experience, which may include work in an acute care hospital, public health clinic, home health agency, rehabilitation hospital, or ~~NF~~ nursing facility, specialized care nursing facility, or long-stay hospital or as an LPN who worked for at least one year in one of these settings; and (iii) ~~submit to a criminal records check~~ meet the requirements of subdivision A 19 of this section regarding criminal record checks and consent to a search of the VDSS Child Protective Services Central Registry if the waiver individual is a minor child. The RN shall not be compensated for services provided to the waiver individual if this record check verifies that the RN has been convicted of a barrier crime described in § 32.1-162.9:1 of the Code of Virginia or if the RN has a founded complaint confirmed by the VDSS Child Protective Services Central Registry.

2. LPNs shall work under supervision as set out in ~~18VAC90-20-37~~ 18VAC90-19-70. LPNs shall (i) be currently licensed to practice in the Commonwealth as an LPN, or shall hold multi-state licensure privilege pursuant to Chapter 30 (§ 54.1-3000 et seq.) of Title 54.1 of the Code of Virginia; (ii) shall have at least one year of related clinical nursing experience, which may include work in an acute care hospital, public health clinic, home health agency, rehabilitation hospital, ~~or~~ NF, specialized care NF, or long-stay hospital. The LPN shall meet the qualifications and skills, prior to being assigned to care for the waiver individual, that are required by the individual's POC; and (iii) ~~submit to a criminal records check~~ meet the requirements of subdivision A 19 of this section regarding criminal record checks and consent to a search of the VDSS Child Protective Services Central Registry if the waiver individual is a minor child. The LPN shall not be compensated for services provided to the waiver individual if this record check verifies that the LPN has been convicted of a barrier crime described in § 32.1-162.9:1 of the Code of Virginia or if the LPN has a founded complaint confirmed by the VDSS Child Protective Services Central Registry.

3. All RNs and LPNs who provide PDN services shall have either (i) at least six months of related clinical experience as documented in their work history, which may include work in acute care hospitals, long-stay hospitals, rehabilitation hospitals, or specialized care nursing facilities, or (ii) completed a provider training program related to the care and technology needs of the assigned waiver individual.

a. Training programs established by providers shall include, at a minimum, the following:

(1) Trainers (either RNs or respiratory therapists) shall have at least six months hands-on successful experience in the areas in which the trainer provides training, such as ventilators, tracheostomies, peg tubes, and nasogastric tubes.

(2) Training shall include classroom time as well as direct hands-on demonstration of mastery by the trainee of the specialized skills required to work with individuals who have technology dependencies.

(3) The training program shall include the following subject areas as they relate to the care to be provided by

the nurse: (i) human anatomy and physiology, (ii) medications frequently used by technology dependent individuals, (iii) emergency management, and (iv) the operation of the relevant equipment.

(4) Providers shall ensure a nurse's competency and mastery of the skills necessary to care successfully for a waiver individual prior to assignment. Documentation of successful completion of such training course and mastery of the specialized skills required to work with individuals who have technology dependencies shall be maintained in the provider's personnel records. This documentation shall be provided to DMAS upon request.

b. The RN supervisor for nurses providing PDN shall be currently licensed to practice nursing in the Commonwealth and have at least one year of related clinical nursing experience, which may include work in an acute care hospital, long-stay hospital, rehabilitation hospital, or specialized care nursing facility.

~~3.~~ 4. Personal care aides who are employed by personal care agencies that are licensed by VDH shall meet the requirements of 12VAC5-381. In addition, personal care aides shall also receive annually a minimum of 12 documented hours of agency-provided training in the performance of these services.

~~4.~~ 5. Personal care aides who are employed by personal care agencies that are not licensed by ~~the~~ VDH shall have 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 ensured by the provider prior to being assigned to the care of an individual, and shall have the required skills and training to perform the services as specified in the waiver individual's POC and related supporting documentation.

a. Personal care aides' required initial (that is, at the onset of employment) training~~, as further detailed in the applicable provider manual,~~ shall be met in one of the following ways: (i) registration with the Board of Nursing as a certified nurse aide; (ii) graduation from an approved educational curriculum as listed by the Board of Nursing; or (iii) completion of the provider's educational curriculum, which must be a minimum of 40 hours in duration, as taught by an RN who meets the same requirements as the RN listed in subdivision 1 of this subsection.

b. In addition, personal care aides shall also be required to receive annually a minimum of 12 documented hours of agency-provided training in the performance of these services, which shall be documented in the aide's record.

~~5.~~ 6. Personal care aides shall:

a. Be at least 18 years of age or older;

b. Be able to read and write English to the degree necessary to perform the expected tasks and create and maintain the required documentation;

c. Be physically able to perform the required tasks and have the required skills to perform services as specified in the waiver individual's supporting documentation;

d. Have a valid social security number that has been issued to the personal care aide by the Social Security Administration;

e. ~~Submit to a criminal records check~~ Meet the requirements of subdivision A 19 of this section regarding criminal record checks and, if the waiver individual is a minor, consent to a search of the VDSS Child Protective Services Central Registry. ~~The aide shall not be compensated for services provided to the waiver individual effective the date in which the record check verifies that the aide has been convicted of barrier crimes described in § 32.1-162.9:1 of the Code of Virginia or if the aide has a founded complaint confirmed by the VDSS Child Protective Services Central Registry;~~

f. Understand and agree to comply with the DMAS ~~EDCD~~ CCC Plus Waiver requirements; and

g. Receive tuberculosis (TB) screening as specified in the criteria used by ~~the~~ VDH.

~~6.~~ 7. Consumer-directed personal care attendants shall:

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 documentation;

c. Be physically able to perform the required tasks and have the required skills to perform consumer-directed services as specified in the waiver individual's supporting documentation;

d. Have a valid social security number that has been issued to the personal care attendant by the Social Security Administration;

e. ~~Submit to a criminal records check~~ Meet the requirements of subdivision A 19 of this section and, if the waiver individual is a minor, consent to a search of the VDSS Child Protective Services Central Registry. ~~The attendant shall not be compensated for services provided to the waiver individual effective the date in which the record check verifies that the attendant has been convicted of barrier crimes described in § 32.1-162.9:1 of the Code of Virginia or if the attendant has a founded complaint confirmed by the VDSS Child Protective Services Central Registry~~;

f. Understand and agree to comply with the DMAS ~~EDCD~~ CCC Plus Waiver requirements;

g. Receive tuberculosis (TB) screening as specified in the criteria used by ~~the~~ VDH; and

h. Be willing to attend training at the ~~individual's or family or caregiver's~~ request of the individual, family, caregiver, or EOR.

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

A. The personal care providers, respite care providers, ADHC providers, private duty nursing 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,~~ family, caregiver, or EOR, as appropriate.

B. DMAS shall not reimburse for any waiver services rendered to waiver individuals when either (i) the spouse of the waiver individual or (ii) the natural, adoptive, step, or foster parent or other legal guardian of the minor child waiver individual is the one providing the service.

1. Payment shall not be made for personal care or respite services furnished by other family members living under the same roof as the waiver individual unless there is objective written documentation as to why no other person or provider is available to render the service. The nurse supervisor or services facilitator shall initially make the determination and document it fully in the individual's record.

2. Payment shall not be made for AT, EM, transition services, or services facilitation services furnished by other family members living under the same roof as the waiver individual receiving services.

3. Payment shall not be made for PDN services furnished by other family members, legal guardians of the waiver individual, or other persons living under the same roof as the waiver individual receiving the service.

4. Family members who are approved to be reimbursed for providing personal care or respite care services shall meet the same qualifications as all other personal care aides or CD attendants.

5. Payment shall not be made for respite care services if the primary caregiver, as identified in the records, receives payment for providing personal care services to the individual. Providers shall document the primary caregiver and whether the caregiver is paid or unpaid in the individual's record prior to requesting respite care service authorization.

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

~~C. Agency staff (RN, LPNs, or aides) or CD attendants shall not be reimbursed by DMAS for services rendered to waiver individuals when the agency staff or the CD 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. Agency staff (RNs, LPNs, or aides) or CD attendants shall only be reimbursed by DMAS for services if they are physically present with the waiver individual and are awake to perform the services outlined in the individual's plan of care.

E. A single agency-directed aide, consumer-directed attendant, RN, or LPN who provides personal care or respite services shall be reimbursed at a maximum limit of 16 hours per day for services rendered to an individual in order to ensure the health and safety of the individual receiving these services.

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

~~E.~~ G. 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~~ home and community-based services, ~~the~~ adult day ~~care~~ health center ~~(ADCC)~~ (ADHC) shall:

a. ~~Make~~ Hold a license with VDSS for adult day care center (ADCC) and make available a copy of the current VDSS license for DMAS review and verification ~~purposes~~ prior to the provider applicant's enrollment as a Medicaid provider;

b. ~~Adhere to the ADCC standards of VDSS as defined in 22VAC40-60 including provision of activities for waiver individuals;~~ Meet and maintain compliance with provisions of home and community-based rules as detailed in the provider agreement and as described in 42 CFR 441.301; 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~~ provider's contact person for DMAS and the designated ~~Srv Auth~~ service authorization contractor and shall be responsible for responding to communication from DMAS and the designated ~~Srv Auth~~ service authorization 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~~ a staff member to act as the ~~care~~ ADHC coordinator for each waiver individual and shall document ~~in the individual's medical record~~ the identity of the ~~care~~ ADHC coordinator in each individual's record. The ADHC coordinator can be the director, the activities director, RN, or therapist. The ~~care~~ ADHC 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 at least every 90 days or sooner when there is a change in the individual's ADHC level of care needs;

(b) Providing the nursing care and treatment as documented in 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~~ social or 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 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) An activities director who shall be responsible for directing recreational and social activities for the ADHC recipients. The director, at a minimum, shall have the following qualifications:

(a) A minimum of 48 semester hours or 72 quarter hours of post-secondary education from an accredited college or university with a degree in recreational therapy, occupational therapy, or a related field such as art, music, or physical education, and

(b) Have one year of related experience, which may include work in an acute care hospital, rehabilitation hospital, or nursing home, or have completed a course of study including the prescribed internship in occupation, physical, or recreational therapy or music, dance, art therapy, or physical education.

(5) The ADHC coordinator who shall coordinate, pursuant to 22VAC40-60-695, the delivery of the activities and services as prescribed in the waiver individual's POC and keep such plans updated, record 30-day progress notes concerning each waiver individual, and review the waiver 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. Copied or re-dated notes are not acceptable.

~~2.~~ d. Recreation and social activities responsibilities. The center shall provide planned recreational and social activities suited to the waiver individual's needs and

interests and designed to encourage physical exercise, prevent deterioration of each waiver individual's condition, and stimulate social interaction.

~~3.~~ e. The ADHC shall allow the care coordinator, DMAS, or the managed care organization to meet with waiver individuals to complete the annual individual experience survey, as required in the provisions of 42 CFR 441.301.

f. 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.~~ (1) DMAS required forms as specified in the center's provider-appropriate guidance documents;

~~b.~~ (2) Interdisciplinary POCs developed, in collaboration with the waiver individual ~~or family/caregiver~~, family, or 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.~~ (3) 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.~~ (4) 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 (copied or re-dated notes are not acceptable);

~~e.~~ (5) 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~~, family, or caregiver, and it shall also be maintained in the waiver ~~individual specific~~ individual's medical record; and

~~f.~~ (6) All contacts shall be documented in the waiver individual's medical record, including correspondence made to and from the individual with ~~family/caregivers~~ family, caregivers, physicians, DMAS, the designated ~~Srv Auth~~ service authorization contractor, formal and informal services providers, and all other professionals related to the waiver individual's Medicaid services or medical care.

~~F.~~ 2. 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 individual's health, safety, and welfare needs.

~~1.~~ a. 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~~ the individual is transferred from another provider, ADHC, or ~~from a CD services program~~ other waiver service.

~~2.~~ b. Within 30 days after the initial home assessment visit, the RN supervisor shall visit the individual and the individual's family or caregiver, as appropriate, to monitor the plan of care, to reassess the individual's needs, and to determine if the services rendered are adequate to ensure the health, safety, and welfare of the individual.

c. 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.~~ d. The ~~RN/LPN~~ nurse 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.~~ (1) 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 individual's ~~records~~ record by the RN on the initial assessment and in the ongoing assessment records.

~~b.~~ (2) If DMAS determines that the waiver individual's health, safety, or welfare is in jeopardy, DMAS may require the provider's ~~RN or LPN~~ nurse 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.~~ (3) During visits to the waiver individual's home, the ~~RN/LPN~~ nurse supervisor shall observe, evaluate, and document the adequacy and appropriateness of personal care services with regard to the individual's current functioning status ~~and~~, medical needs, and social needs.

~~The personal care aide's record shall be reviewed and the waiver individual's or family's/caregiver's, or both,~~ The nurse supervisor shall review the record of the aide or LPN and discuss with the individual, family, or caregiver the satisfaction with the type and amount of services ~~discussed~~.

~~d.~~ (4) If the ~~supervising RN/LPN~~ nurse supervisor 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.~~ (5) A ~~RN/LPN~~ nurse supervisor shall be available to the personal care aide for conferences pertaining to waiver individuals being served by the aide.

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

~~(2)~~ (b) The ~~RN/LPN~~ nurse 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.~~ (6) Licensed practical nurses (LPNs). As permitted by ~~his~~ the 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 individual's POC as developed by the RN in collaboration with the individual and the individual's ~~family/caregivers~~ family or caregivers, or both, as appropriate.

~~(1)~~ (a) 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, medical needs and social needs. The personal care aide's record shall be reviewed and the waiver individual's ~~or family/caregiver's,~~ family's, or caregiver's, ~~or both,~~ satisfaction with the type and amount of services discussed.

~~(2)~~ (b) 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)~~ (c) An LPN supervisor shall be available to personal care aides for conferences pertaining to waiver individuals being served by them.

~~g.~~ (7) Personal care aides. The agency provider may employ and the ~~RN/LPN~~ nurse 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 no other provider or 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.~~ e. Required documentation for a waiver 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~~ waiver 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.~~ (1) 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.~~ (2) 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)~~ (a) An employee of the provider shall not sign for the waiver individual unless ~~he~~ that employee is a family member or unpaid caregiver of the waiver individual.

~~(2)~~ (b) 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~~ no more than seven calendar days from the date of the last service.

~~C.~~ 3. Agency-directed respite care services.

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

~~a.~~ (1) 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~~ aides or LPNs, as appropriate. A RN shall provide supervision to all direct care and supervisory LPNs.

~~(1)~~ (a) When respite care services are received on a routine basis, the minimum acceptable frequency of the required

~~RN/LPN~~ nurse supervisor's visits shall not exceed every 90 days, based on the initial assessment. If a waiver individual is also receiving personal care or private duty nursing services, the respite care ~~RN/LPN~~ nurse supervisory visit may coincide with the personal care ~~RN/LPN~~ nurse supervisory visits. However, the ~~RN/LPN~~ nurse 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)~~ (b) When respite care services are not received on a routine basis but are episodic in nature, a ~~RN/LPN~~ nurse supervisor shall conduct the home supervisory visit with the ~~aide/LPN~~ aide or LPN on or before the start of care. The ~~RN/LPN~~ RN or 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 from the same provider, the respite care ~~RN/LPN~~ nurse supervisory visit may coincide with the personal care ~~RN/LPN~~ nurse supervisory visit.

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

~~(4)~~ (d) Should the required ~~RN/LPN~~ nurse 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.~~ (2) 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 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.~~ (3) Employ ~~an~~ a LPN or RN to perform skilled respite care services when skilled respite services are offered. Such services shall be reimbursed by DMAS under the following circumstances:

~~(1)~~ (a) 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)~~ (b) 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 unpaid primary caregiver's absence; and

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

~~e.~~ (4) Document in the waiver individual's record the circumstances that require the provision of skilled respite services by an LPN or RN. At the time of the LPN's or RN's service, the LPN or RN shall also provide all of the skilled respite 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 no other provider or 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.~~ b. Required documentation for a waiver individual's records. The provider shall maintain all records for each waiver individual receiving respite services. These records shall be ~~separate~~ clearly labeled and maintained separately from those of non-home and community-based ~~care~~ waiver 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~~ records. At a minimum these records shall contain:

~~a.~~ (1) Forms as specified in the DMAS guidance documents.

~~b.~~ (2) All respite care ~~LPN/aide~~ LPN, RN, or aide records shall contain:

~~(1)~~ (a) The specific services delivered to the waiver individual by the ~~LPN/aide~~ LPN, RN, or aide;

~~(2)~~ (b) The respite care ~~LPN's/aide's~~ LPN's, RN's, or aide's daily arrival and departure times;

~~(3)~~ (c) Comments or observations recorded weekly about the waiver individual. ~~LPN/aide~~ LPN, RN, or aide comments shall include observation of the waiver individual's physical, medical, 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~~ (3) Skilled respite care LPN or RN records ~~(DMAS-90A)~~, which may be documented on the DMAS 90-A, shall be reviewed and signed by the supervising RN and shall contain:

~~(1)~~ (a) The signatures of the skilled respite care ~~LPN/aide's~~ LPN or RN and waiver individual's or responsible

~~family/caregiver's signatures~~ family or caregiver, including the date, verifying that skilled respite care services have been rendered during the week of service delivery as documented in the record.

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

~~(3)~~ (c) Signatures, times, and dates shall not be placed on the skilled respite care ~~LPN/aide~~ LPN or 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~~ LPN or aide records later than seven calendar days from the date of the last service.

~~H.~~ 4. Consumer-directed (CD) services facilitation for personal care and respite services.

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

~~2.~~ b. 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.

~~3.~~ c. The ~~consumer-directed~~ services facilitator~~, whether employed or contracted by a DMAS enrolled services facilitator,~~ or any staff or volunteer of the services facilitator providing direct service to Medicaid individuals shall meet the following qualifications:

~~a.~~ (1) To be enrolled as a Medicaid ~~consumer-directed~~ services facilitator and maintain provider status, the ~~consumer-directed~~ services facilitator shall have sufficient knowledge, skills, and abilities to perform the activities required of such providers. In addition, the ~~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.~~ (2) Effective January 11, 2016, all ~~consumer-directed~~ services facilitators and volunteers providing direct service to Medicaid individuals shall:

~~(1)~~ (a) Have a satisfactory work record as evidenced by at least two references from prior job ~~experiences from any human services work; such references shall not include any~~ experience with no evidence of abuse, neglect, or exploitation of incapacitated or 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)~~. In instances of employees who have worked for only one employer, such employees shall be permitted to provide one appropriate employment reference and one appropriate personal reference, including no evidence of abuse, neglect, or exploitation of incapacitated or older adults or children.

(b) Within 30 calendar days of employment, the services facilitator, staff, or volunteer shall obtain an original criminal record clearance with respect to convictions for offenses specified in § 19.2-392.02 of the Code of Virginia or an original criminal history record from the Central Criminal Records Exchange. The staff or volunteer shall also submit to a screening through the VDSS Child Protective Services (CPS) Central Registry if serving a waiver individual who is a minor child. Provider staff and volunteers shall not be reimbursed for services provided to the waiver individual effective on the date and thereafter that the VDSS CPS Central Registry check confirms the provider's staff person or volunteer has a finding.

(i) DMAS shall not reimburse a provider for services provided by a staff or volunteer who works in a position that involves direct contact with a waiver individual until an original criminal record clearance or original criminal history record has been received. DMAS shall reimburse services provided by such a staff person during only the first 30 calendar days of employment if the provider can produce documented evidence that such person worked only under the direct supervision of another staff person for whom a background check was completed in accordance with the requirements of this section. If an original criminal record clearance or original criminal history record is not received within the first 30 calendar days of employment, DMAS shall not reimburse the provider for services provided by such staff or volunteer on the 31st calendar day through the date on which the provider receives an original criminal record clearance or an original criminal history record.

(ii) DMAS shall not reimburse a provider for services provided by a staff or volunteer who has been convicted of any offense set forth in clause (i) of the definition of

barrier crime in § 19.2-392.02 of the Code of Virginia unless all of the following conditions are met: (i) the offense was punishable as a misdemeanor; (ii) the staff or volunteer has been convicted of only one such offense; (iii) the offense did not involve abuse or neglect; and (iv) at least five years have elapsed since the conviction.

(c) The staff or volunteer shall provide the hiring entity with a sworn statement or affirmation disclosing any criminal convictions or any pending criminal charges, whether within or outside of the Commonwealth.

(d) 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://oig.hhs.gov/exclusions/exclusions_list.asp~~ https://www.oig.hhs.gov.

~~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.~~ (3) Effective January 11, 2016, all ~~consumer-directed~~ services facilitators shall possess the required degree and experience, as follows:

~~(1)~~ (a) Prior to initial enrollment by ~~the department~~ DMAS 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)~~ (b) 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.~~ (4) 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. All new services facilitator training and pass the corresponding competency assessment with a score of at least 80% in order to begin and to continue being reimbursed for or working with waiver individuals for the purpose of reimbursement for services through this waiver.

~~(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.~~ (5) 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.~~ (6) 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.

~~j.~~ (7) The ~~consumer-directed~~ services facilitator must possess a combination of work experience and relevant education that indicates possession of the following knowledge, skills, and abilities. Such knowledge, skills, and abilities must be documented on the ~~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)~~ (a) Knowledge of:

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

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

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

~~(d)~~ (iv) Various long-term care program requirements, including ~~nursing facility~~ institutional 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;~~

(v) CCC Plus Waiver requirements, as well as the administrative duties for which the services facilitator will be responsible;

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

~~(g)~~ (vii) Interviewing techniques;

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

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

~~(j)~~ (x) General principles of record documentation.

~~(2)~~ (b) Skills in:

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

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

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

~~(d)~~ (iv) Identifying services within the established services system to meet the individual's needs.

~~(3)~~ (c) Abilities to:

~~(a)~~ (i) Report findings of the assessment or onsite visit, either in writing or an alternative format for individuals who have visual or hearing impairments;

~~(b)~~ (ii) Demonstrate a positive regard for individuals and their families;

~~(c)~~ (iii) Be persistent and remain objective;

~~(d)~~ (iv) Work independently, performing job position duties under general supervision;

~~(e)~~ (v) Communicate effectively orally and in writing; and

~~(f)~~ (vi) Develop a rapport and communicate with individuals from diverse cultural backgrounds.

(8). 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.

~~4.~~ d. Initiation of services and service monitoring.

~~a. For~~ (1) Upon entry into consumer-directed ~~model of service~~ services, the ~~consumer-directed~~ services facilitator shall make an initial comprehensive home visit at the primary residence of the individual to collaborate with the individual or the individual's ~~family/caregiver~~ family or caregiver, as appropriate, to identify the individual's needs, assist in the development of the plan of care with the waiver individual and individual's ~~family/caregiver~~ family or caregiver, as appropriate, and provide EOR management training within seven days of the initial visit. The initial comprehensive home visit shall be conducted only once upon the individual's entry into consumer-directed services. ~~If the individual changes, either voluntarily or involuntarily, the consumer-directed services facilitator,~~ The individual shall receive one comprehensive visit per lifetime. If the individual changes service facilitators, the new ~~consumer-directed~~ services facilitator shall complete a reassessment visit in lieu of a comprehensive visit. ~~b. After the initial comprehensive~~ The EOR management training shall be limited to one visit per EOR.

(2) Within 30 days after the initial comprehensive visit, the services facilitator shall visit the individual and the individual's family or caregiver, as appropriate, to monitor the plan of care, to reassess the individual's needs, and to determine if the services rendered are adequate to ensure the health, safety, and welfare of the individual. During this visit, the services facilitator, individual, EOR, and family or caregiver, as appropriate, shall agree to the frequency of routine visits, which shall be conducted at least every 90 days but no more frequently than every 30 days. The agreement shall be documented in the service facilitator's records.

(3) During the routine visit, the services facilitator shall continue to monitor the 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 individual and may include the ~~family/caregiver~~ EOR, family, or caregiver. ~~The services facilitator shall review the utilization of 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 individual and may include the family/caregiver.~~ Such ~~monitoring reviews~~ visits shall be documented in the individual's medical record.

~~c.~~ (4) When respite is the sole service provided, the services facilitator shall review the utilization of 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 individual and may include the family or caregiver, as appropriate. Such visits shall be documented in the individual's record.

(5) Every six months, the services facilitator shall conduct a face-to-face reassessment visit with the individual and EOR, family, or caregiver, as appropriate. During the visit, the services facilitator shall review the individual's current functional and support status, review all services the individual receives, including the existing plan of care, discuss the individual's and EOR's satisfaction with services, update the plan of care as necessary, and submit new service authorization requests for personal care hours and other waiver services if necessary. The services facilitator shall not conduct a routine visit and reassessment visit during the same visit but shall submit reimbursement for only a reassessment visit.

(6) During all visits with the individual, the services facilitator shall observe, evaluate, and consult with the ~~individual/EOR~~ individual or EOR and may include the ~~family/caregiver, and~~ family or caregiver to document the adequacy and appropriateness of consumer-directed services with regard to the individual's current functioning, cognitive status, and medical and social needs. The ~~consumer-directed~~ services facilitator's written summary of the visit shall include at a minimum:

~~(1)~~ (a) Discussion with the waiver individual ~~or family/caregiver/EOR~~, family, caregiver, or EOR, as appropriate, concerning whether the service is adequate to meet the waiver individual's needs;

~~(2)~~ (b) Any suspected abuse, neglect, or exploitation and to whom it was reported;

~~(3)~~ (c) Any special tasks performed by the consumer-directed attendant and the consumer-directed attendant's qualifications to perform these tasks;

~~(4)~~ (d) The individual's ~~or family/caregiver's/EOR's,~~ family's, caregiver's, or EOR's satisfaction with the service;

~~(5)~~ (e) Any hospitalization or change in medical condition, functioning, or cognitive status; ~~and~~

~~(6)~~ (f) The presence or absence of the ~~consumer-directed~~ attendant ~~in the home~~ during the ~~consumer-directed~~ services facilitator's visit and;

(g) The appropriateness of the EOR to fulfill the responsibilities of the role.

(7) The services facilitator shall provide follow-up management training to the individual or EOR, as appropriate, under the following circumstances:

(a) The training shall be requested by the individual or EOR. Training shall not be provided at the request of the services facilitator, family, caregiver, or attendant;

(b) The training shall be limited to the role and responsibilities of the EOR. Training shall not include duties that are to be performed by the attendant;

(c) The training shall be provided in a face-to-face visit; and

(d) The services facilitator shall utilize the management training service to reimburse for tuberculosis screening, cardiopulmonary resuscitation training, and influenza immunization for the attendant at the request of the EOR. Requests for reimbursement shall be limited to the exact cost of the activity. Documentation of the cost and receipt of such activities shall be maintained in the individual's record.

~~5.~~ e. 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.

~~6.~~ f. The ~~consumer-directed~~ services facilitator shall review and verify copies of timesheets ~~during the face-to-face visits~~ work shift entries to ensure that the hours approved in the plan of care are being provided and are not exceeded. If discrepancies are identified, the ~~consumer-directed~~ services facilitator shall discuss these with the individual or EOR to resolve discrepancies and shall notify the fiscal/employer agent. The ~~consumer-directed~~ services facilitator shall also review the individual's plan of care to ensure that the individual's needs are being met. Failure to conduct such reviews and verifications of ~~timesheets~~ work shift entries and maintain the documentation of these reviews shall result in a recovery by DMAS of payments made in accordance with 12VAC30-80-130.

~~7.~~ g. The services facilitator shall maintain records of each individual ~~that he serves~~ served. At a minimum, these records shall contain:

~~a.~~ (1) 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.~~ (2) The personal care 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 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 plan of care is modified, the plan of care shall be reviewed with the individual, the ~~family/caregiver~~ family or caregiver, and EOR, as appropriate;

~~c.~~ (3) The ~~consumer-directed~~ services facilitator's dated notes documenting any contacts with the individual ~~or family/caregiver/EOR~~, family, caregiver, or EOR and visits to the individual (copied or re-dated notes are not acceptable);

~~d.~~ (4) All contacts, including correspondence, made to and from the individual, EOR, ~~family/caregiver,~~ family or caregiver, physicians, DMAS, the designated service authorization contractor, MCO, formal and informal services provider, and all other professionals related to the individual's Medicaid services or medical care;

~~e.~~ (5) All employer management training provided to the individual or EOR to include, for example, (i) ~~the individual's or EOR's~~ receipt of training on ~~their~~ the individual's or EOR's responsibilities for the accuracy of the consumer-directed attendant's ~~timesheets~~ work shift entries and (ii) the availability of the Consumer-Directed ~~Waiver Services~~ Employer of Record Manual available at ~~www.dmas.virginia.gov~~ http://dmas.virginia.gov;

~~f.~~ (6) All documents signed by the individual or EOR, as appropriate, that acknowledge the responsibilities as the employer; and

~~g.~~ (7) The DMAS required forms as specified in the ~~agency's waiver-specific guidance document~~ DMAS Commonwealth Coordinated Care Plus Waiver Manual.

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.

~~8.~~ h. In instances when the individual is consistently unable either to hire or retain the employment of a personal care ~~consumer-directed~~ attendant to provide consumer-directed personal care or respite services such as, for example, a pattern of discrepancies with the ~~consumer-directed~~ attendant's ~~timesheets~~ work shift entries, the ~~consumer-directed~~ services facilitator shall make arrangements, after conferring with DMAS or the managed care organization, to have the needed services transferred to an agency-directed services provider of the individual's choice or discuss with the individual ~~or family/caregiver/EOR, or both~~, family, caregiver, or EOR other service options.

~~9.~~ i. Waiver individual, ~~family/caregiver~~ family or caregiver, and EOR responsibilities.

~~a.~~ (1) The individual shall be authorized for the consumer-directed model of service, and the EOR shall successfully complete EOR management training performed by the ~~consumer-directed~~ services facilitator before the individual or EOR shall be permitted to hire a consumer-directed attendant for Medicaid reimbursement. Any service that may be rendered by a consumer-directed attendant prior to authorization by Medicaid shall not be eligible for reimbursement by Medicaid. Individuals who are eligible for consumer-directed services shall have the capability to hire and train their own consumer-directed attendants and supervise the consumer-directed attendants' performances. In lieu of handling their consumer-directed attendants themselves, individuals may have a ~~family/caregiver~~ family or 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 individual.

~~b.~~ (2) Individuals shall acknowledge that ~~they will not knowingly continue to accept~~ consumer-directed personal care services shall not continue when the service is no longer appropriate or necessary for ~~their~~ the individual's care needs and that the individual shall inform the services facilitator of ~~their~~ a change in care needs. If the consumer-directed model of services continue after services have been terminated by DMAS or the designated service authorization contractor, the individual shall be held liable for the consumer-directed attendant compensation.

~~c.~~ (3) Individuals shall notify the ~~consumer-directed~~ services facilitator of all hospitalizations or admissions, for example, any rehabilitation ~~facility~~ hospital, rehabilitation hospital unit, ~~or~~ nursing facility, specialized care nursing facility, or long-stay hospital as consumer-directed attendant services shall not be reimbursed during such admissions. Failure to do so may result in the individual being held liable for the consumer-directed employee compensation.

~~i.~~ 5. Personal emergency response systems. In addition to meeting the general conditions and requirements for home and community-based waiver services participating providers as specified in 12VAC30-120-930, PERS providers must also meet the following qualifications and requirements:

~~1.~~ a. A PERS provider shall be~~, 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.~~ b. 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.~~ c. 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.~~ d. 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.~~ e. 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.~~ f. 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.~~ g. 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.~~ (1) Delivery date and installation date of the PERS equipment;

~~b.~~ (2) Waiver ~~individual/caregiver~~ individual or caregiver signature verifying receipt of the PERS equipment;

~~c.~~ (3) Verification by a monthly test that the PERS device is operational ~~and the waiver individual is still using it monthly or more frequently as needed~~;

~~d. Waiver individual~~ (4) The waiver individual's contact information, to be updated annually or more frequently as needed, as provided by the individual or the individual's ~~caregiver/EOR~~ caregiver or EOR;

~~e.~~ (5) A case log documenting the waiver individual's utilization of the system, all contacts, and all communications with the individual, ~~caregiver/EOR~~ caregiver or EOR, and responders;

~~f.~~ (6) Documentation that the waiver individual is able to use the PERS equipment through return demonstration; and

~~g.~~ (7) Copies of all equipment checks performed on the PERS unit;

~~8.~~ h. The PERS provider shall have backup monitoring capacity in case the primary system cannot handle incoming emergency signals;

~~9.~~ i. 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.~~ j. 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.~~ (1) A primary receiver and a backup receiver, which shall be independent and interchangeable;

~~b.~~ (2) A backup information retrieval system;

~~c.~~ (3) 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.~~ (4) A backup power supply;

~~e.~~ (5) A separate telephone service;

~~f.~~ (6) A toll-free number to be used by the PERS equipment in order to contact the primary or backup response center; and

~~g.~~ (7) A telephone line monitor, which shall give visual and audible signals when the incoming telephone line is disconnected for more than 10 seconds;

~~11.~~ k. 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.~~ l. 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.~~ m. 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.~~ 6. 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.~~ a. 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~~ service authorization 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~~ speech or 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~~ assessment or 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.~~ b. 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.~~ c. 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.

d. Providers of AT and EM services shall maintain in each individual's record all supporting documentation of the costs and estimates of the service. Should there be a change in the cost of the service, the new cost and estimate documentation shall also be included along with justification of the change in cost.

~~K. Transition coordination. This service shall be provided consistent with 12VAC30-120-2000 and 12VAC30-120-2010.~~

~~L.~~ 7. Transition services. This service shall be provided consistent with ~~12VAC30-120-2000 and 12VAC30-120-2010~~ Part XX (12VAC30-120-2000 et seq.) of 12VAC30-120.

8. Private duty nursing (PDN).

a. This service shall be provided through a home health agency licensed or certified by VDH for Medicaid participation and with which DMAS has a contract for either PDN or congregate PDN or both.

b. The provider shall operate from a business office.

c. The provider shall employ (or subcontract with) and directly supervise an RN or an LPN. The LPN and RN shall be currently licensed to practice in the Commonwealth. Prior to providing PDN services, the RN or LPN shall have either (i) at least six months of related clinical nursing experience or (ii) completed a provider training program related to the care and technology needs of the waiver individual as described in 12VAC30-120-930 J 3. Regardless of whether a nurse has six months of experience or completes a provider training course, the provider agency shall be responsible for assuring all nurses who are assigned to an individual are competent in the care needs of that individual.

d. As part of direct supervision, the RN supervisor shall make, at a minimum, a visit every 30 days to ensure both quality and appropriateness of PDN to assess the individual's and the family's or caregiver's satisfaction with the services being provided, to review the medication and treatments, and to update and verify that the most current physician signed orders are in the home record.

(1) The waiver individual shall be present when the supervisory visits are made;

(2) At least every other visit shall be in the individual's primary residence;

(3) When a delay occurs in the RN supervisor's visits because the individual is unavailable, the reason for the delay shall be documented in the individual's record, and the visit shall occur as soon as the individual is available.

Failure to meet this standard may result in a DMAS recovery of payments made; and

(4) Additional supervisory visits may be required under the following circumstances: (i) at the provider's discretion; (ii) at the request of the individual; (iii) when a change in the individual's condition has occurred; (iv) any time the health, safety, or welfare of the individual could be at risk; and (v) at the request of the DMAS staff.

e. When skilled respite services are routine in nature and offered in conjunction with personal care (PC) services for adults, the RN supervisory visit conducted for personal care may serve as the supervisory visit for respite services. However, the supervisor shall document supervision of skilled respite services separately. For this purpose, the same individual record can be used with a separate section clearly labeled for documentation of skilled respite services.

f. For DMAS-enrolled PDN providers that also provide PC services, the provider shall employ or subcontract with and directly supervise an RN who will provide ongoing supervision of all personal care aides. The supervising RN shall be currently licensed to practice nursing in the Commonwealth and have at least one year of related clinical nursing experience, which may include work in an acute care hospital, long-stay hospital, rehabilitation hospital, nursing facility, or specialized care nursing facility. In addition to meeting the general conditions and requirements for home and community-based waiver services participating providers as specified in 12VAC30-120-930 and this section, the provision of PC services shall also comply with the requirements of 12VAC30-120-930.

g. The following documentation shall be maintained for every individual for whom DMAS-enrolled providers render these services:

(1) Physicians' orders for these services shall be maintained in the individual's record as well as at the individual's primary residence. All recertifications of the POC shall be performed within the last five business days of each current 60-day period. The physician shall sign the recertification before Medicaid reimbursement shall occur;

(2) All assessments, reassessments, and evaluations (including the complete LTSS screening packet or risk evaluations) made during the provision of services, including any required initial assessments by the RN supervisor completed prior to or on the date services are initiated and changes to the supporting documentation by the RN supervisor;

(3) Progress notes reflecting the individual's status and, as appropriate, progress toward the identified goals in the POC (copied or re-dated notes are not acceptable);

(4) All related communication with the individual and the individual's representative, the DMAS designated agent for service authorization, consultants, DMAS, VDSS, formal and informal service providers, all required referrals, as appropriate, to adult protective services or child protective services and all other professionals concerning the individual;

(5) All service authorization decisions rendered by the DMAS staff or the DMAS-designated service authorization contractor;

(6) All POCs completed with the individual, family, or caregiver, as appropriate, and specific to the service being provided and all supporting documentation related to any changes in the POC; and

(7) Notes of any verbal or nonverbal cues, motions, signals, or actions the individual makes to indicate distress or uses to call in case of an emergency. The individual, primary caregiver, or family, as appropriate, shall share this information with the RN or LPN at the onset of services. Documentation of these cues shall be kept in the individual's record and shall be reviewed periodically to ensure the individual is still able to perform these cues.

12VAC30-120-945. Payment for covered services.

A. DMAS shall not reimburse providers, either agency-directed or consumer-directed, for any staff training required by these waiver regulations or any other training that may be required.

B. All services provided in the ~~EDCD~~ CCC Plus Waiver shall be reimbursed at a rate established by DMAS in its agency fee schedule.

1. DMAS or its contractor shall reimburse a per diem fee for ADHC services that shall be considered as payment in full for all services rendered to that waiver individual as part of the individual's approved ADHC plan of care.

2. ~~Agency personal care/respite~~ Personal care (agency-directed and consumer-directed), respite (agency-directed and consumer-directed), and PDN care services shall be reimbursed on an hourly basis consistent with the agency's fee schedule. Effective July 1, 2021, a single consumer-directed attendant who provides personal care or respite services shall be reimbursed at the regular rate for up to 40 hours per week for authorized services rendered and at one and a half times the regular rate for up to 16 hours per week beyond 40 hours. This shall not apply to consumer-directed attendants who are exempt from overtime requirements under 29 USC § 552.102 of the federal Fair Labor Standards Act, 29 USC § 201 et seq.

~~3. Consumer-directed personal care/respite care services shall be reimbursed on an hourly basis consistent with the agency's fee schedule.~~

~~4.~~ 3. Transition services. The total costs of these transition services shall be limited to $5,000 per waiver individual per lifetime and shall be expended within nine months from the start date of authorization. Transition services shall be reimbursed at the actual cost of the item; no mark ups shall be permitted.

~~5.~~ 4. Reimbursement for assistive technology (AT) and environmental modification (EM) services shall be ~~limited to those waiver individuals who are also participating in the MFP demonstration program~~ as follows:

a. All AT services provided in the ~~EDCD~~ CCC Plus Waiver shall be reimbursed as a service limit of one and up to a per member annual maximum of $5,000 per calendar year regardless of waiver. ~~AT services in this waiver shall be reimbursed up to a per individual annual MFP enrollment period not to exceed 12 months.~~ These limits shall apply regardless of whether the waiver individual remains in this waiver or changes to another waiver program. AT services shall be reimbursed in a manner that is reasonable and customary not to exceed the provider's usual and customary charges to the general public. No markups shall be permitted.

b. All EM services provided in the ~~EDCD~~ CCC Plus Waiver shall be reimbursed ~~per individual annual MFP enrollment period not to exceed 12 months~~ as a service limit of one and up to a per member annual maximum of $5,000 per calendar year regardless of waiver. These limits shall apply regardless of whether the individual remains in this waiver or changes to another waiver program. All EM services shall be reimbursed at the actual cost of material and labor and no mark ups shall be permitted.

~~6. DMAS shall reimburse a monthly fee for transition coordination consistent with the agency's fee schedule.~~

~~7.~~ 5. PERS monthly fee payments shall be consistent with the agency's fee schedule.

C. Duplication of services.

1. DMAS shall not duplicate services that are required as a reasonable accommodation as a part of the American with Disabilities Act (42 USC §§ 12131 through 12165), the Rehabilitation Act of 1973 (29 USC § 794), or the Virginians with Disabilities Act (§ 51.5-1 et seq. of the Code of Virginia).

2. Payment for waiver services shall not duplicate payments made to public agencies or private entities under other program authorities for this same purpose. All private insurance benefits for these ~~waiver covered~~ waiver-covered services shall be exhausted before Medicaid reimbursement can occur as Medicaid shall be the payer of last resort.

3. DMAS payments for EM services shall not be duplicative in homes where multiple waiver individuals reside.

Part XVII
Home and Community-Based Services for Technology Assisted Individuals Waiver (Repealed)

12VAC30-120-1700. ~~Definitions.~~ (Repealed.)

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

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

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

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

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

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

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

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

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

~~"Applicant" means an individual (or representative on his behalf) who has applied for or is in the process of applying for~~

and is awaiting a determination of eligibility for admission to the technology assisted waiver.

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

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

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

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

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

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

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

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

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

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

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

"Congregate private duty respite" means skilled respite care provided to three or fewer waiver individuals. This service shall be limited to 360 hours per calendar year per household.

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

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

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

"DMAS" means the Department of Medical Assistance Services.

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

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

"Direct supervision" means that the supervising registered nurse (RN) is immediately accessible by phone to the RN,

licensed practical nurse or personal care aide who is delivering waiver covered services to individuals.

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

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

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

"Enrollment" means the process where an individual has been determined to meet the eligibility requirements for a Medicaid program or service and the approving entity has verified the availability of services for the individual requesting waiver enrollment and services.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

"Monitoring" means the ongoing oversight of the provision of waiver and other services to determine that they are furnished according to the waiver individual's plan of care and effectively meet his needs, thereby assuring his health, safety, and welfare. Monitoring activities may include, but shall not be limited to, telephone contact; observation; interviewing the individual or the trained individual representative, as appropriate, in person or by telephone; or interviewing service providers.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

"VDH" or "Department of Health" means the Virginia Department of Health.

"VDSS" means the Virginia Department of Social Services.

"Ventilator dependence" means that the waiver individual is dependent on such machines in order to sustain life or compensate for the loss of body function.

"Virginia Uniform Assessment Instrument" or "UAI" means the standardized multidimensional questionnaire that assesses an individual's physical health, mental health, psychosocial, and functional abilities to determine if the individual meets the nursing facility LOC.

12VAC30-120-1705. ~~Waiver description and legal authority.~~ (Repealed.)

A. Home and community-based waiver services shall be available through a § 1915(c) waiver of the Social Security Act. Under this waiver, DMAS has waived § 1902(a)(10)(B) and (C) of the Social Security Act related to comparability of services.

B. Technology-assisted waiver services shall be covered only for Medicaid-eligible individuals who have been determined eligible for waiver services and who also require the level of care provided in either long-stay hospitals or specialized care nursing facilities as long as age-appropriate criteria are met. These services shall be the critical service necessary to delay or avoid the individual's placement in an appropriate facility. These waiver services shall not be covered for Medicaid-eligible individuals who reside in, but not necessarily limited to, the following types of facilities: assisted living facilities, nursing facilities, rehabilitation hospitals, long-stay hospitals, skilled or intermediate care nursing facilities, Intermediate Care Facilities for the Intellectually Disabled, group homes licensed by DBHDS, general acute care hospitals, or adult foster care homes.

C. An individual shall demonstrate the medical necessity for skilled private duty nursing services in order to be approved for this waiver.

D. The cost-effectiveness standard that shall be applied for individuals in this waiver shall be in the aggregate.

E. Payments for tech waiver services shall not be provided to any financial institution or entity located outside of the United States pursuant to the Social Security Act § 1902(a)(80). Payments for tech waiver services furnished in another state shall (i) be provided for an individual who meets the requirements of 42 CFR § 431.52 and (ii) be limited to the same number of skilled PDN hours approved for the individual's home-based skilled PDN.

F. An individual shall not simultaneously be in a managed care program and enrolled in this waiver. An individual shall not be simultaneously enrolled in more than one waiver program.

G. For individuals admitted to this waiver, when their waiver services must be interrupted due to their primary caregiver's emergency unavailability, then hospitalization or placement in a specialized nursing facility, should a specialized care nursing facility bed be available, shall occur.

H. DMAS shall be responsible for assuring appropriate placement of the individual in home and community based waiver services and shall have the authority to terminate such services.

I. No waiver services shall be reimbursed until after both the provider enrollment process and individual eligibility process have been completed.

12VAC30-120-1710. ~~Individual eligibility requirements; preadmission screening.~~ (Repealed.)

~~A. Individual eligibility requirements.~~

~~1. The Commonwealth covers these optional categorically needy groups: ADC and AFDC-related individuals; SSI and SSA-related individuals; aged, blind, or disabled Medicaid-eligible individuals under 42 CFR 435.121; and the home and community-based waiver group at 42 CFR 435.217 that includes individuals who are eligible under the State Plan if they were institutionalized.~~

~~a. The income level used for the home and community-based waiver group at 42 CFR 435.217 shall be 300% of the current Supplemental Security Income payment standard for one person.~~

~~b. Medically needy Medicaid-eligible individuals shall be eligible if they meet the medically needy financial requirements for income and resources.~~

~~2. Under this waiver, the coverage groups authorized under § 1902(a)(10)(A)(ii)(VI) of the Social Security Act shall be considered as if they were institutionalized for the purpose of applying institutional deeming rules. All individuals in the waiver must meet the financial and non-financial Medicaid eligibility criteria and meet the institutional LOC criteria. The deeming rules shall be applied to waiver eligible individuals as if they were residing in an institution or would require that level of care.~~

~~3. An applicant for technology assisted waiver shall meet specialized care nursing facility criteria, including both medical and functional needs, and also be dependent on waiver services to avoid or delay facility placement and meet all criteria for the age appropriate assessments in order to be eligible for the tech waiver. Applicants shall not be enrolled in the tech waiver unless skilled private duty nursing (PDN) hours are ordered by the physician. The number of skilled PDN hours shall be based on the total technology and nursing score on the Technology Assisted Waiver Pediatric Referral form, DMAS-109 (when individuals are younger than 21 years of age). The number of skilled PDN hours for adults shall be based on the Technology Assisted Waiver Adult Referral form (DMAS-108).~~

~~4. Applicants who are eligible for third party payment for skilled private duty nursing services shall not be eligible for these waiver services. If an individual or an individual's legally responsible party voluntarily drops any insurance plan that would have provided coverage of skilled private duty nursing services in order to become eligible for these waiver services within one year prior to the date waiver services are requested, eligibility for the waiver shall be denied. From the date that such insurance plan is discontinued, such applicants shall be barred for one year from reapplying for waiver services. After the passage of the one year time period, the applicant may reapply to DMAS for admission to the tech waiver.~~

~~5. In addition to the medical needs identified in this section, the Medicaid-eligible individual shall be determined to need substantial and ongoing skilled nursing care. The Medicaid-eligible individual shall be required to meet a minimum standard on the age appropriate referral forms to be eligible for enrollment in the tech waiver.~~

~~6. Medicaid eligible individuals who entered the waiver prior to their 21st birthday shall, on the date of their 21st birthday, conform to the adult medical criteria and cost-effectiveness standards.~~

~~7. Every individual who applies for Medicaid funded waiver services must have his Medicaid eligibility evaluated or re-evaluated, if already Medicaid eligible, by the local DSS in the city or county in which he resides. This determination shall be completed at the same time the preadmission screening (PAS) team completes its evaluation (via the use of the Uniform Assessment Instrument (UAI)) of whether the applicant meets waiver criteria. DMAS payment of waiver services shall be contingent upon the DSS determination that the individual is eligible for Medicaid services for the dates that waiver services are to be provided and that DMAS or the designated service authorization contractor has authorized waiver enrollment and has prior authorized the services that will be required by the individual.~~

~~8. In order for an enrolled waiver individual to retain his enrolled status, tech waiver services must be used by the individual at least once every 30 days. Individuals who do not utilize tech waiver services at least once every 30 days shall be terminated from the waiver.~~

~~9. The waiver individual shall have a trained primary caregiver, as defined in 12VAC30-120-1700, who accepts responsibility for the individual's health, safety, and welfare. This primary caregiver shall be responsible for all hours not provided by the provider agency's RN or LPN. The name of the trained primary caregiver shall be documented in the provider agency records. This trained primary caregiver~~

shall also have a back up system available in emergency situations.

B. Screening and community referral for authorization for tech waiver. Tech waiver services shall be considered only for individuals who are eligible for Medicaid and for admission to a specialized care nursing facility, ICF/ID, long stay hospital, or acute care hospital when those individuals meet all the criteria for tech waiver admission. Such individuals, with the exception of those who are transferring into this tech waiver from a long stay hospital, shall have been screened using the Uniform Assessment Instrument (UAI).

1. The screening team shall provide the individual and family or caregiver with the choice of tech waiver services or specialized care nursing facility or long stay hospital placement, as appropriate, as well as the provider of those services from the time an individual seeks waiver information or application and referral. Such provision of choice includes the right to appeal pursuant to 12VAC30-110 when applicable.

2. The screening team shall explore alternative care settings and services to provide the care needed by the applicant being screened when Medicaid funded home and community based care services are determined to be the critical service necessary to delay or avoid facility placement.

3. Individuals must be screened to determine necessity for nursing facility placement if the individual is currently financially Medicaid eligible or anticipates that he will be financially eligible within 180 days of the receipt of nursing facility care or if the individual is at risk of nursing facility placement.

a. Such covered waiver services shall be critical, as certified by the participant's physician at the time of assessment, to enable the individual to remain at home and in the community rather than being placed in an institution. In order to meet criteria for tech waiver enrollment, the applicant requesting consideration for waiver enrollment must meet the level of care criteria.

b. Individuals who are younger than 21 years of age shall have the Technology Assisted Waiver Pediatric Referral form (DMAS-109) completed and must require substantial and ongoing nursing care as indicated by a minimum score of at least 50 points to qualify for waiver enrollment. This individual shall require a medical device and ongoing skilled PDN care by meeting the categories described in subdivision (1), (2), or (3) below:

(1) Applicants depending on mechanical ventilators;

(2) Applicants requiring prolonged intravenous administration of nutritional substances or drugs or requiring ongoing peritoneal dialysis; or

(3) Applicants having daily dependence on other device-based respiratory or nutritional support, including tracheostomy tube care, oxygen support, or tube feeding.

c. Individuals who are 21 years of age or older shall have the Technology Assisted Waiver Adult Referral form (DMAS-108) completed and must be determined to be dependent on a ventilator or must meet all eight specialized care criteria (12VAC30-60-320) for complex tracheostomy care in order to qualify for waiver enrollment.

4. When an applicant has been determined to meet the financial and waiver eligibility requirements and DMAS has verified the availability of the services for that individual and that the individual has no other payment sources for skilled PDN, tech waiver enrollment and entry into home and community based care may occur.

5. A PAS is considered valid for the following timeframes. The validity of a PAS applies to individuals who are screened, meet the criteria for long term care services, but have not yet begun receiving services during the periods outlined in subdivisions 5 a through 5 f of this subsection.

a. Zero to 180 days. Screenings are valid and do not require revisions or a new screening.

b. 181 days to 12 months. Screening revisions are required; revisions may also be done if there is a significant change in an individual's medical or physical condition. Revisions should be entered into the ePAS system, per the Medicaid web portal instructions, resulting in a claim being generated for the screening revision. For the purposes of this subdivision, "Electronic preadmission screening" or "ePAS" means the automated system for use by all entities contracted by DMAS to perform preadmission screenings pursuant to § 32.1-330 of the Code of Virginia. DMAS will cover the cost of the PAS.

c. Over 12 months. A new screening is required and reimbursement is made by DMAS. New screenings must be entered into ePAS according to the Medicaid web portal instructions.

d. Break in services. When an individual starts and then stops services for a period of time exceeding 30 consecutive calendar days, the PAS team will need to complete a revised screening prior to service resumption if the individual has not received any Medicaid funded long-term care services during the break in service delivery. DMAS will cover the cost of the PAS.

e. In any other circumstances, including hospitalization, that cause services to cease or to be interrupted for more than 30 consecutive calendar days, the individuals shall be referred back to the local department of social services for redetermination of his Medicaid eligibility. The provider shall be responsible for notifying the local department of social services via the DMAS-225 form when there is an

interruption of services for 30 consecutive calendar days or upon discharge from the provider's services.

f. If the individual has been receiving ongoing services either through a nursing facility or a home and community based service program, the screening timeframes do not apply.

6. When an individual was not screened prior to admission to a specialized care nursing facility, or the individual resides in the community at the time of referral initiation to DMAS, the locality in which the individual resides at the time of discharge shall complete the preadmission screening prior to enrollment into the tech waiver.

7. DMAS shall be the final determining body for enrollment in the tech waiver and the determination of the number of approved skilled PDN hours for which DMAS will pay. DMAS has the ultimate responsibility for authorization of waiver enrollment and Medicaid skilled PDN reimbursement for tech waiver services.

C. Waiver individuals' rights and responsibilities. DMAS shall ensure that:

1. Each waiver individual shall receive, and the provider and provider staff shall provide, the necessary care and services, to the extent of provider availability, to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the individual's comprehensive assessment and POC.

2. Waiver individuals shall have the right to receive services from the provider with reasonable accommodation of the individuals' needs and preferences except when DMAS makes a determination that the health, safety, or welfare of the individuals or other waiver individuals would be endangered.

3. Waiver individuals formulate their own advance directives based on information that providers must give to adult waiver individuals at the time of their admissions to services.

4. All waiver individuals shall have the right to:

a. Voice grievances to the provider or provider staff without discrimination or reprisal. Such grievances include those with respect to treatment that has been furnished or has not been furnished;

b. Prompt efforts by the provider or staff, as appropriate, to resolve any grievances the waiver individual may have;

c. Be free from verbal, sexual, physical, and mental abuse, neglect, exploitation, and misappropriation of property;

d. Be free from any physical or chemical restraints of any form that may be used as a means of coercion, discipline, convenience, or retaliation and that are not required to treat the individual's medical symptoms; and

e. Their personal privacy and confidentiality of their personal and clinical records.

5. Waiver individuals shall be provided by their health care providers, at the time of their admission to this waiver, with written information regarding their rights to participate in medical care decisions, including the right to accept or refuse medical treatment and the right to formulate advance directives.

6. The legally competent waiver individual, the waiver individual's legal guardian, or the parent (natural, adoptive or foster) of the minor child shall have the right to:

a. Choose whether the individual wishes to receive home and community based care waiver services instead of institutionalization in accordance with the assessed needs of the individual. The PAS team shall inform the individual of all available waiver service providers in the community in which the waiver individual resides. The tech waiver individual shall have the option of selecting the provider and services of his choice. This choice must be documented in the individual's medical record;

b. Choose his own primary care physician in the community in which he lives;

c. Be fully informed in advance about the waiver POC and treatment needs as well as any changes in that care or treatment that may affect the individual's well-being; and

d. Participate in the care planning process, choice, and scheduling of providers and services.

12VAC30-120-1720. ~~Covered services; limits; changes to or termination of services.~~ (Repealed.)

A. Coverage statement.

1. These waiver services shall be medically necessary, cost-effective as compared to the costs of institutionalization, and necessary to maintain the individual safely in the community and prevent institutionalization.

2. Services shall be provided only to those individuals whose service needs are consistent with the service description and for which providers are available who have adequate and appropriate staffing to meet the needs of the individuals to be served.

3. All services covered through this waiver shall be rendered according to the individuals' POCs that have been certified by physicians as medically necessary and also reviewed by DMAS to enable the waiver enrolled individuals to remain at home or in the community.

4. Providers shall be required to refund payments received to DMAS if they (i) are found during any review to have billed Medicaid contrary to policy, (ii) have failed to maintain records to support their claims for services, or (iii) have billed for medically unnecessary services.

5. DMAS shall perform service authorization for skilled PDN services, PC for adults, and transition services. DMAS or the service authorization contractor shall perform service authorization for skilled private duty respite services, AT services and EM services.

6. When a particular service requires service authorization, reimbursement shall not be made until the service authorization is secured from either DMAS or the DMAS-designated service authorization contractor.

B. Covered services. Covered services shall include: skilled PDN; skilled private duty respite care; personal care only for adults, assistive technology; environmental modifications; and transition services only for individuals needing to move from a designated institution into the community or for waiver individuals who have already moved from an institution within 30 days of their transition. Coverage shall not be provided for these services for individuals who reside in any facilities enumerated in 12VAC30-120-1705. Skilled PDN shall be a required service. If an individual has no medical necessity for skilled PDN, he shall not be admitted to this waiver. All other services provided in this waiver shall be provided in conjunction with the provision of skilled PDN.

1. Skilled PDN, for a single individual and congregate group settings, as defined in 12VAC30-120-1700, shall be provided for waiver enrolled individuals who have serious medical conditions or complex health care needs. To receive this service, the individuals must require specific skilled and continuous nursing care on a regularly scheduled or intermittent basis performed by an RN or an LPN. Upon completion of the required screening and required assessments and a determination that the individual requires substantial and ongoing skilled nursing care and waiver enrollment then the PDN hours shall be authorized by the DMAS staff.

a. PDN services shall be rendered according to a POC authorized by DMAS and shall have been certified by a physician as medically necessary to enable the individual to remain at home.

b. No reimbursement shall be provided by DMAS for either RN or LPN services without signed physician orders that specifically identify skilled nursing tasks to be performed for the individual.

c. Limits placed on the amount of PDN that will be approved for reimbursement shall be consistent with the individual's age-appropriate technology assisted waiver referral form (DMAS-108 or DMAS-109) and medical necessity. Except for a minor individual's care during his first 15 days following initial enrollment into this waiver, in no instances shall the individual's POC or ongoing multiple POCs result in coverage of more than 112 hours of skilled PDN per week (Sunday through Saturday). The maximum number of approved hours authorized per week for minor children shall be based on their total approved points documented on the Technology Assisted Waiver Pediatric Referral form (DMAS-109). The maximum skilled PDN hours authorized per week for adult individuals shall be based on their technology and medical necessity justification documented on the Technology Assisted Waiver Adult Referral form (DMAS-108).

(1) The number of skilled PDN hours for minor individuals shall be based on the total technology and nursing score on the Technology Assisted Waiver Pediatric Referral form (DMAS-109) and updated by the DMAS staff when changes occur and with annual waiver eligibility redetermination by DMAS.

(2) Once the minor individual's composite score (total score) is derived, a LOC is designated for the individual as a Level A, B, or C. This LOC designation determines the maximum number of hours per week of skilled PDN that DMAS may allocate for a pediatric individual. Any hours beyond the approved maximum for such individual's LOC shall be medically necessary and service authorized by DMAS. Any POC submitted without approval for hours beyond the approved maximum for any particular LOC will only be entered for the approved maximum for that LOC.

(3) The results of the scoring assessment determine the maximum amount of hours available and authorization shall occur as follows:

(a) 50 – 56 points = 70 hours per week.

(b) 57 – 79 points = 84 hours per week.

(c) 80 points or greater = 112 hours per week.

(4) For minor individuals, whether living separately or in a congregate setting, during the first 15 calendar days after such individuals' initial admission to the waiver, skilled PDN may be covered for up to 24 hours per day, if required and appropriate to assist the family in adjustment to the care associated with technology assistance. After these first 15 calendar days, skilled PDN shall be reimbursed up to the maximum allowable hours per week based on the individual's total technology and nursing scores and provided that the aggregate cost-effectiveness standard is not exceeded for the individual's care.

(5) When reimbursement is to be made for skilled PDN services to be provided in schools, the nurse shall be in the same room as the waiver individual for the hours of skilled PDN care billed. When an individual receives skilled PDN while attending school, the total skilled PDN hours shall not exceed the authorized number of hours under his nursing score category on the Technology Assisted Waiver Pediatric Referral form (DMAS-109).

(6) For adult individuals, whether living separately or in a congregate setting, skilled PDN shall be reimbursed up to a maximum of 112 hours per week (Sunday through Saturday) per tech waiver individual living in the household based on the individual's technology and

medical justification and provided that the aggregate cost-effectiveness standard is not exceeded for the individual's care.

(7) The adult individual shall be determined to need a medical device and ongoing skilled nursing care when such individual meets Category A or all eight criteria in Category B:

(a) Category A. Individuals who depend on mechanical ventilators; or

(b) Category B. Individuals who have a complex tracheostomy as defined by:

(i) Tracheostomy with the potential for weaning off of it, or documentation of attempts to wean, with subsequent inability to wean;

(ii) Nebulizer treatments ordered at least four times a day or nebulizer treatments followed by chest physiotherapy provided by a nurse or respiratory therapist at least four times a day;

(iii) Pulse oximetry monitoring at least every shift due to unstable oxygen saturation levels;

(iv) Respiratory assessment and documentation every shift by a licensed respiratory therapist or nurse;

(v) Have a physician's order for oxygen therapy with documented usage;

(vi) Receives tracheostomy care at least daily;

(vii) Has a physician's order for tracheostomy suctioning; and

(viii) Deemed at risk to require subsequent mechanical ventilation.

(8) Skilled PDN services shall be available to individuals in their primary residence with some community integration (e.g., medical appointments and school) permitted.

(9) Skilled PDN services may include consultation and training for the primary caregiver.

d. The provider shall be responsible for notifying DMAS should the primary residence of the individual be changed, should the individual be hospitalized, should the individual die, or should the individual be out of the Commonwealth for 48 hours or more.

e. Exclusions from DMAS' coverage of skilled PDN:

(1) This service shall not be authorized when intermittent skilled nursing visits could be satisfactorily utilized while protecting the health, safety, and welfare of the individual.

(2) Skilled PDN hours shall not be reimbursed while the individual is receiving emergency care or during emergency transport of the individual to such facilities. The RN or LPN shall not transport the waiver individual to such facilities.

(3) Skilled PDN services may be ordered but shall not be provided simultaneously with PDN respite care or personal care services as described in this section.

(4) Parents (natural, adoptive, legal guardians), spouses, siblings, grandparents, grandchildren, adult children, other legal guardians, or any person living under the same roof with the individual shall not provide skilled PDN services for the purpose of Medicaid reimbursement for the waiver individual.

(5) Providers shall not bill prior to receiving the physician's dated signature on the individual's POC for services provided and the DMAS staff's authorization/determination of skilled PDN hours.

(6) Time spent driving the waiver individual shall not be reimbursed by DMAS.

f. Congregate skilled PDN.

(1) If more than one waiver individual will reside in the home, the same waiver provider or providers shall be chosen to provide all skilled PDN services for all waiver individuals in the home.

(2) Only one nurse shall be authorized to care for no more than two waiver individuals in such arrangements. In instances when three waiver individuals share a home, nursing ratios shall be determined by DMAS or its designated agent based on the needs of all the individuals who are living together. These congregate skilled PDN hours shall be at the same scheduled shifts.

(3) The primary caregiver shall be shared and shall be responsible for providing all care needs when a private duty nurse is not available.

(4) DMAS shall not reimburse for skilled PDN services through the tech waiver and skilled PDN services through the EPSDT benefit for the same individual at the same time.

2. Skilled private duty respite care services. Skilled private duty respite care services may be covered for a maximum of 360 hours per calendar year for individuals who are qualified for tech waiver services and regardless of whether the waiver individual changes waivers and whose primary caregiver requires temporary or intermittent relief from the burden of caregiving.

a. This service shall be provided by skilled nursing staff licensed to practice in the Commonwealth under the direct supervision of a licensed, certified, or accredited home health agency and with which DMAS has a provider agreement to provide skilled PDN.

b. Skilled private duty respite care services shall be comprised of both skilled and hands-on care of either a supportive or health related nature and includes (i) all skilled nursing care as ordered on the physician-certified POC, (ii) assistance with ADLs and IADLs, (iii) administration of medications or other medical needs, and

(iv) monitoring of the health status and physical condition of the individual or individuals.

c. When skilled private duty respite services are offered in conjunction with skilled PDN, the same individual record may be used with a separate section for skilled private duty respite services documentation.

d. Individuals who are living in congregate arrangements shall be permitted to share skilled private duty respite care service providers. The same limits on this service in the congregate setting (360 hours per calendar year per household) shall apply.

e. Skilled private duty respite care services shall be provided in the individual's primary residence as is designated upon admission to the waiver.

3. Assistive technology (AT) services. Assistive technology, as defined in 12VAC30-120-1700, devices shall be portable and shall be authorized per calendar year.

a. AT services shall be available for enrolled waiver individuals who are receiving skilled PDN. AT services are the specialized medical equipment and supplies, including those devices, controls, or appliances, specified in the individual's plan of care, but that are not available under the State Plan for Medical Assistance, that enable waiver individuals to increase their abilities to perform ADLs/IADLs, or to perceive, control, or communicate with the environment in which they live. This service includes ancillary supplies and equipment necessary to the proper functioning of such items.

b. An independent, professional consultation shall be obtained from qualified professionals who are knowledgeable of that item for each AT request prior to approval by DMAS or the designated service authorization contractor. Individual professional consultants include speech/language therapists, physical therapists, occupational therapists, physicians, certified rehabilitation engineers or rehabilitation specialists. A prescription shall not meet the standard of an assessment.

c. In order to qualify for these services, the individual must have a demonstrated need for equipment for remedial or direct medical benefit primarily in the individual's primary residence or primary vehicle to specifically serve to improve the individual's personal functioning.

d. AT shall be covered in the least expensive, most cost-effective manner. The cost of AT services shall be included in the total cost of waiver services.

e. Service units and service limitations. AT equipment and supplies shall not be rented but shall be purchased through a Medicaid enrolled durable medical equipment provider.

(1) The service unit is always one, for the total cost of all AT being requested for a specific timeframe. The maximum Medicaid funded expenditure per individual for all AT covered procedure codes combined shall be $5,000 per individual per calendar year.

(2) The cost for AT shall not be carried over from one calendar year to the next. Each item must be service authorized by either DMAS or the DMAS designated contractor for each calendar year.

(3) Unexpended portions of the maximum amount shall not be accumulated across one or more calendar years to be expended in a later year.

(4) Shipping/freight/delivery charges are not billable to DMAS or the waiver individual, as such charges are considered noncovered items.

(5) All products must be delivered, demonstrated, installed and in working order prior to submitting any claim for them to Medicaid.

(6) The date of service on the claim shall be within the service authorization approval dates, which may be prior to the delivery date as long as the initiation of services commenced during the approved dates.

(7) The service authorization shall not be modified to accommodate delays in product deliveries. In such situations, new service authorizations must be sought by the provider.

(8) When two or more waiver individuals live in the same home or congregate living arrangement, the AT shall be shared to the extent practicable consistent with the type of AT.

f. AT exclusions.

(1) Medicaid shall not reimburse for any AT devices or services that may have been rendered prior to authorization from DMAS or the designated service authorization contractor.

(2) Providers of AT shall not be spouses, parents (natural, adoptive, or foster), or stepparents of the individual who is receiving waiver services. Providers that supply AT for the waiver individual may not perform assessments/consultation or write specifications for that individual. Any request for a change in cost (either an increase or a decrease) requires justification and supporting documentation of medical need and service authorization by DMAS or the designated service authorization contractor. The vendor shall receive a copy of the professional evaluation in order to purchase the items recommended by the professional. If a change is necessary then the vendor shall notify the assessor to ensure the changed items meet the individual's needs.

(3) All equipment or supplies already covered by the State Plan shall not be purchased under the waiver as AT. Such examples include:

(a) Specialized medical equipment, durable or nondurable medical equipment (DME), ancillary equipment, and supplies necessary for life support;

(b) Adaptive devices, appliances, and controls that enable an individual to be more independent in areas of personal care and ADLs/IADLs; and

(c) Equipment and devices that enable an individual to communicate more effectively.

(4) AT services shall not be approved for purposes of the convenience of the caregiver, restraint of the individual, recreation or leisure, educational purposes, or diversion activities. Examples of these types of items shall be listed in DMAS guidance documents.

4. Environmental modifications services shall be covered as defined in 12VAC30-120-1700. Medicaid reimbursement shall not occur before service authorization of EM services is completed by DMAS or the DMAS designated service authorization contractor. EM services shall entail limited physical adaptations to preexisting structures and shall not include new additions to an existing structure that simply increase the structure's square footage.

a. In order to qualify for EM services, the individual shall have a demonstrated need for modifications of a remedial nature or medical benefit to the primary residence to specifically improve the individual's personal functioning. Such modifications may include, but shall not necessarily be limited to, the installation of ramps and grab bars, widening of doorways and other adaptations to accommodate wheelchairs, modification of bathroom facilities to accommodate wheelchairs (but not strictly for cosmetic purposes), or installation of specialized electrical and plumbing systems required to accommodate the medical equipment and supplies that are necessary for the individual's welfare. Modifications may include a generator for waiver individuals who are dependent on mechanical ventilation for 24 hours a day and when the generator is used to support the medical equipment and supplies necessary for the individual's welfare.

b. EM shall be available costing up to a maximum amount of $5,000 per calendar year regardless of waiver for individuals who are receiving skilled PDN services.

c. Costs for EM shall not be carried over from one calendar year to the next year. Each item shall be service authorized by DMAS or the DMAS designated agent for each calendar year. Unexpended portions of this maximum amount shall not be accumulated across one or more years to be expended in a later year.

d. When two or more waiver individuals live in the same home or congregate living arrangement, the EM shall be shared to the extent practicable consistent with the type of requested modification.

e. Only the actual cost of material and labor is reimbursed. There shall be no additional markup.

f. EM shall be carried out in the most cost-effective manner possible to achieve the goal required for the individual's health, safety, and welfare. The cost of EM waiver services shall be included in the individual's costs of all other waiver services, which shall not exceed the total annual cost for placement in an institution.

g. All services shall be provided in the individual's primary residence in accordance with applicable state or local building codes and appropriate permits or building inspections, which shall be provided to DMAS or the DMAS contractor.

h. Proposed modifications that are to be made to rental properties must have prior written approval of the property's owner. Modifications to rental properties shall only be valid if it is an independently operated rental facility with no direct or indirect ties to any other Medicaid service provider.

i. Modifications may be made to a vehicle if it is the primary vehicle used by the individual. This service shall not include the purchase of or the general repair of vehicles. Repairs of modifications that have been reimbursed by DMAS shall be covered.

j. The EM provider shall ensure that all work and products are delivered, installed, and in good working order prior to seeking reimbursement from DMAS. The date of service on this provider's claim shall be within the service authorization approval dates, which may be prior to the completion date as long as the work commenced during the approval dates. The service authorization shall not be modified to accommodate installation delays. All requests for cost changes (either increases or decreases) shall be submitted to DMAS or the DMAS designated service authorization contractor for revision to the previously issued service authorization and shall include justification and supporting documentation of medical needs.

k. EM exclusions.

(1) There shall be no duplication of previous EM services within the same residence such as (i) multiple wheelchair ramps or (ii) previous modifications to the same room. There shall be no duplication of EM within the same plan year.

(2) Adaptations or improvements to the primary home that shall be excluded are of general utility and are not of direct medical or remedial benefit to the waiver individual, such as, but not necessarily limited to, carpeting, flooring, roof repairs, central air conditioning or heating, general maintenance and repairs to a home, additions or maintenance of decks, maintenance/replacement or addition of sidewalks, driveways, carports, or adaptations that only increase the total square footage of the home.

(3) EM shall not be covered by Medicaid for general leisure or diversion items or those items that are recreational in nature or those items that may be used as an outlet for adaptive/maladaptive behavioral issues. Such noncovered items may include, but shall not necessarily be limited to, swing sets, playhouses, climbing walls,

trampolines, protective matting or ground cover, sporting equipment or exercise equipment, such as special bicycles or tricycles.

(4) EM shall not be approved for Medicaid coverage when the waiver individual resides in a residential provider's facility program, such as sponsored homes and congregate residential and supported living settings. EM shall not be covered by Medicaid if, for example, the Fair Housing Act (42 USC § 3601 et seq.), the Virginia Fair Housing Law (§ 36-96.1 et seq. of the Code of Virginia) or the Americans with Disabilities Act (42 USC § 12101 et seq.) requires the modification and the payment for such modifications are to be made by a third party.

(5) EM shall not include the costs of removal or disposal, or any other costs, of previously installed modifications, whether paid for by DMAS or any other source.

(6) Providers of EM shall not be the waiver individual's spouse, parent (natural, adoptive, legal guardians), other legal guardians, or conservator. Providers who supply EM to waiver individuals shall not perform assessments/consultations or write EM specifications for such individuals.

5. Personal care (PC) services as defined in 12VAC30-120-1700, shall be covered for individuals older than 21 years of age who have a demonstrated need for assistance with ADLs and IADLs and who have a trained primary caregiver for skilled PDN interventions during portions of their day. PC services shall be rendered by a provider who has a DMAS provider agreement to provide PC, home health care, or skilled PDN. Due to the complex medical needs of this waiver population and the need for 24-hour supervision, the trained primary caregiver shall be present in the home and rendering the required skilled services during the entire time that the PCA is providing nonskilled care.

a. PC services are either of a supportive or health-related nature and include assistance with ADLs/IADLs, community access (such as, but not necessarily limited to, going to medical appointments), monitoring of self-administration of medication or other medical needs, and monitoring of health status and physical condition. In order to receive PC, the individual must require assistance with ADLs/IADLs. When specified in the POC, PC services may also include assistance with IADLs to include making or changing beds, and cleaning areas used by the individual. Assistance with IADLs must be essential to the health and welfare of the individual, rather than the individual's representative, as applicable.

(1) The unit of service for PC services shall be one hour. The hours that may be authorized by DMAS or the designated service authorization contractor shall be based on the individual's need as documented in the individual's POC and assessed on the Technology Assisted Waiver Adult Aide Plan of Care (DMAS-97-T).

(2) Supervision of the waiver individual shall not be covered as part of the tech waiver personal care service.

(3) Individuals may have skilled PDN, PC, and skilled private duty nursing respite care in their plans of care but shall not be authorized to receive these services simultaneously.

b. PC services shall not include either practical or professional nursing services or those practices regulated in Chapters 30 (§ 54.1-3000 et seq.) and 34 (§ 54.1-3400 et seq.) of Title 54.1 of the Code of Virginia, as appropriate, with the exception of skilled nursing tasks that may be delegated in accordance with Part VIII (18VAC90-20-420 et seq.). The PCA may perform ADL functions such as assistance to the primary caregiver but shall not perform any nursing duties or roles except as permitted by Part VIII (18VAC90-20-420 et seq.). At a minimum, the staff providing PC must have been certified through coursework as either PCAs or home health aides.

c. DMAS will pay for any PC services that the PCA gives to individuals to assist them in preparing for school or when they return home. DMAS shall not pay for the PCA to assist the individual with any functions related to the individual completing post-secondary school functions or for supervision time during school.

d. PC exclusions.

(1) Time spent driving the waiver individual shall not be reimbursed.

(2) Regardless of the combination of skilled PDN and PC hours, the total combined number of hours that shall be reimbursed by DMAS in a week shall not exceed 112 hours.

(3) The consumer-directed services model shall not be covered for any services provided in the tech waiver.

(4) Spouses, parents (natural, adoptive, legal guardians), siblings, grandparents, grandchildren, adult children, other legal guardians, or any person living under the same roof with the individual shall not provide PC services for the purpose of Medicaid reimbursement for the waiver individual.

6. Transition services shall be covered two ways: (i) as defined at 12VAC30-120-1700 to provide for applicants to move from institutional placements to community private homes and shall be service authorized by DMAS or the designated service authorization contractor in order for reimbursement to occur, and (ii) for applicants who have already moved from an institution to the community within 30 days of their transition. The applicant's transition from an institution to the community shall be coordinated by the facility's discharge planning team. The discharge planner shall coordinate with the DMAS staff to ensure that technology assisted waiver eligibility criteria shall be met.

a. Transition services shall be service authorized by DMAS or its designated service authorization contractor in order for reimbursement to occur.

b. For the purposes of transition funding for the technology assisted waiver, an institution means an ICF/ID, a specialized care nursing facility or a long stay hospital as defined at 42 CFR 435.1009. Transition funding shall not be available for individuals who have been admitted to an acute care hospital.

C. Changes to services or termination of services.

1. DMAS or its designated agent shall have the final authority to approve or deny a requested change to an individual's skilled PDN and PC hours. Any request for an increase to an individual's skilled PDN or PC hours that exceeds the number of hours allowed for that individual's LOC shall be service authorized by DMAS staff and accompanied by adequate documentation justifying the increase.

a. The provider may decrease the amount of authorized care if the revised skilled PDN hours are appropriate and based on the needs of the individual. The provider agency shall work with the DMAS staff for coordination and final approval of any decrease in service delivery. A revised tech waiver skilled PDN authorization shall be completed by DMAS for final authorization and forwarded to the provider agency.

b. The provider shall be responsible for documenting in writing the physician's verbal orders and for inclusion of the changes on the recertification POC in accordance with the DMAS skilled private duty nursing authorization. The provider agency's RN supervisor, who is responsible for supervising the individual's care, shall use a person-centered approach in discussing the change in care with the individual and the individual's representative to include documentation in the individual's record. The DMAS staff or the DMAS designated service authorization contractor shall notify in writing the individual or the individual's representative of the change.

c. The provider shall be responsible for submitting the DMAS-225 form to the local department of social services when the following situations occur: (i) when Medicaid eligibility status changes; (ii) when the individual's level of care changes; (iii) when the individual is admitted to or discharged from an institution, a home and community-based waiver, or a provider agency's care; (iv) the individual dies; or (v) any other information that causes a change in the individual's eligibility status or patient pay amounts.

2. At any time the individual no longer meets LOC criteria for the waiver, termination of waiver enrollment shall be initiated by DMAS staff who is assigned to the individual. In such instances, DMAS shall forward the DMAS-225 form to the local department of social services.

3. In an emergency situation when the health, safety, or welfare of the provider staff is endangered, the provider agency may immediately initiate discharge of the individual and contact the DMAS staff. The provider must issue written notification containing the reasons for and the effective date of the termination of services. The written notification period in subdivision 4 of this subsection shall not be required. Other entities (e.g., licensing authorities, APS, CPS) shall also be notified as appropriate. A copy of this letter shall be forwarded to the DMAS staff within five business days of the letter's date.

4. In a nonemergency situation (i.e., when the health, safety, or welfare of the waiver individual or provider personnel is not endangered), the provider shall provide the individual and the individual's representative 14 calendar days' written notification (plus three days to allow for mail transmission) of the intent to discharge the individual from agency services. Written notification shall provide the reasons for and the effective date of the termination of services as well as the individual's appeal rights. A copy of the written notification shall also be forwarded to the DMAS staff within five business days of the date of the notification.

5. Individuals who no longer meet the tech waiver criteria as certified by the physician for either children or adults shall be terminated from the waiver. In such cases, a reduction in skilled PDN hours may occur that shall not exceed two weeks in duration as long as such skilled PDN was previously approved in the individual's POC. The agency provider of skilled PDN for such individuals shall document with DMAS the decrease in skilled PDN hours and prepare for cessation of skilled PDN hours and waiver services.

6. When a waiver individual, regardless of age, requires admission to a specialized care nursing facility or long stay hospital, the individual shall be discharged from waiver services while he is in the specialized care nursing facility or long stay hospital. Readmission to waiver services may resume once the individual has been discharged from the specialized care nursing facility or long stay hospital as long as the waiver eligibility and medical necessity criteria continue to be met. For individuals 21 years of age and older, the individual shall follow the criteria for specialized care nursing facility admission. For individuals who are younger than 21 years of age, the individual shall follow the criteria for long stay hospital admissions as well as the age appropriate criteria.

7. When a waiver individual, regardless of age, requires admission to an acute care hospital for 30 days or more, the individual shall be discharged from waiver services. When such hospitalization exceeds 30 days and upon hospital discharge, readmission to waiver services is required. Such readmission requires reassessment by the discharge team and a determination that the individual continues to meet Medicaid eligibility, level of care criteria and medical

criteria on the DMAS-108 or DMAS-109 form, as appropriate. If these criteria are met, the individual shall be readmitted to waiver services. For adults, ages 21 years and older, the individual shall meet the criteria for specialized care admissions. For children, younger than 21 years of age, the individual shall meet the criteria for long stay hospital admissions and the age appropriate criteria.

8. Waiver individuals, regardless of age, who require admission to any type of acute care facility for less than 30 days shall, upon discharge from such acute care facility, be eligible for waiver services as long as all other requirements continue to be met.

12VAC30-120-1730. General requirements for participating providers. (Repealed.)

A. All agency providers shall sign the appropriate technology assisted waiver provider agreement in order to bill and receive Medicaid payment for services rendered. Requests for provider enrollment shall be reviewed by DMAS to determine whether the provider applicant meets the requirements for Medicaid participation and demonstrates the abilities to perform, at a minimum, the following activities:

1. Be able to render the medically necessary services required by the waiver individuals. Accept referrals for services only when staff is available and qualified to initiate and perform the required services on an ongoing basis.

2. Assure the individual's freedom to reject medical care and treatment.

3. Assure freedom of choice to individuals in seeking medical care from any institution, pharmacy, or practitioner qualified to perform the service or services that may be required and participating in the Medicaid program at the time the service or services are performed.

4. Actively involve the individual and the authorized representative, as applicable, in the assessment of needs, strengths, goals, preferences, and abilities and incorporate this information into the person centered planning process. A provider shall protect and promote the rights of each individual for whom he is providing services and shall provide for each of the following individual rights:

a. The individual's rights are exercised by the person appointed under state law to act on the individual's behalf in the case of an individual adjudged incompetent under the laws of the Commonwealth by a court of competent jurisdiction.

b. The individual, who has not been adjudged incompetent by the state court, may designate any legal surrogate in accordance with state law to exercise the individual's rights to the extent provided by state law.

c. The individual shall have the right to receive services from the provider with reasonable accommodation of individual needs and preferences, except when the health or safety of the individual or other waiver individuals would be endangered.

5. Perform a criminal background check on all employees, including the business owner, who may have any contact or provide services to the waiver individual. Such record checks shall be performed by the Virginia State Police for the Commonwealth. When the Medicaid individual is a minor child, searches shall also be made of the Virginia CPS Central Registry.

a. Provider documentation of the results of these searches must be made available upon request of DMAS or its authorized representatives. Persons convicted of having committed barrier crimes as defined in § 32.1-162.9:1 of the Code of Virginia shall not render services to waiver individuals for the purposes of seeking Medicaid reimbursement.

b. Persons having founded dispositions in the CPS Central Registry at DSS shall not be permitted to render services to children in this waiver and seek Medicaid reimbursement. Medicaid reimbursement shall not be made for providers' employees who have findings with the Virginia Board of Nursing of the Department of Health Professions concerning abuse, neglect, or mistreatment of individuals or misappropriation of their property.

6. Screen all new and existing employees and contractors to determine whether any of them have been excluded from participation in federal programs. Search the HHS-OIG List of Excluded Individuals and Entities (LEIE) website monthly by name for employees, contractors and entities to validate the eligibility of such persons and entities for federal programs.

a. Immediately report to DMAS any exclusion information identified.

b. Such information shall be sent in writing and shall include the individual or business name, provider identification number (if applicable), and what, if any, action has been taken to date.

c. Such information shall be sent to: DMAS, ATTN: Program Integrity/Exclusions, 600 E. Broad St., Suite 1300, Richmond, VA 23219 or emailed to providerexclusion@dmas.virginia.gov.

7. Provide services and supplies to individuals in full compliance with Title VI of the Civil Rights Act of 1964, as amended (42 USC § 2000 et seq.), which prohibits discrimination on the grounds of race, color, religion, or national origin; the Virginians with Disabilities Act (§ 51.5-1 et seq. of the Code of Virginia); § 504 of the Rehabilitation Act of 1973, as amended (29 USC § 794), which prohibits discrimination on the basis of a disability; and the ADA of 1990, as amended (42 USC § 12101 et seq.), which provides comprehensive civil rights protections to individuals with disabilities.

8. Report all suspected violations, pursuant to § 63.2-100, §§ 63.2-1508 through 63.2-1513, and § 63.2-1606 et seq. of the Code of Virginia, involving mistreatment, neglect, or abuse, including injuries of an unknown source, and misappropriation of individual property to either CPS, APS, or other officials in accordance with state law. Providers shall also train their staff in recognizing all types of such injuries and how to report them to the appropriate authorities. Providers shall ensure that all employees are aware of the requirements to immediately report such suspected abuse, neglect, or exploitation to APS, CPS or human rights, as appropriate.

9. Notify DMAS or its designated agent immediately, in writing, of any change in the information that the provider previously submitted to DMAS. When ownership of the provider changes, notify DMAS at least 15 calendar days before the date of such a change.

10. Provide services and supplies to individuals in full compliance of the same quality and in the same mode of delivery as are provided to the general public. Submit charges to DMAS for the provision of services and supplies to individuals in amounts not to exceed the provider's usual and customary charges to the general public.

11. Accept as payment in full the amount established and reimbursed by DMAS' payment methodology beginning with individuals' authorization dates for the waiver services. The provider shall not attempt to collect from the individual or the individual's responsible relative or relatives any amount the provider may consider a balance due amount or an uncovered amount. Providers shall not collect balance due amounts from individuals or individuals' responsible relatives even if such persons are willing to pay such amounts. Providers shall not bill DMAS, individuals or their responsible relatives for broken or missed appointments.

12. Collect all applicable patient pay amounts pursuant to 12VAC30-40-20, 12VAC30-40-30, 12VAC30-40-40, 12VAC30-40-50, and 12VAC30-40-60.

13. Use only DMAS designated forms for service documentation. The provider shall not alter the required DMAS forms in any manner unless DMAS' approval is obtained prior to using the altered forms.

14. Not perform any type of direct marketing activities to Medicaid individuals.

15. Furnish access to the records of individuals who are receiving Medicaid services and furnish information, on request and in the form requested, to DMAS or its designated agent or agents, the Attorney General of Virginia or his authorized representatives, the state Medicaid Fraud Control Unit, the State Long-Term Care Ombudsman and any other authorized state and federal personnel. The Commonwealth's right of access to individuals receiving services and to provider agencies and records shall survive any termination of the provider agreement.

16. Disclose, as requested by DMAS, all financial, beneficial, ownership, equity, surety, or other interests in any and all firms, corporations, partnerships, associations, and business enterprises, joint ventures, agencies, institutions, or other legal entities providing any form of services to participants of Medicaid.

17. Pursuant to 42 CFR 431.300 et seq. and § 32.1-325.3 of the Code of Virginia, all information associated with a waiver applicant or individual that could disclose the individual's identity is confidential and shall be safeguarded. Access to information concerning waiver applicants or individuals shall be restricted to persons or agency representatives who are subject to the standards of confidentiality that are consistent with that of the agency, and any such access must be in accordance with the provisions found in 12VAC30-20-90.

18. Meet staffing, financial solvency, disclosure of ownership, assurance of comparability of services requirements, and other requirements as specified in the provider's written program participation agreement with DMAS.

19. Maintain and retain business and professional records sufficient to document fully and accurately the nature, scope, and details of the services provided fully and accurately with documentation necessary to support services billed. Failure to meet this requirement may result in DMAS' recovery of expenditures resulting from claims payment.

20. Maintain a medical record for each individual who is receiving waiver services. Failure to meet this requirement may result in DMAS recovering expenditures made for claims paid that are not adequately supported by the provider's documentation.

21. Retain business and professional records at least six years from the last date of service or as provided by applicable federal and state laws, whichever period is longer. However, if an audit is initiated within the required retention period, the records shall be retained until the audit is completed and every exception resolved. Policies regarding retention of records shall apply even if the provider discontinues operation. DMAS shall be notified in writing of the storage location and procedures for obtaining records for review should the need arise. The location, agent, or trustee shall be within the Commonwealth.

22. Retain records of minors for at least six years after such minors have reached 21 years of age.

23. Ensure that all documentation in the individual's record is completed, signed, and dated with the name or names of the person or persons providing the service and the appropriate title, dated with month, day, and year, and in

accordance with accepted professional practice. This documentation shall include the nurses' or PCAs', as appropriate, arrival and departure times for each shift that is worked.

24. Begin PDN services for which it expects reimbursement only when the admission packet is received and DMAS' authorization for skilled PDN services has been given. This authorization shall include the enrollment date that shall be issued by DMAS staff. It shall be the provider agency's responsibility to review and ensure the receipt of a complete and accurate screening packet.

25. Ensure that there is a backup caregiver who accepts responsibility for the oversight and care of the individual in order to ensure the health, safety, and welfare of the individual when the primary caregiver is ill, incapacitated, or using PDN respite. Documentation in the medical record shall include this backup caregiver's name and phone number.

26. Notify the DMAS staff every time the waiver individual's primary residence changes.

27. Ensure that minimum qualifications of provider staff are met as follows:

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

b. Staff and agencies shall meet any certifications, licensure, or registration, as applicable and as required by applicable state law. Staff qualifications shall be documented and maintained for review by DMAS or its designated agent. All additional provider requirements as may be required under a specific waiver service in this part shall also be met.

c. All RNs and LPNs providing skilled PDN services shall be currently licensed to practice nursing in the Commonwealth. The LPN shall be under the direct supervision of an RN.

d. All RNs and LPNs who provide skilled PDN services shall have either (i) at least six months of related clinical experience as documented in their history, which may include work in acute care hospitals, long stay hospitals, rehabilitation hospitals, or specialized care nursing facilities, or (ii) completed a provider training program related to the care and technology needs of the assigned tech waiver individual.

e. Training programs established by providers shall include, at a minimum, the following:

(1) Trainers (either RNs or respiratory therapists) shall have at least six months hands on experience in the areas in which they provide training, such as ventilators, tracheostomies, peg tubes, and nasogastric tubes.

(2) Training shall include classroom time as well as direct hands on demonstration of mastery of the specialized skills required to work with individuals in the technology assisted waiver by the trainee.

(3) The training program shall include the following subject areas as they relate to the care to be provided by the tech waiver nurse: (i) human anatomy and physiology, (ii) medications frequently used by technology dependent individuals, (iii) emergency management, and (iv) the operation of the relevant equipment.

(4) Providers shall assure the competency and mastery of the skills necessary to care for tech waiver individuals by the nurses prior to assigning them to a tech waiver individual. Documentation of successful completion of such training course and mastery of the specialized skills required to work with individuals in the technology assisted waiver shall be maintained in the provider's personnel records. This documentation shall be provided to DMAS upon request.

f. The RN supervisor shall be currently licensed to practice nursing in the Commonwealth and have at least one year of related clinical nursing experience, which may include work in an acute care hospital, long stay hospital, rehabilitation hospital, or specialized care nursing facility.

B. DMAS shall have the authority to require the submission of any other medical documentation or information as may be required to complete a decision for a waiver individual's eligibility, waiver enrollment, or coverage for services.

1. Review of individual specific documentation shall be conducted by DMAS or its designated agent. This documentation shall contain, up to and including the last date of service, all of the following, as may be appropriate for the service rendered:

a. All supporting documentation, including physicians' orders, from any provider rendering waiver services for the individual;

b. All assessments, reassessments, and evaluations (including the complete UAI screening packet or risk evaluations) made during the provision of services, including any required initial assessments by the RN supervisor completed prior to or on the date services are initiated and changes to the supporting documentation by the RN supervisor;

c. Progress notes reflecting individual's status and, as appropriate, progress toward the identified goals on the POC;

d. All related communication with the individual and the family/caregiver, the designated agent for service authorization, consultants, DMAS, DSS, formal and informal service providers, referral to APS or CPS and all other professionals concerning the individual, as appropriate;

e. Service authorization decisions performed by the DMAS staff or the DMAS designated service authorization contractor;

f. All POCs completed for the individual and specific to the service being provided and all supporting documentation related to any changes in the POCs; and

g. Attendance logs documenting the date and times services were rendered, the amount and type of services rendered and the dated professional signature with title.

2. Review of provider participation standards and renewal of provider agreements. DMAS shall be responsible for ensuring continued adherence to provider participation standards by conducting ongoing monitoring of compliance.

a. DMAS shall recertify each provider for agreement renewal, contingent upon the provider's timely license renewal, to provide home and community based waiver services.

b. A provider's noncompliance with DMAS policies and procedures, as required in the provider agreement, may result in a written request from DMAS for a corrective action plan that details the steps the provider shall take and the length of time required to achieve full compliance with the corrective action plan that shall correct the cited deficiencies.

c. A provider that has been convicted of a felony, or who has otherwise pled guilty to a felony, in Virginia or in any other of the 50 states, the District of Columbia, or the U.S. territories must, within 30 days of such conviction, notify DMAS of this conviction and relinquish its provider agreement. Upon such notice, DMAS shall immediately terminate the provider's Medicaid provider agreement pursuant to § 32.1 325 D of the Code of Virginia and as may be required for federal financial participation. Such provider agreement terminations shall be immediate and conform to § 32.1 325 E of the Code of Virginia.

d. Providers shall not be reimbursed for services that may be rendered between the conviction of a felony and the provider's notification to DMAS of the conviction.

e. Except as otherwise provided by applicable state or federal law, the Medicaid provider agreement may be terminated at will on 30 days' written notice. The agreement may be terminated if DMAS determines that the provider poses a threat to the health, safety, or welfare of any individual enrolled in a DMAS administered program.

12VAC30-120-1740. ~~Participation standards for provision of services.~~ (Repealed.)

A. Skilled PDN, skilled PDN respite, and PC services. DMAS or its designated agent shall periodically review and audit providers' records for these services for conformance to regulations and policies, and concurrence with claims that have been submitted for payment. When an individual is receiving multiple services, the records for all services shall be separated from those of non-home and community-based care services, such as companion or home health services. The following documentation shall be maintained for every individual for whom DMAS-enrolled providers render these services:

1. Physicians' orders for these services shall be maintained in the individual's record as well as at the individual's primary residence. All recertifications of the POC shall be performed within the last five business days of each current 60-day period. The physician shall sign the recertification before Medicaid reimbursement shall occur;

2. All assessments, reassessments, and evaluations (including the complete UAI screening packet or risk evaluations) made during the provision of services, including any required initial assessments by the RN supervisor completed prior to or on the date services are initiated and changes to the supporting documentation by the RN supervisor;

3. Progress notes reflecting the individual's status and, as appropriate, progress toward the identified goals on the POC;

4. All related communication with the individual and the individual's representative, the DMAS-designated agent for service authorization, consultants, DMAS, DSS, formal and informal service providers, all required referrals, as appropriate, to APS or CPS and all other professionals concerning the individual;

5. All service authorization decisions rendered by the DMAS staff or the DMAS-designated service authorization contractor;

6. All POCs completed with the individual, or family/caregiver, as appropriate, and specific to the service being provided and all supporting documentation related to any changes in the POC;

7. Attendance logs documenting the date and times services were rendered, the amount and type of services rendered and the dated signatures of the professionals who rendered the specified care, with the professionals' titles. Copies of all nurses' records shall be subject to review by either state or federal Medicaid representatives or both. Any required nurses' visit notes, PCA notes, and all dated contacts with service providers and during supervisory visits to the individual's home and shall include:

a. The private duty nurse's or PCA's daily visit note with arrival and departure times;

b. The RN, LPN, or PCA daily observations, care, and services that have been rendered, observations concerning the individual's physical and emotional condition, daily activities and the individual's response to service delivery; and

c. Observations about any other services, such as and not limited to meals on wheels, companion services, and home health services, that the participant may be receiving shall be recorded in these notes;

8. Provider's HIPAA release of information form;

9. All Long Term Care Communication forms (DMAS-225);

10. Documentation of rejection or refusal of services and potential outcomes resulting from the refusal of services communicated to the individual or the individual's representative;

11. Documentation of all inpatient hospital or specialized care nursing facility admissions to include service interruption dates, the reason for the hospital or specialized care nursing facility admission, the name of the facility or facilities and primary caregiver notification when applicable including all communication to DMAS;

12. The RN, LPN, or PCA's and individual's, or individual's representative's weekly or daily, as appropriate, signatures, including the date, to verify that services have been rendered during that week as documented in the record. For records requiring weekly signatures, such signatures, times, and dates shall be placed on these records no earlier than the last day of the week in which services were provided and no later than seven calendar days from the date of the last service. An employee providing services to the tech waiver individual cannot sign for the individual. If the individual is unable to sign the nurses' records, it shall be documented in the record how the nurses' records will be signed or who will sign in the individual's place. An employee of the provider shall not sign for the individual unless he is a family member of the individual or legal guardian of the individual;

13. Contact notes or progress notes reflecting the individual's status; and

14. Any other documentation to support that services provided are appropriate and necessary to maintain the individual in the home and in the community.

B. In addition to meeting the general conditions and requirements for home and community based services participating providers and skilled PDN, private duty respite, and PC services, providers shall also meet the following requirements:

1. This service shall be provided through either a home health agency licensed or certified by the VDH for Medicaid participation and with which DMAS has a contract for either skilled PDN or congregate PDN or both;

2. Demonstrate a prior successful health care delivery;

3. Operate from a business office; and

4. Employ (or subcontract with) and directly supervise an RN or an LPN. The LPN and RN shall be currently licensed to practice in the Commonwealth. Prior to assignment to a tech waiver individual, the RN or LPN shall have either (i) at least six months of related clinical nursing experience or (ii) completed a provider training program related to the care and technology needs of the tech waiver individual as described in 12VAC30-120-1730 A 27 e. Regardless of whether a nurse has six months of experience or completes a provider training course, the provider agency shall be responsible for assuring all nurses who are assigned to an individual are competent in the care needs of that individual.

5. As part of direct supervision, the RN supervisor shall make, at a minimum, a visit every 30 days to ensure both quality and appropriateness of PDN, PDN respite services, and personal care services to assess the individual's and the individual's representative's satisfaction with the services being provided, to review the medication and treatments and to update and verify the most current physician signed orders are in the home.

a. The waiver individual shall be present when the supervisory visits are made.

b. At least every other visit shall be in the individual's primary residence.

c. When a delay occurs in the RN supervisor's visits because the individual is unavailable, the reason for the delay shall be documented in the individual's record, and the visit shall occur as soon as the individual is available. Failure to meet this standard may result in DMAS' recovery of payments made.

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

e. Additional supervisory visits may be required under the following circumstances: (i) at the provider's discretion; (ii) at the request of the individual when a change in the individual's condition has occurred; (iii) any time the health, safety, or welfare of the individual could be at risk; and (iv) at the request of the DMAS staff.

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

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

a. For DMAS enrolled skilled PDN providers that also provide PC services, the provider shall employ or subcontract with and directly supervise an RN who will provide ongoing supervision of all PCAs. The supervising RN shall be currently licensed to practice nursing in the Commonwealth and have at least one year of related clinical nursing experience, which may include work in an acute care hospital, long stay hospital, rehabilitation hospital, or specialized care nursing facility.

b. In addition to meeting the general conditions and requirements for home and community based services participating providers as specified elsewhere in this part, the provision of PC services shall also comply with the requirements of 12VAC30-120-930.

8. Skilled monthly supervisory reassessments shall be performed in accordance with regulations by the PDN agency provider. The agency RN supervisor shall complete the monthly assessment visit and submit the "Technology Assisted Waiver Supervisory Monthly Summary" form (DMAS-103) to DMAS for review by the sixth day of the month following the month when the visit occurred.

9. Failure of the provider to ensure timely submission of the required assessments may result in retraction of all skilled PDN payments for the period of time of the delinquency.

C. Assistive technology and environmental modification.

1. All AT and EM services shall be provided by DMAS-enrolled DME providers that have a DMAS provider agreement to provide AT or EM or both.

2. AT and EM shall be covered in the least expensive, most cost-effective manner. The provider shall document and justify why more cost-effective solutions cannot be used. DMAS and the DMAS designated service authorization contractor may request further documentation on the alternative cost-effective solutions as necessary.

3. The provider documentation requirements for AT and EM shall be as follows:

a. Written documentation setting out the medical necessity for these services regarding the need for service, the process and results of ensuring that the item is not covered by the State Plan as DME and supplies and that it is not available from a DME provider when purchased elsewhere and contacts with vendors or contractors of service and cost;

b. Documentation of any or all of the evaluation, design, labor costs or supplies by a qualified professional;

c. Documentation of the date services are rendered and the amount of service needed;

d. Any other relevant information regarding the device or modification;

e. Documentation in the medical record of notification by the designated individual or the individual's representative of satisfactory completion or receipt of the service or item;

f. Instructions regarding any warranty, repairs, complaints, or servicing that may be needed; and

g. Any additional cost estimates requested by DMAS.

7. The EM or AT provider shall maintain a copy of all building permits and all building inspections for modifications, as required by code. All instructions regarding any warranty, repairs, complaints, and servicing that may be needed and the receipt for any purchased goods or services. More than one cost estimate may be required.

8. Individuals who reside in rental property shall obtain written permission from the property's owner before any EM shall be authorized by DMAS. This letter shall be maintained in the provider's record.

12VAC30-120-1750. ~~Payment for services.~~ (Repealed.)

A. PC services provided in the tech waiver shall be reimbursed at an hourly rate established by DMAS. All skilled PDN services and skilled PDN respite care services shall be reimbursed in increments of 15 minutes as a unit and shall be reimbursed at a rate established by DMAS.

B. Reimbursement for AT and EM shall be as follows.

1. All AT covered procedure codes provided in the tech waiver shall be reimbursed as a service limit of one and up to a per member annual maximum of $5,000 per calendar year regardless of waiver. Such service shall only be provided to individuals who are also receiving private duty nursing.

2. All EM services shall be reimbursed up to $5,000 per individual per calendar regardless of waiver year as long as such services are not duplicative. All EM services shall be reimbursed at the actual cost of material and labor and no mark ups shall be permitted. Such service shall only be provided to individuals who are also receiving private duty nursing.

C. Duplication of services.

1. DMAS shall not duplicate services that are required as a reasonable accommodation as a part of the ADA (42 USC §§ 12131 through 12165), the Rehabilitation Act of 1973 (29

~~USC 791 et seq.), or the Virginians with Disabilities Act (§ 51.5-1 et seq. of the Code of Virginia).~~

~~2. Payment for services under the POC shall not duplicate payments made to public agencies or private entities under other program authorities for this same purpose. All private insurance benefits for skilled PDN shall be exhausted before Medicaid reimbursement can occur as Medicaid shall be the payer of last resort.~~

~~3. DMAS payments for EM shall not be duplicative in homes where multiple waiver individuals reside. For example, one waiver individual may be approved for required medically necessary bathroom modifications while a second waiver individual in the same household would be approved for a medically necessary access ramp but not for the same improvements to the same bathroom.~~

~~D. Cost effectiveness computations for the tech waiver shall be completed by DMAS upon completion of the POC for all individuals entering the waiver. The total annual aggregate cost of the waiver shall not exceed the cost of backup facility placement. For individuals, regardless of age, the DMAS staff shall ensure the anticipated cost to DMAS for the individual's waiver services for a 12 month period shall not exceed the annual average aggregate costs to DMAS for specialized nursing facility care for those individuals 21 years of age or older or for continued hospitalization for individuals younger than 21 years of age.~~

12VAC30-120-1760. ~~Quality management review; utilization reviews; level of care (LOC) reviews.~~ (Repealed.)

~~A. DMAS shall perform quality management reviews for the purpose of ensuring high quality of service delivery consistent with the attending physicians' orders, approved POCs, and service authorized services for the waiver individuals. Providers identified as not rendering reimbursed services consistent with such orders, POCs, and service authorizations shall be required to submit corrective action plans (CAPs) to DMAS for approval. Once approved, such CAPs shall be implemented to resolve the cited deficiencies.~~

~~B. If the DMAS staff determines, during any review or at any other time, that the waiver individual no longer meets the aggregated cost effectiveness standards or medical necessity criteria, then the DMAS staff, as appropriate, shall deny payment for such waiver individual. Such waiver individuals shall be discharged from the waiver.~~

~~C. Securing service authorization shall not necessarily guarantee reimbursement pursuant to DMAS utilization review of waiver services.~~

~~D. DMAS shall perform annual quality assurance reviews for tech waiver enrollees. Once waiver enrollment occurs, the Level of Care Eligibility Re-determination audits (LOCERI) shall be performed by DMAS. This independent electronic calculation of eligibility determination is performed and communicated to the DMAS supervisor for tech waiver. Any failure for waiver eligibility requires higher level of review by the supervisor and may include a home visit by the DMAS staff.~~

12VAC30-120-1770. ~~Appeals; provider and recipient.~~ (Repealed.)

~~A. Providers shall have the right to appeal actions taken by DMAS. Provider appeals shall be considered pursuant to § 32.1-325.1 of the Code of Virginia and the Virginia Administrative Process Act (§ 2.2-4000 et seq. of the Code of Virginia) and DMAS regulations at 12VAC30-10-1000 and 12VAC30-20-500 through 12VAC30-20-560.~~

~~B. Individuals shall have the right to appeal actions taken by DMAS. Individuals' appeals shall be considered pursuant to 12VAC30-110-10 through 12VAC30-120-370. DMAS shall provide the opportunity for a fair hearing, consistent with 42 CFR Part 431, Subpart E.~~

~~C. The individual shall be advised in writing of such denial and of his right to appeal consistent with DMAS client appeals regulations 12VAC30-110-70 through 12VAC30-110-80.~~

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TITLE 16. LABOR AND EMPLOYMENT

VIRGINIA EMPLOYMENT COMMISSION

Fast-Track Regulation

Title of Regulation: **16VAC5-60. Benefits (amending 16VAC5-60-10, 16VAC5-60-20, 16VAC5-60-40).**

Statutory Authority: §§ 60.2-11 and 60.2-623 of the Code of Virginia.

Public Hearing Information: No public hearing is currently scheduled.

Public Comment Deadline: January 4, 2023.

Effective Date: January 19, 2023.

Agency Contact: Jacob Shuford, Regulatory Coordinator, Virginia Employment Commission, 6606 West Broad Street, Henrico, VA 23230, telephone (804) 486-2360, FAX (804) 786-9034, or email jacob.shuford@vec.virginia.gov.

Basis: Statutory authority for the Virginia Employment Commission to promulgate such regulatory action is derived from §§ 60.2-113, 60.2-611, and 60.2-612 of the Code of Virginia, which authorize the commission to adopt, amend, or repeal regulations as necessary, including methods of procedure and changes in procedure in handling interstate claims.

Purpose: The commission must take all necessary steps to aid employment stabilization in the Commonwealth of Virginia under its duty to administer the Virginia Unemployment Compensation Act (§ 60.2-100 et seq. of the Code of Virginia) for the welfare of the citizens of the Commonwealth through unemployment benefits, the labor exchange system, job services programs, and solvency of the administered trust fund. Adapting to the shift away from brick and mortar local offices through an increased utilization of technology and stream lining of claim filing processes are necessary to gain efficiency in the pursuit of those mandated goals.

Rationale for Using Fast-Track Rulemaking Process: This action is noncontroversial because the changes revise timelines in the administration of unemployment benefits to reflect a best practice recommended by the U.S. Department of Labor and also update language to reflect current practices. None of the proposed changes have a significant economic effect other than updating the language for consistency with ongoing processes, practices, and procedures used by the agency. Additionally, no individual, business, or locality appears to be adversely affected by the proposed changes to definitions.

Substance: The amendments include (i) expanding how claims can be filed to include via telephone, Internet, or other means at the discretion of the commission; (ii) allowing for correspondence electronically or by mail; (iii) adjusting timeframes for different aspects of the claims process; (iv) allowing that a claim that was filed in error by an employer on behalf of a claimant may be canceled upon the claimant's written request and that all records of a canceled claim shall be deleted from the agency's automated benefits database; (v) providing that when the commission is at fault due to a representative of the commission giving inadequate or misleading information to an individual about filing a claim, the claim may be canceled; (vi) generally streamlining language; and (vii) updating forms required by the regulation.

Issues: The primary advantage to the public is the ability to file claims forms electronically and over the telephone as well as more clarity and up-to-date information, including removing language rendered obsolete by the modernization of processes, practices, and procedures used by the agency. There are no disadvantages to the public. The Commonwealth will benefit from the timely processing of claims and ensuring practices are accurately represented in the regulations, meet U.S. Department of Labor performance requirements, and align with the forms in use by the agency. There are no disadvantages to the agency.

Department of Planning and Budget's Economic Impact Analysis:

The Department of Planning and Budget (DPB) has analyzed the economic impact of this proposed regulation in accordance with § 2.2-4007.04 of the Code of Virginia (Code) and Executive Order 14 (as amended, July 16, 2018). The analysis presented represents DPB's best estimate of these economic impacts.[1] Summary of the Proposed Amendments to Regulation

The Virginia Employment Commission (VEC) proposes to revise several timelines in the administration of unemployment benefits and also update language to reflect current practices.

Background. VEC is charged with aiding employment stabilization under its duty to administer the Virginia Unemployment Compensation Act for the welfare of the citizens of the Commonwealth through unemployment benefits, the labor exchange system, job services programs, and solvency of the administered trust fund. This chapter of the regulation contains rules for administration of unemployment benefits.

VEC reports that the federal Workforce Innovation and Opportunity Act required dramatic changes in how it delivered services across the Commonwealth. Consequently, starting in September 2018, VEC has modernized its unemployment claim filing process by shifting away from pen-and-paper based claim filing to online filing, which necessitates making changes to some claim processing timelines. VEC also proposes to revise one of the filing timelines to reflect a best practice recommended by the United States Department of Labor (USDOL). VEC also proposes amendments to this chapter to reflect the revised claim filing timelines and the description of the process currently in effect.

Estimated Benefits and Costs. VEC proposes to update the time period for filing a new claim for benefits for partial unemployment (i.e. working less hours in a week than the regular hours) from 14 days to 10 days after the employee receives evidence of partial unemployment from his or her employer. According to VEC, under the old system (before modernization), the employee was at the mercy of the employer to file partial unemployment. But under the new system, the employee can file online or over the phone and the necessary form is then mailed to them. Because the employee is now responsible to provide their form to the employer, VEC reports that 10 days is sufficient under the new approach. VEC reports that this change is to ensure timely processing of partial claims now that claim-related forms can be filed electronically. Additionally, the 10-day requirement is now standard for any document the benefits division gives claimants to be completed and returned.

Similarly, VEC proposes to update the timeline to file the first continued claim form from within 28 days of the day the initial claim was filed to within 21 days. In the past, claimants had 28 days to file their first claim from the date of the initial application, or risk having to renew their application for benefits. However, USDOL recommends allowing a shorter time period, 21 days, to file a continued claim following the initial application. Consequently, VEC adopted the new 21-day standard in 2016 and now proposes to update the regulation to reflect this change in practice.

The last timeline being proposed to be updated is an increase from 8 days to 10 days in the time allowed for employing units

to complete and return their report of separation and wage information. This change reflects current practice, and will update the regulation regarding the time employers currently have to complete and submit the separation and wage information when a worker is terminated.

The remaining proposed changes are updates of the language to reflect changes in the description of the processes. For example, language regarding mass separations is being amended as such separations are handled differently following the recent modernized process. Another example is the addition of new language to include an additional reason the claimant may cancel their initial claim to account for agency errors, expand filing methods, and remove processes no longer applicable.

Based on information available from VEC, all of the proposed changes reflect current practices and the agency is not aware of any complaints due to the changes in timelines included in this action. Thus, none of the proposed changes appear to have a significant economic effect other than updating the language for consistency with ongoing processes, practices, and procedures used by the agency.

Businesses and Other Entities Affected. The proposed amendments apply to all individuals and businesses required to file or report an unemployment benefit claim or event.

The Code of Virginia requires DPB to assess whether an adverse impact may result from the proposed regulation.[2] An adverse impact is indicated if there is any increase in net cost or reduction in net revenue for any entity, even if the benefits exceed the costs for all entities combined. As noted above, VEC has not received any complaints due to the proposed timeline changes in claims processing and reporting. Thus, based on information available from VEC, no individual or business appears to be adversely affected by the proposed changes to definitions.

Small Businesses[3] Affected.[4] The proposed amendments do not appear to adversely affect small businesses.

Localities[5] Affected.[6] The proposed amendments do not disproportionately affect any particular localities and do not introduce costs for local governments.

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

Effects on the Use and Value of Private Property. The proposed amendments do not affect the use and value of private property or the real estate development costs.

[1]Section 2.2-4007.04 of the Code of Virginia requires that such economic impact analyses determine the public benefits and costs of the proposed amendments. Further the analysis should include but not be limited to: (1) the projected number of businesses or other entities to whom the proposed regulatory action would apply, (2) the identity of any localities and types of businesses or other entities particularly affected, (3) the projected number of persons and employment positions to be affected, (4) the projected costs to affected businesses or entities to implement or comply with the regulation, and (5) the impact on the use and value of private property.

[2]Pursuant to § 2.2-4007.04 D: In the event this economic impact analysis reveals that the proposed regulation would have an adverse economic impact on businesses or would impose a significant adverse economic impact on a locality, business, or entity particularly affected, the Department of Planning and Budget shall advise the Joint Commission on Administrative Rules, the House Committee on Appropriations, and the Senate Committee on Finance. Statute does not define "adverse impact," state whether only Virginia entities should be considered, nor indicate whether an adverse impact results from regulatory requirements mandated by legislation.

[3]Pursuant to § 2.2-4007.04, 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."

[4]If the proposed regulatory action may have an adverse effect on small businesses, § 2.2-4007.04 requires that such economic impact analyses include: (1) an identification and estimate of the number of small businesses subject to the proposed regulation, (2) the projected reporting, recordkeeping, and other administrative costs required for small businesses to comply with the proposed regulation, including the type of professional skills necessary for preparing required reports and other documents, (3) a statement of the probable effect of the proposed regulation on affected small businesses, and (4) a description of any less intrusive or less costly alternative methods of achieving the purpose of the proposed regulation. Additionally, pursuant to § 2.2-4007.1 of the Code of Virginia, if there is a finding that a proposed regulation may have an adverse impact on small business, the Joint Commission on Administrative Rules shall be notified.

[5]"Locality" can refer to either local governments or the locations in the Commonwealth where the activities relevant to the regulatory change are most likely to occur.

[6]Section 2.2-4007.04 defines "particularly affected" as bearing disproportionate material impact.

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 amendments (i) conform regulatory text to meet U.S. Department of Labor performance requirement timelines and accurately reflect the claims filing process as the agency increasingly moves away from local offices and into a modernized claim filing process; (ii) alter the continued and weekly claim filing deadline; and (iii) update forms required by the regulation.

16VAC5-60-10. Total and part-total unemployment.

A. An individual's week of total or part-total unemployment shall consist of the seven-consecutive-day period beginning with the Sunday prior to the first day ~~he~~ the individual files ~~his~~ a claim ~~at the field office~~ and registers for work, ~~except as provided in subdivisions 1 and 2 of this subsection;~~ and, thereafter, the seven-consecutive-day period following any week of such unemployment~~, provided the individual reports as required by subsection C of this section~~. An initial claim may be filed ~~in person at a field office, or at the discretion of the commission,~~ by telephone ~~or,~~ Internet, or by other means at the discretion of the commission. ~~Upon implementation of Internet and telephonic claims processes, a claimant may file an initial claim for benefits by any of the three methods described herein.~~

~~1. A week of total or part-total unemployment of an individual located in an area served only by the itinerant service of the commission shall consist of the seven consecutive day period beginning with the Sunday prior to the first day of such individual's unemployment, provided that such individual registers in person with such itinerant service at the first available opportunity following the commencement of his total or part-total unemployment except as provided in subdivision 2 of this subsection; and, thereafter, the seven consecutive day period following any week of such unemployment provided the individual reports as required by subsection C of this section.~~

~~2. A week of total or part-total unemployment of an individual affected by a mass separation with respect to which arrangements are made for group filing by the employer shall consist of the seven consecutive day period beginning with the Sunday prior to the first day of his unemployment provided that the group filing is conducted within 13 days following the first day of unemployment.~~

B. Whenever an employing unit receives an Employer's Report of Separation and Wage Information ~~form~~ correspondence electronically or by mail from the commission informing it that an individual has filed a claim for benefits, such employing unit shall, within ~~eight~~ 10 days from the date of ~~mailing~~ notification, complete the report and return or submit it to the ~~office from which the informatory notice was sent~~ commission as directed. That portion of the Employer's Report of Separation and Wage Information to be completed by the employing unit shall set forth:

1. The date the worker began working;

2. The last day on which he actually worked;

3. ~~A check mark in the block indicating the~~ The reason for separation ~~and a brief statement of the reason for the separation~~;

4. Such other information as is required by such form. The employing unit's official name and account number, if any, assigned to such employing unit by the commission shall appear on the ~~signed~~ completed report;

5. The name and title of the official ~~signing~~ completing the report shall be provided as well as certification that the information contained in the report is accurate and complete to the best knowledge of that official.

C. ~~In cases involving a mass separation, as defined in 16VAC5-10-10, an employer shall not be required to file individual reports for such workers as otherwise provided by this section if such employer files a list of workers involved in the mass separation with the commission as soon as possible, but in no case later than 24 hours after the date of separation. Such list shall include the workers' social security account numbers and any other information the commission may require.~~

~~D.~~ To file a claim for benefits, a claimant shall report in a manner prescribed by the commission~~,~~ and shall file a claim for benefits setting forth (i) ~~his~~ the claimant's unemployment and that ~~he~~ the claimant claims benefits, (ii) that ~~he~~ the claimant is able to work and is available for work, and (iii) such other information as is required. A claim for benefits, when filed, may also constitute the individual's registration for work.

Upon written request by the claimant, an initial claim for benefits, not to include combined-wage claims, may be canceled if (i) the request is made within the appeal period shown on the monetary determination; (ii) there has been no payment made on the claim; ~~and~~ (iii) the deputy has not rendered a determination based on the claimant's separation from employment; and (iv) the commission is at fault due to a representative of the commission giving inadequate or misleading information to an individual about filing a claim. ~~Notwithstanding the foregoing, a claim that was filed in error by an employer on behalf of a claimant may be canceled upon the claimant's written request. All records of a canceled claim shall be deleted from the agency's automated benefits database.~~ Upon written request by the claimant, a claim may be withdrawn if the commission determines that the provisions of § 60.2-107 of the Code of Virginia have been met and any benefits paid the claimant have been repaid.

Combined wage claims may be canceled under the provisions set forth in 16VAC5-70-20 B.

1. Except as otherwise provided in this section the claimant shall continue to report as directed during a continuous period of unemployment.

2. The commission shall permit continued or weekly claims to be filed by ~~mail~~ Internet, telephone, or such other means as the commission may authorize~~, unless special conditions require or allow in-person reporting. Such special conditions may include:~~

~~a. When a claimant is reporting back to claim his first week(s) after filing an initial, additional, or reopened claim and he has not returned to work in the meantime;~~

~~b. When a claimant needs assistance in order to completely and accurately fill out his claim forms so as to avoid delays in processing his claims by mail;~~

~~c. When, in the opinion of the field office manager or deputy, there is a question of eligibility or qualification which must be resolved through an in-person interview;~~

~~d. When a claimant who would normally be reporting by mail receives no additional claim forms and he wishes to continue claiming benefits;~~

~~e. When a claimant requests to report in person due to problems associated with the receipt of mail~~.

~~E.~~ D. All initial total, partial, or part-total unemployment claims shall be effective consistent with the provisions set forth in subsection A of this section, except that an earlier effective date may apply for late filing of claims in the following cases:

1. The commission is at fault due to a representative of the commission giving inadequate or misleading information to an individual about filing a claim;

2. A previous claim was filed against a wrong liable state;

3. Filing was delayed due to circumstances attributable to the commission;

4. A transitional claim is filed within 14 days from the date the Notice of Benefit Year Ending was mailed to the claimant by the commission;

5. When claiming benefits under any special unemployment insurance program, the claimant becomes eligible for regular unemployment insurance when the calendar quarter changes;

6. The wrong type of claim was ~~taken~~ processed by ~~a field office~~ the commission;

7. With respect to reopened or additional claims only, the claimant can show circumstances beyond ~~his~~ the claimant's control which prevented or prohibited him from reporting earlier.

~~F.~~ E. In order to claim benefit rights with respect to a given week, the claimant must file a continued or weekly claim ~~form~~ for such week. The first continued or weekly claim ~~form~~ must be filed within ~~28~~ 21 days of the day the initial ~~claim~~ application was filed. Thereafter, a subsequent continued or weekly claim must be filed within ~~28~~ 21 days after the week ending date of the last week claimed. If filing by mail is permitted by the commission, the postmark date constitutes the date of claim filing with the commission. If no postmark appears on the envelope, the continued or weekly claim shall be presumed to be filed on the date it was received by the commission. If the ~~28th~~ 21st day falls upon a date when the ~~field~~ commission's office is closed, the final date for filing shall be extended to the next day the office is open. Failure to file a continued or weekly claim within the ~~28-day~~ 21-day period will result in the denial of benefits for the weeks in question unless good cause is shown, and an additional or reopened claim must be filed in order to initiate any further claim for benefits. Good cause for a delay in filing may be shown for any of the following reasons:

1. The commission is at fault due to a representative of the commission giving inadequate or misleading information to an individual about filing a claim;

2. Filing was delayed due to circumstances attributable to the commission; or

3. The claimant can show circumstances beyond ~~his~~ the claimant's control ~~which~~ that prevented or prohibited ~~him~~ the claimant from filing earlier.

~~G.~~ F. Normally, all claimants whose unemployment is total or part-total must make an active search for work by contacting prospective employers in an effort to find work during each week claimed in order to meet the eligibility requirements of § 60.2-612 of the Code of Virginia. A claimant who is temporarily unemployed with an expected return to work date within a reasonable period of time as determined by the commission ~~which~~ that can be verified from employer information may be considered attached to ~~his~~ the claimant's regular employer so as to meet the requirement that ~~he~~ the claimant be actively seeking and unable to find suitable work if ~~he~~ the claimant performs all suitable work ~~which his~~ that the claimant's regular employer has for ~~him~~ the claimant during ~~the~~ any week ~~or weeks~~ claimed while attached. Attachment will end if the claimant does not return to work as scheduled or if changed circumstances indicate ~~he~~ the claimant has become separated.

~~H.~~ G. In areas of high unemployment as defined in 16VAC5-10-10, the commission has the authority, in the absence of federal law to the contrary, to adjust the work search requirement of the Act. Any adjustment will be made quarterly within the designated area of high unemployment as follows:

1. The adjustment will be implemented by requiring claimants filing claims ~~for benefits through the office serving~~ who reside in an area experiencing a total unemployment rate of 10% through 14.9% to make one job contact with an employer each week.

2. The adjustment will be implemented by waiving the search for work requirement of all claimants filing claims for benefits ~~through the office serving~~ who reside in an area experiencing a total unemployment rate of 15% or more.

3. No adjustment will be made for claimants filing claims for benefits ~~through the office serving~~ who reside in an area experiencing a total unemployment rate below 10%.

16VAC5-60-20. Partial unemployment.

A. With respect to a partially unemployed individual, a week of partial unemployment shall consist of a calendar week beginning on Sunday and ending at midnight on Saturday. Total wages payable to partially unemployed workers are to be reported on a calendar week basis.

B. Upon filing of a new claim for partial benefits in each claimant's benefit year the commission shall promptly notify the employer of such claimant's weekly benefit amount, the date on which ~~his~~ the claimant's benefit year commenced, and the effective date of the claim for partial benefits. Similar notice shall likewise be given at least once during the claimant's benefit year to each subsequent employer to whom the claimant is attached during a period of partial unemployment for which ~~he~~ the claimant claims benefits. Upon receipt of the notice the employer shall record this information for use in the preparation of the evidence ~~he~~ the employer is required to furnish periodically as required in subsection C of this section.

C. After the employer has been notified of the benefit year, the weekly benefit amount, and the effective date of the claim for partial benefits of any worker in ~~his~~ the employer's employ (pursuant to subsection B of this section) the employer shall, within seven days, furnish the employee with written evidence concerning any week ~~or weeks~~ of partial unemployment ~~which~~ that ended on or before the receipt of such notice and ~~which~~ that began on or after the effective date of the employee's claim for partial benefits. The employer, until otherwise notified, shall, within 14 days after the termination of any pay period ~~which~~ that includes a week ~~or weeks~~ of partial unemployment, and ~~which~~ that ends after the date of receipt of such notification, furnish the employee with written evidence concerning ~~his~~ the employee's partial unemployment with respect to such week ~~or weeks~~. Written evidence of partial unemployment required by this subsection shall be furnished by means of a Statement of Partial Unemployment, Form VEC-B-31, or other suitable medium approved by the commission. Such evidence need not be furnished, however, where the worker's earnings for a week of partial unemployment equals or exceeds ~~his~~ the worker's weekly benefit amount.

The information contained on such medium shall be in ink or typewritten and shall show:

1. The name of the employer and employer account number;

2. The name and social security account number of the worker;

3. The date delivered to the worker;

4. The calendar week ending date;

5. The gross amount of wages earned in such week, by day;

6. The reason and the number of days or hours involved where the worker's earnings were reduced for any cause other than lack of work;

7. The following certification, or one similar:

"During the week or weeks covered by this report, the worker whose name is entered worked less than full time and earned less than his weekly benefit amount for total unemployment because of lack of work, or otherwise shown. I certify that to the best of my knowledge, this information is true and correct";

8. ~~A~~ An original signature ~~(actual or facsimile)~~ by the employer to the ~~above~~ certification in subdivision 7 of this subsection or other identification of the authority supplying the evidence.

D. The new claim for benefits for partial unemployment shall be ~~dated to~~ effective Sunday, the first day of the beginning of the individual's week ~~of~~ in which the partial unemployment ~~as defined in subsection A of this section. However, in no event shall such new claim be back dated to include a week which ended more than 28 days prior to the date the individual was furnished the Statement of Partial Unemployment, or other written evidence concerning his partial unemployment, as provided in subsection C, by the employer~~ claim is filed.

E. 1. Upon filing a claim as specified in subsection D of this section, the commission shall cause the notice referred to in subsection B of this section to be sent to the employer. Thereafter, the employer shall make available to the claimant the Statement of Partial Unemployment, Form VEC-B-31, or other written evidence concerning ~~his~~ the claimant's partial unemployment, as provided in subsection C of this section. Such written evidence of partial unemployment shall be presented to the ~~field office~~ commission within ~~14~~ 10 days after it is delivered to ~~him~~ the claimant by the employer, and failure to do so, within that time, shall ~~render~~ result in the claim ~~invalid as to the week or weeks to which the statement or other evidence relates~~ being processed based on the available information.

2. For each subsequent week the partial claim is continued, the employer shall furnish the claimant with the evidence of partial unemployment as provided in subsection C of this section, and the claimant shall continue to present such evidence to the ~~field office~~ commission within ~~14~~ 10 days after it is delivered to ~~him~~ the claimant by the employer. Failure to do so shall render the claim invalid with respect to ~~the~~ any week ~~or weeks~~ to which the statement or other evidence relates.

3. Notwithstanding the provisions of subdivisions 1 and 2 of this subsection, the commission shall permit the claimant to file a continued or weekly claim ~~by mail, or otherwise,~~ in the same circumstances applicable to a claimant for total or part-total unemployment compensation.

F. With respect to any week claimed, a partially unemployed claimant shall be deemed to be actively seeking work if ~~he~~ the claimant performs all suitable work offered to ~~him~~ the claimant by ~~his~~ the claimant's regular employer.

16VAC5-60-40. Commission approval of training other than that under ~~Section~~ § 134 of the Workforce ~~Investment~~ Innovation and Opportunity Act or ~~Section~~ § 2296 of the Trade Act.

A. Training shall be approved for an eligible claimant under the provisions of § 60.2-613 of the Code of Virginia only if the commission finds that:

1. Prospects for continuing employment for which the claimant is qualified by training and experience are minimal and are not likely to improve in the foreseeable future in the locality in which ~~he~~ the claimant resides or is claiming benefits;

2. The proposed training course of instruction is vocational or technical training or retraining in schools or classes that are conducted as programs designed to prepare an individual for gainful employment in the occupation for which training

is applicable. The training course shall require a minimum of 30 hours attendance each week;

3. The proposed training course has been approved by an appropriate accrediting agency or, if none exists in the state, the training complies with quality and supervision standards established by the commission, or is licensed by an agency of the state in which it is being given;

4. The claimant has the required qualifications and aptitude to complete the course successfully;

5. The training does not include programs of instruction which are primarily intended to lead toward a baccalaureate or higher degree from an institution of higher education.

B. Benefits may be paid to an otherwise eligible claimant while ~~he~~ the claimant is attending training only if the commission finds that the claimant is enrolled in and regularly attending the course of instruction approved for ~~him~~ the claimant by the commission.

C. A claimant shall request training approval ~~on forms provided~~ as prescribed by the commission. The claimant's enrollment and attendance shall be reported ~~to the commission periodically~~ as directed by the commission.

NOTICE: The following forms used in administering the regulation have been filed by the agency. Amended or added forms are reflected in the listing and are published following the listing. Online users of this issue of the Virginia Register of Regulations may also click on the name to access a form. The forms are also available from the agency contact or may be viewed at the Office of Registrar of Regulations, 900 East Main Street, 11th Floor, Richmond, Virginia 23219.

FORMS (16VAC5-60)

~~Continued Claim for Benefits -- First Payments, B-3FP (eff. 11/92).~~

~~Benefits, Rights, and Responsibilities -- Instructionsfor Person on Temporary Layoff, B-19~~

~~Verification of Offer of Continuing Employment, B-25~~

~~Request for Reconsideration of Monetary Determination, B-28.~~

~~Request for Name/Address/Telephone Number Changes, B-41~~

~~Work Search Requirement, B-76.~~

~~Continued Claim for Benefits, VEC-B-3 (rev. 7/93)~~

~~Notice of Exhaustion, VEC-B-3a (rev. 8/88)~~

~~Claim Correction Notice, VEC-B-5M (rev. 9/87).~~

~~Appointment Notice, VEC-B-6M (rev. 1/83).~~

~~Claim for Benefits, VEC-B-10 (rev. 10/93)~~

~~Employer's Report of Separation and Wage Information, B-10SEP (rev. 7/93)~~

~~Eligibility Review Interview Notice, VEC-B-11D (rev. 7/88).~~

~~Record of Contacts for Employment, VEC-B-11E.~~

~~Request for Physician's Certificate of Health, VEC-B-14 (rev. 2/76)~~

~~Notice to Workers, VEC-B-29 (rev. 10/93)~~

~~Monetary Determination, VEC-B-30 (rev. 6/90)~~

~~Notice of Benefit Liability, VEC-B-30R (rev. 4/93)~~

~~Statement of Partial Unemployment, VEC-B-31 (rev. 5/96)~~

~~Notification of Claim Filed for Benefits, VEC-B-32 (rev. 9/91)~~

~~Unemployment Insurance Handbook for Claimants (rev. 1992). (Although issued for informational purposes only, this booklet contains some interpretative material.)~~

~~Claimant's Request for Training Approval, VEC-B-60.7 (rev. 11/94).~~

~~Notice to Trade Readjustment Allowance Claimants Concerning Training, VEC-B-72 (rev. 10/87).~~

~~Training Certification, VEC-TB-1 (eff. 1/1/72)~~

~~Notice of Child Support Intercept, VEC-CSI-1 (rev. 7/93)~~

~~Request for Gross Wages, VEC-BPC-45A (eff. 12/86).~~

~~Wage Verification Request, VEC-BPC-65 (rev. 6/90)~~

~~Cross Match, VEC-BPC-65A (rev. 6/90)~~

~~Billing Statement, VEC-BPC-89 (rev. 5/93)~~

~~Consent of Disclosure, VEC-CD-1 (eff. 1/89).~~

~~Affidavit of (DUA), DUA-1 (rev. 5/78)~~

~~Affidavit of Earnings, DUA-2 (rev. 10/76).~~

~~Weekly Request for DUA, DUA-3 (rev. 10/76)~~

~~Notice of Overpayment, DUA-4 (rev. 10/76).~~

~~Release Authorization, RA-1 (rev. 11/92).~~

~~Election of Regular TAA or NAFTA-TAA By Worker, VEC-NAFTA/TAA-1.~~

~~Entitlement Determinations to NAFTA Transitional Adjustment Assistance (NAFTA-NAA)/Trade Readjustment Allowances (TRA) Trade Act of 1974, As Amended September 1994, ETA-8-5-7A)~~

~~Request for Verification of Work Search, VEC-B-78 (rev. 11/94). (This form had been numbered as VEC-B-72; the number is being changed to eliminate duplicate numbers.)~~

Instructions to Partial Claimants, VEC-B-19 (rev. 9/2016)

Verification of Offer of Continuing Employment, VEC-B-25 (rev. 6/2012)

Request for Name Changes, VEC-B-41 (rev. 8/2012)

Continued Claim for Benefits, VEC-B-3 (rev. 12/2011)

Notice of Exhaustion, VEC-B-3a (rev. 3/2014)

VEC Claim for Benefits, VEC-B-10 (rev. 8/2013)

Employer's Report of Separation and Wage Information, B-10SEP (rev. 1/2013)

Request for Physician's Certificate of Health, VEC-B-14 (rev. 6/2012)

Request for Licensed Medical Professional's Certificate of Health, VEC-B-14A (rev. 6/2012)

Notice of Benefit Year Ending (BYE), VEC-B-22, (filed 11/2022)

Notice to Workers, VEC-B-29 (rev. 4/2015)

Monetary Determination, VEC-B-30 (rev. 1/2013)

Notice of Benefit Liability, VEC-B-30R (rev. 9/1995)

Statement of Partial Unemployment, VEC-B-31 (rev. 3/2014)

Notification of Claim Filed for Benefits, VEC-B-32 (rev. 10/2015)

Verification of Work Search Revised, VEC-B-36 (rev. 8/2013)

Unemployment Benefits Tax Withholding, VEC- B-38 (rev. 9/2012)

Your Unemployment Benefits Rights and Responsibilities (rev. 1/2016). (Although issued for informational purposes only, this booklet contains some interpretative material.)

Training Certification, VEC-TB-1 (rev. 11/1972)

Notice of Child Support Intercept Deduction, VEC-CSI-1 (rev. 2/2010)

Wage Verification Request, VEC-BPC-65 (rev. 4/2016)

New Hire Audit, VEC-BPC-65A (rev. 4/2016)

Claimant's Statement Concerning Report of New Hire, VEC-BPC-66A (rev. 8/2013)

UI Billing Statement, VEC-BPC-89-UI (rev. 11/2013)

Initial Application for Disaster Unemployment Assistance, DUA-1 (rev. 1/1996)

Weekly Request for DUA, DUA-3 (rev. 719/96)

Bi-weekly Request for Allowances by Workers in Training - Trade Act of 1974, ETA 8-58A (rev. 8/2013)

Claim Cancellation Request (rev. 12/2014)

Notice of Reemployment and Eligibility Assessment (REA) Interview (rev. 10/2015)

VA.R. Doc. No. R23-7204; Filed October 27, 2022, 11:04 a.m.

Fast-Track Regulation

Title of Regulation: **16VAC5-70. Interstate and Multistate Claimants (amending 16VAC5-70-10, 16VAC5-70-20).**

Statutory Authority: §§ 60.2-111 and 60.2-623 of the Code of Virginia.

Public Hearing Information: No public hearing is currently scheduled.

Public Comment Deadline: January 4, 2023.

Effective Date: January 19, 2023.

Agency Contact: Jacob Shuford, Regulatory Coordinator, Virginia Employment Commission, 6606 West Broad Street, Henrico, VA 23230, telephone (804) 486-2360, FAX (804) 786-9034, or email jacob.shuford@vec.virginia.gov.

Basis: Statutory authority for the Virginia Employment Commission to promulgate such regulatory action is derived from §§ 60.2-113, 60.2-611, and 60.2-612 of the Code of Virginia, which authorize the commission to adopt, amend, or repeal regulations as necessary, including methods of procedure and changes in procedure in handling interstate claims.

Purpose: The commission must take all necessary steps to aid employment stabilization in the Commonwealth of Virginia under its duty to administer the Virginia Unemployment Compensation Act (§ 60.2-100 et seq. of the Code of Virginia) for the welfare of the citizens of the Commonwealth through unemployment benefits, labor exchange system, job services programs, and solvency of the administered trust fund. Adapting to the shift away from brick and mortar local offices through an increased utilization of technology and stream lining of claim filing processes are necessary to gain efficiency in the pursuit of those mandated goals.

Rationale for Using Fast-Track Rulemaking Process: The amendments were prompted by changes in procedure in handling interstate claims such as automation. Furthermore, the shift from mail to email and telephone are part of an effort to increase efficiency and as such would be expected to benefit applicants by reducing processing times. The amendments are expected to increase flexibility and efficiency for applicants and reduce paperwork for other state employment agencies. There are no known economic or adverse impacts, so this action is considered noncontroversial.

Substance: Amendments include (i) deleting references to field offices; (ii) adding that a combined wage claim can only by established if there are base period wages in the paying state; (iii) clarifying how wages are paid to a claimant; (iv) removing redundant or outdated requirements; and (v) updating forms.

Issues: The primary advantage to the public is more accessibility and ease of use through modernized processes,

increased usage of technology, and updated forms used by the agency. There are no disadvantages to the public. The Commonwealth will benefit by using technology to increase capacity and efficiency and updating the regulations to accurately reflect the current practices in use. There are no disadvantages to the agency.

Department of Planning and Budget's Economic Impact Analysis:

The Department of Planning and Budget (DPB) has analyzed the economic impact of this proposed regulation in accordance with § 2.2-4007.04 of the Code of Virginia (Code) and Executive Order 14 (as amended, July 16, 2018). The analysis presented represents DPB's best estimate of these economic impacts.[1]

Summary of the Proposed Amendments to Regulation. The Virginia Employment Commission (VEC) seeks to update 16VAC5-70, Interstate and Multistate Claimants, to conform to current practice, which has adapted to reflect the agency's shift from local offices to a modernized claim filing process.

Background. The 2014 federal Workforce Innovation and Opportunity Act required significant changes to VEC operations and service delivery. VEC reports that these changes included closing VEC local offices and offering services through "One-Stop" service centers operated with mandated partners and local Workforce Development Boards.[2] Further, interstate claims for all 50 states are controlled by processes established by the U.S. Department of Labor, including the State Identification Inquiry (SIDI) and Interstate Benefits Inquiry (IBIQ) systems.[3] Increased automation in the SIDI/IBIQ systems have reduced the reliance on paper-based processes leading to some requirements being verified automatically and some paperwork becoming redundant.

Specifically, the proposed changes would (i) amend 16VAC5-70-10 by replacing "mail" with "Internet, telephone" as ways to file interstate claims and removing a requirement that claims be filed "in field offices, at an itinerant point or by mail;" (ii) amend 16VAC5-70-20 B to add "A combined wage claim can only be established if there are base period wages in the paying state;" and (iii) amend 16VAC5-70-20 E to remove three paper-based verification and recordkeeping requirements for paying and transferring states.

VEC reported that the proposed change to 16VAC5-70-20 B would not affect eligibility for interstate claims since there were no changes to the interstate agreement. Rather, these changes were prompted by changes in procedure in handling interstate claims such as automation in SIDI/IBIQ.[4] Similarly, the changes to 16VAC5-70-20 E only remove paper-based requirements that are now obsolete.

Estimated Benefits and Costs. The proposed changes benefit claimants to the extent that the underlying modernization and automation has made the claim filing process more secure, reliable, and convenient. Some applicants would benefit by being able to submit interstate unemployment insurance claims via phone or email rather than mail. Some applicants may be made worse off by no longer being able to send claims through the mail; however, VEC reports that the shift from mail to email and telephone are part of an effort to increase efficiency and as such would be expected to benefit applicants by reducing processing times. VEC has not indicated any economic impact to its own operations as a result of these changes.[5]

Other states involved in interstate claims in Virginia would benefit from not having to send paperwork to Virginia for verification or recordkeeping, and VEC would likely benefit from not having to process and store hard-copies of that paperwork. These benefits have likely started to be realized since these changes have already been implemented through the automation in the SIDI/IBIQ processes.

Lastly, since the proposed changes are intended to conform the regulation to current practice, the primary benefits of the proposed changes would be to update the regulation and provide greater clarity regarding Virginia's regulatory requirements with respect to interstate and multistate claims.

Businesses and Other Entities Affected. The proposed amendments affect individuals filing interstate or multistate unemployment insurance claims in the Commonwealth as well as all 49 other states that might be party to an interstate or multistate claim.

The Code of Virginia requires DPB to assess whether an adverse impact may result from the proposed regulation.[6] An adverse impact is indicated if there is any increase in net cost or reduction in net revenue for any entity, even if the benefits exceed the costs for all entities combined. As noted, the proposed changes are expected to increase flexibility and efficiency for applicants, and reduce paperwork for other states' employment agencies. Thus, an adverse impact is not indicated.

Small Businesses[7] Affected.[8] The proposed amendments do not affect requirements for small businesses at all. Thus they would not adversely affect small businesses.

Localities[9] Affected.[10] The proposed amendments would not affect any locality in particular or create new costs for any local government. Consequently, an adverse economic impact is not indicated for localities.

Projected Impact on Employment. The proposed amendments do not appear to affect total employment. The closure of local field offices may have reduced employment; however, those changes have been implemented as part of a broader modernizing process and would not result from the changes proposed here.

Effects on the Use and Value of Private Property. The proposed changes do not affect employers and thus would not affect the value of private property. The proposed amendments do not affect real estate development costs.

[1]Section 2.2-4007.04 of the Code of Virginia requires that such economic impact analyses determine the public benefits and costs of the proposed amendments. Further the analysis should include but not be limited to: (1) the

projected number of businesses or other entities to whom the proposed regulatory action would apply, (2) the identity of any localities and types of businesses or other entities particularly affected, (3) the projected number of persons and employment positions to be affected, (4) the projected costs to affected businesses or entities to implement or comply with the regulation, and (5) the impact on the use and value of private property.

[2]See https://www.dol.gov/agencies/eta/wioa for information on the Workforce Innovation and Opportunity Act.

[3]These systems appear to have been first introduced in the middle 1990s and early 2000s; see https://oui.doleta.gov/dmstree/uipl/uipl94/uipl_1794.htm and https://oui.doleta.gov/dmstree/uipl/uipl2k5/uipl_0105.htm for memos relating to the rollout of internet-based applications for these processes.

[4]Email from VEC, June 24, 2022.

[5]Agency Background Document, page 5. See https://townhall.virginia.gov/l/GetFile.cfm?File=108\5957\9616\AgencyStatement_VEC_9616_v1.pdf.

[6]Pursuant to § 2.2-4007.04 D: In the event this economic impact analysis reveals that the proposed regulation would have an adverse economic impact on businesses or would impose a significant adverse economic impact on a locality, business, or entity particularly affected, the Department of Planning and Budget shall advise the Joint Commission on Administrative Rules, the House Committee on Appropriations, and the Senate Committee on Finance. Statute does not define "adverse impact," state whether only Virginia entities should be considered, nor indicate whether an adverse impact results from regulatory requirements mandated by legislation.

[7]Pursuant to § 2.2-4007.04, 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."

[8]If the proposed regulatory action may have an adverse effect on small businesses, § 2.2-4007.04 requires that such economic impact analyses include: (1) an identification and estimate of the number of small businesses subject to the proposed regulation, (2) the projected reporting, recordkeeping, and other administrative costs required for small businesses to comply with the proposed regulation, including the type of professional skills necessary for preparing required reports and other documents, (3) a statement of the probable effect of the proposed regulation on affected small businesses, and (4) a description of any less intrusive or less costly alternative methods of achieving the purpose of the proposed regulation. Additionally, pursuant to § 2.2-4007.1 of the Code of Virginia, if there is a finding that a proposed regulation may have an adverse impact on small business, the Joint Commission on Administrative Rules shall be notified.

[9]"Locality" can refer to either local governments or the locations in the Commonwealth where the activities relevant to the regulatory change are most likely to occur.

[10]Section 2.2-4007.04 defines "particularly affected" as bearing disproportionate material impact.

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 amendments conform regulation to agency practice and procedure, remove obsolete information, accurately reflect the current claims filing process as the agency moves away from local offices and modernizes its claim filing process, and update forms required by the regulation.

16VAC5-70-10. Cooperative agreement.

A. This section shall govern the commission in its administrative cooperation with other states adopting a similar regulation for the payment of benefits to interstate claimants.

B. A week of unemployment for an interstate claimant shall consist of any week of unemployment as defined in the law of the liable state from which benefits with respect to such week are claimed.

C. Each interstate claimant shall be registered for work through any public employment office in the agent state when and as required by the law, regulations, and procedures of the agent state. Such registration shall be accepted as meeting the registration requirements of the liable state.

Each agent state shall duly report to the liable state in question whether each interstate claimant meets the registration requirements of the agent state.

D. If a claimant files a claim against any state and it is determined by such state that the claimant has available benefit credits in such state, then claims shall be filed only against such state as long as benefit credits are available in that state. Thereafter, the claimant may file claims against any other state in which there are available benefit credits. For the purposes of this chapter, benefit credits shall be deemed to be unavailable whenever benefits have been exhausted, terminated, or postponed for an indefinite period or for the entire period in which benefits would otherwise be payable or whenever benefits are affected by the application of a seasonal restriction.

E. Claims for benefits or a waiting period shall be filed by interstate claimants by ~~mail~~ Internet, telephone, or other such means as the commission may authorize.

Claims shall be filed in accordance with agent state regulations for intrastate claims ~~in field offices, at an itinerant point or by mail~~.

1. With respect to claims for weeks of unemployment in which an individual was not working for ~~his~~ the individual's regular employer, the liable state shall, under circumstances which it considers good cause, accept a continued claim filed up to one week or one reporting period late. If a claimant files more than one reporting period late, an initial claim shall be used to begin a claim series and no continued claim for a past period shall be accepted.

2. With respect to weeks of unemployment during which an individual is attached to ~~his~~ the individual's regular employer, the liable state shall accept any claim which is filed within the time limit applicable to such claims under the law of the agent state.

F. The agent state shall, in connection with each claim filed by an interstate claimant, ascertain and report to the liable state in question such facts relating to the claimant's availability for

work and eligibility for benefits as are readily determinable in and by the agent state. The liable state may utilize the telephone or mail to directly ascertain facts from the parties.

The agent state's responsibility and authority in connection with the determination of interstate claims shall be limited to investigation and reporting of relevant facts. The agent state shall not refuse to take an interstate claim.

G. The agent state shall afford all reasonable cooperation in the holding of hearings in connection with appealed interstate benefit claims.

With respect to the time limits imposed by the law of a liable state upon the filing of an appeal in connection with a disputed benefit claim, an appeal made by an interstate claimant shall be deemed to have been made and communicated to the liable state on the date when it is received by any qualified officer of the agent state, or the date it was mailed by the claimant, whichever is earlier.

H. This section shall apply in all its provisions to claims taken in and for Canada.

16VAC5-70-20. Interstate cooperation.

A. This section, approved by the Secretary of Labor pursuant to § 3304(a)(9)(B), Federal Unemployment Tax Act and adopted under § 60.2-609 of the Code of Virginia, shall govern the Virginia Employment Commission in its administrative cooperation with other states relating to the Interstate Arrangement for Combining Employment and Wages.

B. A claim for benefits shall be filed by a combined-wage claimant in the same manner as by a claimant who is eligible for benefits under the unemployment insurance law of the paying state. An initial combined-wage claim may be canceled if the cancellation request is made within the appeal period shown on the monetary determination. The request for cancellation must be submitted in writing. A combined wage claim can only be established if there are base period wages in the paying state.

C. Benefits, in all cases, shall be paid to a combined-wage claimant from the unemployment insurance fund of the paying state, and all benefit rights shall be determined by the paying state pursuant to its unemployment insurance law.

D. Wages paid by the paying state to a claimant during the paying state's applicable base period, including wages reported for that period by a transferring state as available for the payment of benefits under the arrangement, shall be included by the paying state in determining such claimant's benefit rights.

Wages, once they have been transferred and used in a determination ~~which~~ that established monetary eligibility for benefits in the paying state, shall be unavailable for determining monetary eligibility for benefits under the unemployment insurance law of the transferring state, except to the extent that wages are usable for redetermination purposes.

E. Each state, with respect to any combined-wage claimant, in utilizing forms approved by the Interstate Benefit Payment Committee, shall:

~~1. Promptly request any other state in which the claimant has worked to furnish a report of the claimant's unused covered wages during the base period of the paying state as well as his current eligibility under the law of such state.~~

~~2. When acting as the transferring state, report promptly upon the request of any state the amount of any claimant's unused covered wages during the applicable base period and the current monetary eligibility of such claimant under the law of the transferring state.~~

~~3. When acting as the paying state, send to each transferring state a copy of the initial determination, together with an explanatory statement.~~

~~4.~~ 1. When acting as the paying state, send to the claimant a copy of the initial determination, noting his rights to appeal.

~~5.~~ 2. When acting as the paying state, send to each transferring state a statement of the benefits chargeable to each state. This is done at the end of each quarter in which any benefits have been paid, and each statement shall include the benefits paid during such quarter as to each combined-wage claimant. The ratio of each charge to total benefits paid shall be equal to the ratio of the wages reported by the transferring state (and used in the monetary determination) to the total wages used in the determination.

F. A transferring state shall, as soon as practicable after receipt of a statement as set forth in subsection E of this section, reimburse the paying state accordingly.

G. A claimant's wages shall not be combined, notwithstanding any other provision of this arrangement, if the paying state finds that based on combined wages the claimant would be ineligible for benefits. Wages reported by the transferring state shall in such event be returned to and reinstated by such state. The provisions of the interstate benefit payment arrangement shall apply to each claimant.

H. Whenever this plan applies, it will supersede any inconsistent provision of the Interstate Benefit Payment Plan and the regulation thereunder.

NOTICE: The following forms used in administering the regulation have been filed by the agency. Amended or added forms are reflected in the listing and are published following the listing. Online users of this issue of the Virginia Register of Regulations may also click on the name to access a form. The forms are also available from the agency contact or may be viewed at the Office of Registrar of Regulations, 900 East Main Street, 11th Floor, Richmond, Virginia 23219.

FORMS (16VAC5-70)

~~Initial Interstate Claim, IB-1 (rev. 11/88)~~

~~Continued Interstate Claim, IB-2 (rev. 6/89).~~

~~Claimant/Employer Separation Statement, IB-3 (rev. 6/88).~~

~~Request for Transfer of Wages Interstate Arrangement Statement for Combining Employment and Wages, IB-4 (rev. 6/88).~~

~~Instructions for Self-Filing Interstate Claims, IB-ISF (rev. 5/90).~~

~~Interstate Internet Information Sheet, IB-7 (rev. 6/89).~~

~~Interstate Eligibility Review, IB-10 (rev. 6/88).~~

~~Interstate Report of Job Search Verification, IB-10B (eff. 8/82).~~

~~Interstate Tracer, IB-12 (rev. 10/79).~~

~~Interstate Memorandum, IB-13 (rev. 1/60).~~

~~Interstate Request for Reconsideration of Monetary Determination/Wage Credits, IB-14 (rev. 6/89)~~.

~~Request for Claim Status Information, IB-15 (rev. 4/81).~~

~~Interstate Change of Address, IB-16 (rev. 8/83).~~

~~Speed Message, IB-20 (rev. 5/76).~~

~~Important Information for Interstate Claimants.~~

~~Important Notice to Combined Wage Claimants, VEC-CW-30 (rev. 5/85).~~

~~Benefit Payment Audit, IB-8605 (rev. 5/87).~~

~~Notice of Wage Transfer Determination, VEC-CW-54 (rev. 2/93)~~

Initial Interstate Claim, VEC 2025 IB-1 (rev. 6/2022)

Interstate Request for Reconsideration of Monetary Determination/Wage Credits, VUIS IB-14 (rev. 9/2017)

Notice of Wage Transfer Determination, VEC-CW-54 (rev. 7/2016)

Combined Wage Claim Cancellation Request, VEC-CW-31 (rev. 3/1994)

VA.R. Doc. No. R23-7205; Filed October 27, 2022, 11:07 a.m.

Fast-Track Regulation

Title of Regulation: **16VAC5-80. Adjudication (amending 16VAC5-80-10 through 16VAC5-80-40).**

Statutory Authority: §§ 60.2-111 and 60.2-623 of the Code of Virginia.

Public Hearing Information: No public hearing is currently scheduled.

Public Comment Deadline: January 4, 2023.

Effective Date: January 19, 2023.

Agency Contact: Jacob Shuford, Regulatory Coordinator, Virginia Employment Commission, 6606 West Broad Street, Henrico, VA 23230, telephone (804) 486-2360, FAX (804) 786-9034, or email jacob.shuford@vec.virginia.gov.

Basis: Statutory authority for the Virginia Employment Commission to promulgate such regulatory action is derived from §§ 60.2-113, 60.2-611, and 60.2-612 of the Code of Virginia, which authorize the commission to adopt, amend, or repeal regulations as necessary, including methods of procedure and changes in procedure in handling interstate claims.

Purpose: The commission must take all necessary steps to aid employment stabilization in the Commonwealth of Virginia under its duty to administer the Virginia Unemployment Compensation Act (§ 60.2-100 et seq. of the Code of Virginia) for the welfare of the citizens of the Commonwealth through unemployment benefits, labor exchange system, job services programs, and solvency of the administered trust fund. Adapting to the shift away from brick and mortar local offices through an increased utilization of technology and stream lining of claim filing processes are necessary to gain efficiency in the pursuit of those mandated goals.

Rationale for Using Fast-Track Rulemaking Process: This action is noncontroversial because the proposed changes are intended to conform the regulation to current practice and the primary benefits of the proposed changes would be to update the regulation to provide accurate information regarding Virginia's regulatory requirements with respect to the appeals process for unemployment claims determinations.

Substance: Amendments (i) update the deputy's determinations or decisions; (ii) clarify methods for gathering information to determine benefit eligibility or qualification and mailing requirements; (iii) update language to conform to statute; (iv) adjust hearing requirements; (v) update the appeals process; (vi) adjust hearings and allow parties to submit affidavits in lieu of a personal appearance at hearings scheduled for additional evidence issues, such as reopening of an appeals examiner's hearing or timeliness of an appeal to the Office of Commission Appeals; and (vii) update forms required by the regulation.

Issues: The primary advantage to the public is more clarity to the flow of information in the modernized processes, practices, and procedures used by the agency. There are no disadvantages to the public. The Commonwealth will benefit by ensuring processes, practices, and procedures are accurately represented in the regulations. There are no disadvantages to the agency.

Department of Planning and Budget's Economic Impact Analysis:

The Department of Planning and Budget (DPB) has analyzed the economic impact of this proposed regulation in accordance with § 2.2-4007.04 of the Code of Virginia (Code) and Executive Order 14 (as amended, July 16, 2018). The analysis

presented represents DPB's best estimate of these economic impacts.[1]

Summary of the Proposed Amendments to Regulation. The Virginia Employment Commission (VEC) seeks to make a number of discretionary changes to 16VAC5-80, Adjudication, that would conform the regulation to current practice.

Background. VEC proposes to update the regulation to reflect how appeals for unemployment benefit decisions are currently handled. VEC reports that some of the proposed changes have been phased in over time while many took place with the implementation of the new online system, Virginia Unemployment Information System in late 2021.[2] Although the regulation was last updated in 2002, VEC reports that individuals filing unemployment insurance claims could access information on the current policies and requirements via the VEC website.[3] As a matter of practical use for both employers and claimants, the information provided on the VEC website contains greater detail than the regulation. Rather than add all of these details to the regulation, the proposed amendments would mainly update outdated and incorrect information, clarify ambiguous language, and update the list of forms at the end of the chapter.

In addition, the 2014 federal Workforce Innovation and Opportunity Act required significant changes to VEC operations and service delivery. VEC reports that these changes included closing VEC local offices and offering services through "One-Stop" service centers operated with mandated partners and local Workforce Development Boards.[4] As a result, references to local offices are obsolete, meetings have been replaced with telephone calls in various instances, and appeals are further streamlined within the Commission's Administrative Law Division between the Office of First Level Appeals and the Office of Commission Appeals. The proposed amendments would also update the regulation to reflect these administrative changes.

The most substantive changes are as follows:

16VAC5-80-10 Deputy's determinations or decisions would be amended to reflect that predetermination fact-finding proceedings may be conducted with a deputy when it is "deemed necessary by the commission in order to resolve an outstanding issue on a claim," whereas the current language states that such proceedings may be conducted "whenever a request is made by the claimant, his liable employer, or his interested subsequent employing unit, for the purpose of gathering information to determine benefit eligibility or qualification." The option to conduct the proceeding in person would be removed, so that the only remaining option would be to conduct the proceeding telephonically.

In general, changes are proposed to reflect the flow of information in new, modernized systems and better align with regulations of the United States Department of Labor (USDOL). VEC states that the USDOL, "has set Core Measures" for Unemployment Insurance Program Performance. To the best of [our] knowledge, these Core Measures are not enforced with penalties, however, the Agency seeks to adhere to DOL best practices whenever possible."[5]

16VAC5-80-20 First level appeals would be updated throughout such that "the Administrative Law Division" would be replaced with "the Administrative Law Division's Office of First Level Appeals." The information to be provided on a written appeal would be updated to match the information currently required on the appeal form (name and last four digits of the claimant's social security number). In-person or split meetings, which would have been scheduled at the "regional adjudication center most convenient for the party who will be appearing in person" (or at VEC's discretion) at any other convenient location" under the current language would now be scheduled "at a location administratively feasible for the commission" under the proposed language.

VEC has clarified that the Administrative Law Division no longer has funds to schedule an in person hearing "at any other convenient location, provided the alternate location does not cause undue hardship or unreasonable travelling expenses to the party participating in person."[6] VEC specifically reported that, "Our current organizational concept, budget realities and growing reliance on telephonic hearings and our centralized adjudication center dictates this change."

16VAC5-80-30 Commission review would be updated throughout such that "the Administrative Law Division" would be replaced with "the Administrative Law Division's Office of Commission Appeals." Under the current language the commission may permit oral arguments via telephone conference call "upon the consent of all interested parties;" the proposed language would only allow this at the commission's discretion. VEC also proposes to add that "Parties may submit affidavits in lieu of personal appearance at hearings scheduled for additional evidence issues such as reopening of an appeals examiner's hearing or timeliness of an appeal to the Office of Commission Appeals."

16VAC5-80-40 Oaths, subpoenas, ex parte communications, and approval of attorney's fees, the word "field" would be removed from "field tax representatives" to reflect the closure of field offices.

Estimated Benefits and Costs. Since the proposed changes are intended to conform the regulation to current practice, the primary benefits of the proposed changes would be to update the regulation to provide accurate information regarding Virginia's regulatory requirements with respect to the appeals process for unemployment claims determinations.

A number of proposed changes would grant greater discretion to VEC regarding whether to schedule predetermination screening proceedings, the location of in-person hearings, and whether hearings are conducted in-person or via telephone conference calls. These changes may make the appeals process

less flexible for claimants or employers, and inconvenience those who may previously have requested an in-person meeting at the local field office closest to them. However, such impact would not result from the regulatory changes proposed here but rather the effort that have already been implemented to streamline VEC's operations and service delivery and make it more efficient. Lastly, these broader efforts to streamline VEC service delivery and make it more efficient may benefit claimants and employers to the extent that it allows for faster resolution of appeals.

Businesses and Other Entities Affected. The proposed amendments affect individuals or their employers who seek to appeal a decision or determination in an unemployment insurance claim, including those seeking to escalate a first level appeal to a commission appeal.

The Code of Virginia requires DPB to assess whether an adverse impact may result from the proposed regulation.[7] An adverse impact is indicated if there is any increase in net cost or reduction in net revenue for any entity, even if the benefits exceed the costs for all entities combined. As noted, the proposed changes may reduce flexibility for some claimants and employers, but are part of a broader process change that likely benefits claimants and employers to the extent that it allows for greater efficiency in appeals resolution. Thus, an adverse impact is not indicated.

Small Businesses[8] Affected.[9] The proposed amendments do not affect requirements for small businesses that are involved in an unemployment insurance claim. Thus they would not adversely affect small businesses.

Localities[10] Affected.[11] The proposed amendments would not affect any locality in particular or create new costs for any local government. Consequently, an adverse economic impact is not indicated for localities.

Projected Impact on Employment. The proposed amendments do not appear to affect total employment. The closure of local field offices may have reduced employment; however, those changes have been implemented as part of a broader modernizing process and would not result from the changes proposed.

Effects on the Use and Value of Private Property. The proposed changes do not create new costs for businesses and thus would not affect the value of private property. The proposed amendments do not affect real estate development costs.

[1]Section 2.2-4007.04 of the Code of Virginia requires that such economic impact analyses determine the public benefits and costs of the proposed amendments. Further the analysis should include but not be limited to: (1) the projected number of businesses or other entities to whom the proposed regulatory action would apply, (2) the identity of any localities and types of businesses or other entities particularly affected, (3) the projected number of persons and employment positions to be affected, (4) the projected costs to affected businesses or entities to implement or comply with the regulation, and (5) the impact on the use and value of private property.

[2]See https://www.vec.virginia.gov/node/13530.

[3]See https://www.vec.virginia.gov/appeals, https://www.vec.virginia.gov/unemployed/Claimant-Handbook/Appeal-Rights, and https://www.vec.virginia.gov/unemployed/appeals/faq.

[4]See https://www.dol.gov/agencies/eta/wioa for information on the Workforce Innovation and Opportunity Act.

[5]VEC email dated June 23, 2022. The USDOL standards can be found here: Core_Measures.pdf (doleta.gov)

[6]VEC email dated June 28, 2022.

[7]Pursuant to § 2.2-4007.04 D: In the event this economic impact analysis reveals that the proposed regulation would have an adverse economic impact on businesses or would impose a significant adverse economic impact on a locality, business, or entity particularly affected, the Department of Planning and Budget shall advise the Joint Commission on Administrative Rules, the House Committee on Appropriations, and the Senate Committee on Finance. Statute does not define "adverse impact," state whether only Virginia entities should be considered, nor indicate whether an adverse impact results from regulatory requirements mandated by legislation.

[8]Pursuant to § 2.2-4007.04, 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."

[9]If the proposed regulatory action may have an adverse effect on small businesses, § 2.2-4007.04 requires that such economic impact analyses include: (1) an identification and estimate of the number of small businesses subject to the proposed regulation, (2) the projected reporting, recordkeeping, and other administrative costs required for small businesses to comply with the proposed regulation, including the type of professional skills necessary for preparing required reports and other documents, (3) a statement of the probable effect of the proposed regulation on affected small businesses, and (4) a description of any less intrusive or less costly alternative methods of achieving the purpose of the proposed regulation. Additionally, pursuant to § 2.2-4007.1 of the Code of Virginia, if there is a finding that a proposed regulation may have an adverse impact on small business, the Joint Commission on Administrative Rules shall be notified.

[10]"Locality" can refer to either local governments or the locations in the Commonwealth where the activities relevant to the regulatory change are most likely to occur.

[11]Section 2.2-4007.04 defines "particularly affected" as bearing disproportionate material impact.

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 amendments (i) update claim filing processes as the agency increasingly moves away from local offices and into a modernized claim filing process; (ii) reflect operational structure changes for increased efficiency, such as altering the continued and weekly claim filing deadline; and (iii) update forms required by the regulation.

16VAC5-80-10. Deputy's determinations or decisions.

A. Whenever, after a claim is filed, a deputy obtains information from a claimant, employer, or third party ~~which~~ that could affect the claimant's entitlement to benefits, ~~he~~ the deputy shall initiate further investigation. The deputy may contact the parties ~~in person or by telephone~~ to obtain information. Documentary evidence prepared specifically for the claim or for other purposes may be considered by the

deputy. Any party to an investigation may be represented by counsel or a duly authorized representative. No information or evidence shall be considered by the deputy unless the claimant has been given the opportunity to see or hear it and comment upon it. Information concerning eligibility or qualification for benefits shall be entered into commission records.

B. A predetermination fact-finding proceeding may be ~~scheduled by the~~ conducted with a deputy ~~whenever a request is made by the claimant, his liable employer, or his interested subsequent employing unit, for the purpose of gathering information to determine benefit eligibility or qualification. Notice of the date, time and location will be mailed to the parties five days before the scheduled proceeding, but such notice may be waived with the parties' consent~~ when deemed necessary by the commission in order to resolve an outstanding issue on a claim.

The proceeding may be conducted telephonically ~~or in person~~ with the deputy presiding. This informal interview shall not be recorded in any way, although notes can be taken by the deputy. Statements made by parties or witnesses shall not be taken under oath and formal examination or cross-examination shall not be permitted. The deputy shall direct questions to the parties and witnesses. ~~The parties may also ask questions of each other and the witnesses.~~ Rebuttal to statements made by opposing parties or witnesses shall be permitted. Any party to a predetermination proceeding may be represented by counsel or other duly authorized agent. The record of facts of the proceeding shall become a part of the commission's records.

C. As soon as possible following the acquisition of facts necessary to make a determination or decision, either from the parties' submissions or from a predetermination proceeding, the deputy shall render a determination or decision in writing which shall include the effective date of any qualification or disqualification, the dates of any eligibility or ineligibility, the law or regulation upon which the determination or decision is based, and the reasons for the determination or decision, together with information concerning the filing of an appeal. This determination or decision shall be promptly delivered or mailed to the parties at their last known addresses or designated point of contact.

16VAC5-80-20. First level appeals.

A. The claimant, ~~his~~ the claimant's liable employer, or any subsequent employing unit with a direct interest in an issue may appeal from an adverse deputy's determination or decision as specified in § 60.2-619 of the Code of Virginia.

1. Appeals shall be filed with the commission's Administrative Law ~~Division~~ Division's Office of First Level Appeals in one of the following ways:

a. In person at any agency service location, including ~~field offices~~ workforce, ~~regional~~ adjudication ~~centers~~, or one-stop centers, or the commission's administrative office in Richmond, Virginia;

b. By mail to the Administrative Law ~~Division~~ Division's Office of First Level Appeals at the address specified on the deputy's determination or decision;

c. By facsimile transmission to the Administrative Law ~~Division~~ Division's Office of First Level Appeals at the facsimile number specified on the deputy's determination or decision; or

d. By the Internet at a site or address specified by the commission.

2. Appeals shall be presumed to be filed on the date of receipt by the commission. An appeal mailed to the commission shall be presumed to be filed on the date of postmark by the United States Postal Service. If no postmark appears on the envelope, the appeal shall be presumed to be filed on the date it was received by the commission.

3. Appeals shall be in writing and should set forth the grounds upon which they are sought, as well as the name and last four digits of the social security account number of the claimant; however, any document in writing submitted to the commission by a party or ~~his~~ a party's authorized representative expressing a desire to appeal shall be sufficient to initiate an appeal. Agency personnel shall furnish an appellant or ~~his~~ an appellant's authorized representative whatever assistance is necessary to file an appeal. The appeal should be signed by the appealing party or that party's authorized representative; however, the absence of a signature shall not result in the dismissal of the appeal.

B. After the filing of an appeal, the record in connection with the claim, together with the notice of appeal, shall be assigned to an appeal tribunal consisting of a salaried examiner only. Should evidence indicate that the appeal was not filed within the time prescribed by law, the first issue to be considered at the hearing shall be whether the appeal was timely filed or whether there exists good cause for extending the appeal period.

1. Except as otherwise provided ~~herein~~ in this chapter, all hearings shall be conducted by telephone conference call. At the discretion of the commission, a split hearing or an in-person hearing may be scheduled if the complexity of the case or the quality of telephone service in a particular locality makes participation in the hearing unreasonably difficult. A split or in-person hearing will be scheduled if a party does not have reasonable access to a telephone that would permit meaningful participation in a telephonic hearing. In assessing the complexity of a particular case, the commission shall consider the number of witnesses involved, the number and length of any documents that will likely be proposed as exhibits, whether one or both parties are represented, whether an interpreter is required, and any other relevant factors. In-person or split hearings shall be scheduled ~~for the regional adjudication center that is most convenient for the party who will be appearing in person. At~~

~~the discretion of the commission, an in-person or split hearing may also be scheduled at any other convenient location, provided that the alternate location does not cause undue hardship or unreasonable travelling expenses to the party participating in person~~ at a location administratively feasible for the commission.

2. Any party who desires to appear in person for the hearing shall be permitted to do so provided a timely request is received by the commission. A request shall be deemed timely if it is received by the commission before the scheduled hearing convenes. If a request to appear in person is received after the hearing has been convened, the presiding appeals examiner may grant or deny the request based upon consideration of all relevant circumstances. A request by a party to appear in person shall not require any other party to also appear in person; however, any other parties to the proceeding should be promptly informed of the request for in-person participation and be given the opportunity to participate in person if the commission grants a party's in person hearing request.

3. A hearing that is postponed or continued to accommodate a request for in-person participation shall be rescheduled as soon as administratively feasible.

4. A notice of hearing shall be mailed to all parties and their known authorized representatives at least 10 days in advance of the hearing. The hearing notice shall set forth the particular statutory provisions and regulations that must be considered to resolve the case. The appeals examiner may consider any other applicable issues ~~which~~ that are raised or become evident during the course of the hearing provided that all parties in interest are present and all agree on the record to waive the 10-day notice requirement with respect to such new issue. The appeals examiner may refer a new issue to the deputy if it has not been ruled upon at that level and may, upon ~~his~~ the appeals examiner's own motion, postpone or continue the case if a new issue has become evident and it is necessary to give proper written notice in order to proceed.

C. The Office of First Level Appeals (First Level Appeals) shall endeavor to schedule hearings as soon as possible in the order in which appeals are received. Special requests regarding dates or times of hearings will be given consideration; however, they need not always be honored. Requests for postponement of scheduled hearings shall be granted only when a party or ~~his~~ the party's authorized representative demonstrates good cause for an inability to appear at the scheduled date and time. Good cause shall be deemed to exist if a likelihood of material and substantial harm is shown. Postponements may be granted only by the Chief Appeals Examiner or the Chief Appeals Examiner's designee, the Clerk of the ~~Commission's~~ Commission for First Level Appeals, the examiner assigned to hear the case, or an appeals examiner acting in charge of the Office of First Level Appeals, although they may be communicated to the parties by other authorized persons. A postponed hearing may be rescheduled without notice if all parties in interest agree. Otherwise, notice of a postponed hearing shall be given as if it were a new hearing.

D. Once a hearing has commenced, it may be continued only by the presiding appeals examiner, either upon ~~his~~ the presiding appeals examiner's own motion or that of a party. Continuances may be granted in situations where~~:~~ (i) there is insufficient time to properly hear the evidence; or (ii) unexpected or unavoidable circumstances arise during the course of a hearing ~~which~~ that require a continuance in order to protect the substantive or procedural rights of the parties.

A continued hearing may be rescheduled by the presiding appeals examiner without written notice if all parties in interest are present and all concur. Otherwise, notice of a continued hearing shall be given as if it were a new hearing.

E. If the appellant wishes to withdraw ~~his~~ the appeal, a request, together with the reasons therefor, must be made in writing and sent to the Clerk of the ~~Commission's~~ Commission of First Level Appeals at the commission's administrative office in Richmond, Virginia. The request will be granted only if the Chief Appeals Examiner, the Chief Appeals Examiner's designee, or the appeals examiner assigned to hear the case is satisfied that:

1. The appellant understands the effect that withdrawal will have upon benefit entitlement, potential benefit charges, and potential overpayment;

2. The request is not the result of any coercion, collusion, or illegal waiver of benefits prohibited under § 60.2-107 of the Code of Virginia; and

3. The appealed determination is not clearly erroneous based upon the existing record.

Once granted, a withdrawal cannot be rescinded unless an evidentiary hearing on the issue of rescission is held before an appeals examiner, and the former appellant demonstrates that the criteria required for withdrawal were not fully met. A request to rescind a withdrawal must be filed with the commission within 30 days from the issuance of the Order of Dismissal or the discovery of information that would establish that withdrawal criteria were not met.

F. In any hearing before an appeals examiner, all testimony shall be taken under oath or affirmation and a record of the proceedings shall be made by the presiding appeals examiner who shall inform all parties of this fact. No other recording of the proceedings other than that specifically authorized by the Virginia Unemployment Compensation Act (§ 60.2-100 et seq. of the Code of Virginia) shall be permitted.

The appeals examiner shall conduct the hearing in such a manner as to ascertain the substantive rights of the parties without having to be bound by common law, statutory rules of evidence, or technical rules of procedure. In addition to

testimony, the appeals examiner may accept relevant documents or other evidence into the record as exhibits, upon the motion of a party.

1. Where a party is unrepresented, the appeals examiner shall assist that party in presenting his case and testing the case of the opposing party.

2. At any hearing before an appeals examiner, an interested party may appear in person, by counsel, or by an authorized representative. All such persons will be permitted to attend the entire hearing.

3. An employer shall be permitted one representative, in addition to counsel or duly authorized agent, who may attend the entire proceeding. The appeals examiner shall exclude any other witnesses from the hearing until such time as their testimony is to be taken. Observers may be permitted to attend the hearing so long as there is no objection by a party.

4. The appeals examiner shall control the order of proof, rule upon the admission of evidence, and may examine and cross-examine witnesses. The examiner shall have the authority to maintain order and eject disruptive or unruly individuals. At a hearing, the parties, counsel, or duly authorized representatives shall be given an opportunity to cross-examine witnesses, to inspect documents, and to offer evidence in explanation and rebuttal. On motion of the appeals examiner, or any party, documents already in a claimant's file or obtained during the course of a hearing may be admitted into the record as exhibits provided they are relevant to the issues in dispute. Before the hearing is closed, the parties shall be given an opportunity to present oral argument on all the issues of law and fact to be decided. In addition, the appeals examiner may permit the parties to submit written arguments.

G. The decision of the appeals examiner shall be reduced to writing and shall state the issues, findings of fact, opinion or reasons for the decision, and final judgement of the examiner. A copy of the decision shall be mailed to each of the interested parties and their known representatives who have requested to be notified of the decision. If the decision is rendered by an appeals examiner other than the one who presided at the hearing, that examiner shall review the record of the hearing and so state in the decision.

H. If any party believes that the appeals examiner exhibits bias ~~towards~~ toward one or more parties in a case, a challenge to the interest of such appeals examiner shall be made promptly after the discovery of facts on which such challenge is based, but not later than the date on which the decision is issued. A challenge to the interest of the appeals examiner made during the course of the hearing shall be decided and ruled upon by the presiding appeals examiner. If the presiding appeals examiner grants the challenge and withdraws from the case, the appeals examiner shall adjourn the hearing and promptly return the case to the Clerk of the Commission for rescheduling before a different appeals examiner. If a party challenges the interest of an appeals examiner after the conclusion of the hearing, but before the decision is issued, the challenge shall be set forth in writing with the reasons therefor, and sent to the chief appeals examiner at the Administrative Office of First Level Appeals of the Commission in Richmond, Virginia. If the Chief Appeals Examiner or ~~his~~ the Chief Appeals Examiner's designee does not remove the challenged appeals examiner, the appeals examiner shall render a decision in the case. If the challenged appeals examiner is removed, is unavailable or chooses to withdraw, the Chief Appeals Examiner or ~~his~~ the Chief Appeals Examiner's designee shall decide the case. Failure to remove the appeals examiner shall be subject to review by the commission on appeal by the aggrieved party, in the same manner as any other issue in the case.

I. Any party who is unable to appear for the scheduled hearing, or who appeared but wishes to present additional evidence, may request a reopening of the case, which will be granted if good cause is shown. The request, together with the reasons therefor, shall be made in writing and sent to the Chief Appeals Examiner in the administrative office of the commission in Richmond, Virginia.

1. Where a request for reopening is received before the decision of the appeals examiner is issued, the decision shall be withheld if the Chief Appeals Examiner, the Chief Appeals Examiner's designee, or the appeals examiner assigned to the case, finds that the reasons given in the request, if proven, would establish good cause to reopen the hearing. In that event, a hearing will be scheduled on the reopening issue. If, after the hearing, the appeals examiner should decide that reopening is warranted, the case shall be reopened for the taking of additional evidence. If no reasons are given for the reopening request, or if the reasons given would not establish good cause to reopen the hearing, the appeals examiner shall render a decision denying the request and adjudicating the merits of the case. In any event, the decision concerning the issue of reopening shall be subject to review by the commission on appeal by the aggrieved party.

2. A request for reopening after the appeals examiner has issued ~~his~~ a decision on the merits of the case, but within the appeal period, shall be mailed to the Administrative Law Division's Office of Commission Appeals in the administrative office of the commission in Richmond, Virginia and shall set forth in writing the reasons therefor. If the commission is of the opinion that the written request establishes good cause for reopening, it shall remand the case to the Chief Appeals Examiner of First Level Appeals. If the commission is of the opinion that the written request does not set forth good cause for reopening, it shall treat the request as an appeal to the commission on the merits of the case pursuant to this part. The commission may, in its discretion, schedule a hearing to receive evidence with

respect to a reopening request or remand the case to the appeals examiner to hear and decide the reopening issue.

3. Once a decision is rendered and becomes final, it cannot be reopened for any reason. A request for a reopening after the decision of the appeals examiner has become final shall be treated as an untimely appeal to the commission pursuant to this chapter. In the discretion of the commission, a hearing on the issue of reopening may be held.

16VAC5-80-30. Commission review.

A. The claimant, ~~his~~ the claimant's liable employer, or any subsequent employing unit with a direct interest in an issue may appeal from an adverse appeals examiner's decision as provided in § 60.2-620 of the Code of Virginia.

1. Appeals should be filed with the commission's Administrative Law ~~Division~~ Division's Office of Commission Appeals, in one of the following ways:

a. In person at any agency service location, including ~~field offices, regional~~ its workforce or adjudication centers, one-stop centers, or the commission's administrative office in Richmond, Virginia;

b. By mail to the Administrative Law ~~Division~~ Division's Office of Commission Appeals, at the address specified on the appeals examiner's decision;

c. By facsimile transmission to the Administrative Law ~~Division~~ Division's Office of Commission Appeals, at the facsimile number specified on the appeals examiner's determination or decision; or

d. By the Internet to the site or address specified by the commission.

2. Appeals shall be presumed to be filed on the date of receipt by the commission. An appeal mailed to the commission shall be presumed to be filed on the date of postmark by the United States Postal Service. If no postmark appears on the envelope, the appeal shall be presumed to be filed on the date it was received by the commission.

3. At any time before the decision of the appeals examiner becomes final, the commission may on its own motion assume jurisdiction of any case pending before an appeals examiner and place such case on the appeal docket of the commission. The commission may consider and review the case and affirm, modify, or set aside and vacate the decision of the appeals examiner on the basis of the evidence previously submitted as shown by the record, or may direct the taking of additional evidence before the commission or the appeals examiner. Such additional evidence may not be taken unless notice of the time and place of the taking thereof has been mailed to all parties to the case at least 10 days before such time.

4. If the appeal to the commission is not filed within the statutory time limit set forth in § 60.2-620 of the Code of Virginia, the appellant shall set forth in writing the reasons for the late filing. If the reasons set forth, if proven, would show good cause for extending the appeal period, the commission shall schedule a hearing to take testimony on the issue of good cause for late filing. If the reasons set forth in the notice of appeal are insufficient to show good cause for late filing, or if no reasons are provided, the appeal shall be dismissed and the decision of the appeals examiner shall become the final decision of the commission.

B. Except as otherwise provided by this chapter, all appeals to the commission shall be decided on the basis of a review of the evidence in the record. The commission, in its discretion, may direct the taking of additional evidence after giving written notice of such hearing to the parties, provided:

1. It is shown that the additional evidence is material and not merely cumulative, corroborative or collateral, could not have been presented at the prior hearing through the exercise of due diligence, and is likely to produce a different result at a new hearing; or

2. The record of the proceedings before the appeals examiner is insufficient to enable the commission to make proper, accurate, or complete findings of fact and conclusions of law.

A party wishing to present additional evidence or oral argument before the commission must file a written request within 14 days from the date of delivery or mailing of the Notice of Appeal. A request for a hearing shall be deemed to be filed on the date of receipt by the commission. A request for a hearing mailed to the Office of Commission Appeals shall be deemed to be filed on the date of postmark by the United States Postal Service. In such cases, the postmark date shall be conclusive as to the date of filing. The commission shall notify the parties of the time and place where additional evidence will be taken or oral argument will be heard. Such notice shall be mailed to the parties and their last known representatives at least 10 days in advance of the scheduled hearing. A request to present additional evidence will be granted only if the ~~aforementioned~~ guidelines in this section are met. A timely request for oral argument will be granted unless, after a review of the record of the case, the commission determines that the record is either defective or insufficient, under which circumstances the case may be remanded to the appeals examiner for further proceedings.

3. Except as otherwise provided ~~herein~~ in this chapter, commission level hearings shall be conducted in person at the administrative office for the agency's Administrative Law Division in Richmond, Virginia. ~~Upon the consent of all interested parties~~ In its discretion, the commission may permit oral argument and other hearings to be conducted by telephone conference call. All parties shall have the right to submit a written argument in lieu of participating in an oral argument hearing. Parties may also submit affidavits in lieu of a personal appearance at hearings scheduled for additional evidence issues such as reopening of an appeals examiner's

hearing or timeliness of an appeal to the Office of Commission Appeals. The commission may prescribe reasonable conditions for the submission of written arguments or affidavits.

4. Notwithstanding any other provision of this chapter, the commission shall have the authority to schedule a hearing on its own motion, to be conducted in person, by telephone conference call, or by split hearing, whenever it believes doing so would serve the ends of justice.

C. Postponements, continuances, and withdrawals of appeals before the commission shall be handled in the same manner as First Level Appeals, as set forth in this chapter, except that requests shall be made through the Office of Commission Appeals or through the special examiner assigned to hear the case. Only a special examiner shall have the authority to grant a postponement.

D. A transcript of the appeals examiner's hearing shall be provided to the parties whenever there has been a timely request for a hearing before the commission; provided, however, that no transcript need be provided if the purpose of the commission hearing is limited to receiving evidence to determine (i) whether the appeal was timely filed and, if not, whether good cause exists to extend the statutory appeal period or (ii) whether good cause exists to reopen the appeals examiner's hearing. A hearing before the commission for additional evidence shall be conducted under the same rules as outlined in subsection F of 16VAC5-80-20 for the conduct of First Level Appeals hearings, except that the party being granted the right to present additional evidence shall proceed first. If both parties are allowed to present additional evidence, the appellant shall proceed first. Oral argument shall commence with the appellant, allowing the appellee the chance to respond with oral argument and rebuttal, and close with the appellant in rebuttal.

E. The decision of the commission affirming, modifying, or setting aside any decision of an appeals examiner shall be in writing and shall be delivered or mailed to each party to the appeal as well as to their known representatives who have requested to be notified of the decision. The date of such notification shall be recorded on the commission's appeal docket.

F. Any party to an appeal before the commission who was unable to appear for the scheduled hearing may request a reopening of the matter. The request shall be in writing to the Office of Commission Appeals and shall set forth the basis upon which it is being made. If the commission is of the opinion that the reasons in the request show good cause to reopen, the request for reopening shall be granted. If the commission is of the opinion that the reasons given in the request do not show good cause, reopening shall be denied. In the discretion of the commission, a hearing on the issue of reopening may be held. Once a decision is rendered and has become final, the case may not thereafter be reopened for any reason.

G. If any party believes that the presiding special examiner exhibits bias, prejudice, a lack of impartiality, or has an interest in the outcome of the proceeding, a challenge to the special examiner's interest shall be promptly made after the discovery of the facts on which such challenge is based. A challenge to the interest of the special examiner may be made orally during a hearing or in writing before or after a hearing, but only prior to the date the commission's decision becomes final. If made before or at the hearing, all parties present shall be afforded an opportunity to address the merits of the challenge. The ruling may be made orally at the hearing or in writing after the hearing has been concluded. If the special examiner rules orally and denies the challenge, that ruling shall also be reduced to writing and included in the commission's final decision. If the special examiner grants the challenge, then the case shall be referred to the chief administrative law judge, or ~~his~~ the chief administrative law judge's designee, for reassignment. A challenge to the interest of the special examiner that is made after the hearing has been conducted shall be referred to the presiding special examiner for review and resolution; provided, however, that if the special examiner has already ruled on the challenge during the hearing or in a decision, the matter shall be referred to the chief administrative law judge for resolution. The commission may schedule a hearing to take evidence with respect to any challenge, or request the parties to submit affidavits, memoranda, or briefs with respect to the challenge.

A written challenge made before or after the hearing has been conducted shall be submitted to the Chief Administrative Law Judge, Administrative Law Division, Office of Commission Appeals, at the commission's administrative office in Richmond, Virginia. A party's disagreement with a procedural or evidentiary ruling is not a basis, standing alone, for challenging the interest of a special examiner.

16VAC5-80-40. Oaths, subpoenas, ex parte communications, and approval of attorney's fees.

A. The special examiner, the appeals examiner, and the Clerk of the Commission shall have the power to administer oaths, to take depositions, certify to official acts, issue subpoenas, compel the attendance of witnesses and the production of books, papers, correspondence, memoranda, and other records, and to take such action as may be necessary in any hearing.

B. Upon the request of any party to a proceeding, the Clerk of the Commission, in the name of the commission, may issue subpoenas requiring the attendance of witnesses at any designated time and place fixed by the special examiner or appeals examiner for the hearing of a claim or any issue therein.

Upon a written request of any party specifying with reasonable certainty any books, papers, correspondence,

memoranda, or other desired records, the Clerk of the Commission may issue a subpoena duces tecum requiring the production of such evidence at any designated time and place fixed by the special examiner or appeals examiner for the hearing of a claim or any issue therein.

A request for a subpoena ad testificandum or subpoena duces tecum may be denied if there is no showing of relevance to the subject of the appeal, if it appears that the request would only produce cumulative evidence or testimony, or if it appears that the request would not serve the interest of the party making it. If such request is denied, it may be renewed at the hearing and a proffer of evidence or testimony may be made. The appeals examiner or special examiner hearing the case shall continue the hearing if it appears that the subpoena should be issued.

C. Witnesses subpoenaed for appeals before the appeals examiner or the commission, or both, shall, upon request, be allowed expenses as provided in § ~~14.1-190~~ 17.1-612 of the Code of Virginia.

D. No party or authorized representative of a party shall confer, engage in ex parte communications, or otherwise communicate in any manner with the presiding appeals examiner or special examiner regarding substantive, procedural, or other matters that could be reasonably expected to influence the outcome of the case or case decision without first giving adequate notice to all other parties, and affording such other parties full opportunity to participate, or otherwise to make appropriate response to the substance of the communication. For the purpose of this subsection, the term "parties" shall include claimants and any employers or employing units that have a direct interest in the outcome of the pending case. Notice of an ex parte communication given to a party's attorney of record or duly authorized representative shall constitute notice to the party.

This provision shall not apply to deputies who conduct predetermination fact-finding proceedings on benefit eligibility issues, and ~~field~~ tax representatives who conduct audits and investigations regarding tax liability issues.

E. Approval of fees for representation of claimants.

1. Pursuant to § 60.2-123 of the Code of Virginia, no attorney or other individual representing a claimant before an officer of the commission may charge or receive a fee unless approved by the commission.

2. All fee requests shall be submitted to the Chief Administrative Law Judge or ~~his~~ the Chief Administrative Law Judge's designee. An attorney or other representative for a claimant shall, upon request, provide the commission with such information as it deems necessary to assess the reasonableness of the request submitted for approval. Such information may include~~, but shall not be limited to,~~ written fee agreements, invoices, and detailed summaries of services provided.

3. In assessing the reasonableness of an attorney's request for approval of a fee, the commission shall consider the Virginia Rules of Professional Conduct adopted by the Virginia Supreme Court, Part 6, II.

When applicable, these factors shall also be considered in approving a fee request from nonlawyer representatives. Notwithstanding these factors, no fee shall be approved that exceeds 25% of the claimant's maximum benefit amount.

4. No fee shall be approved until the agency determination or decision issued pursuant to § 60.2-619, 60.2-620, or 60.2-622 has become final, provided, however, that in those cases where an attorney or representative is representing a claimant through multiple stages of the administrative adjudication and appeal process, the commission may approve an interim fee award not to exceed the lesser of $400 or 10% of the claimant's maximum benefit amount.

NOTICE: The following forms used in administering the regulation have been filed by the agency. Amended or added forms are reflected in the listing and are published following the listing. Online users of this issue of the Virginia Register of Regulations may also click on the name to access a form. The forms are also available from the agency contact or may be viewed at the Office of Registrar of Regulations, 900 East Main Street, 11th Floor, Richmond, Virginia 23219.

FORMS (16VAC5-80)

~~Notice of Appeal Hearing, VEC-AE-1 (rev. 6/91).~~

~~Notice of Telephonic Hearing VEC-AE-1A (rev. 5/92).~~

~~Notice of Appeal VEC-AE-2 (rev. 6/91).~~

~~Request for Withdrawal of Appeal, VEC-AE-10 (rev. 6/1/66).~~

Notice of Telephonic Hearing Before an Appeals Examiner, A-FLA-028 (rev. 7/2012)

Notice of In-Person Hearing Before an Appeals Examiner, A-FLA-028 (rev. 7/2012)

Notice of First Level Appeals, A-FLA-002 (rev. 7/2012)

Notice of Claims Filed During Labor Dispute, VEC-AE-15 (rev. 7/1970)

~~Notice of Commission Hearing for Oral Argument, VEC-C-1 (rev. 6/90).~~

~~Notice of Commission Hearing for Additional Evidence, VEC-C-1A (rev. 6/90).~~

~~Employer Notice of Pre-Determination Proceeding, B-10EX.~~

~~Claimant Notice of Fact Finding Interview, B-10EXP.~~

~~Fact Finding Report, IB-11 (rev. 2/72).~~

~~Separation Fact Finding Report, IB-11S (rev. 10/79).~~

~~Claimant Notice of Predetermination Proceeding, VEC-B-10D (rev. 2/72).~~

~~Employer Notice of Predetermination Proceeding, VEC-B-10E (rev. 4/82).~~

~~Claimant's Statement Concerning Voluntary Quit, VEC-B-60.1 (rev. 11/94).~~

~~Claimant's Statement Concerning Discharge, VEC-B-60.2 (rev. 11/94).~~

~~Claimant's Statement Concerning Able and Available, VEC-B-60.5 (rev. 11/94).~~

~~Claimant's Statement Concerning Refusal of Job or Referral, VEC-B-60.6 (rev. 11/94).~~

~~Claimant's Request for Training Approval, VEC-B-60.7 (rev. 11/94).~~

~~Claimant's Statement Concerning Voluntary Quit Illness, VEC-B-60.8 (rev. 11/94).~~

~~Supplemental Sheet – Claimant and Employer Statement, VEC-B-60SUP (eff. 11/94).~~

~~Notice of Deputy's Determination, VEC-BPC-54 (eff. 6/90).~~

Notice of Commission Appeals, A-CLA-025 (rev. 7/2012)

Notice of Commission Hearing for Oral Argument, A-CLA-067 (rev. 12/2016)

Notice of Commission Hearing for Additional Evidence, A-CLA-067 (rev. 12/2016)

Employer Notice of Telephonic Fact Finding Interview, B-10EX (rev. 1/2015)

Claimant Notice of Telephonic Fact Finding Interview, B-10EXP (rev. 7/2017)

Notice of Deputy's Determination, VEC-54 (rev. 3/2010)

Notice of Deputy's Determination - Overpayment, VEC-BPC-54 (eff. 5/2009)

Notice of Deputy's Determination - Fraud, VEC-BPC-54F (rev. 9/2007)

VA.R. Doc. No. R23-7206; Filed October 27, 2022, 11:08 a.m.

TITLE 18. PROFESSIONAL AND OCCUPATIONAL LICENSING

BOARD OF DENTISTRY

Fast-Track Regulation

Title of Regulation: **18VAC60-21. Regulations Governing the Practice of Dentistry (amending 18VAC60-21-40, 18VAC60-21-220, 18VAC60-21-240).**

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

Public Hearing Information: No public hearing is currently scheduled.

Public Comment Deadline: January 4, 2023.

Effective Date: January 19, 2023.

Agency Contact: Jamie Sacksteder, Executive Director, Board of Dentistry, 9960 Mayland Drive, Suite 300, Henrico, VA 23233, telephone (804) 367-4581, FAX (804) 698-4266, or email jamie.sacksteder@dhp.virginia.gov.

Basis: Regulations are promulgated under the general authority of § 54.1-2400 of the Code of Virginia, which provides the Board of Dentistry the authority to promulgate regulations to levy fees and to administer the regulatory system.

Purpose: The purpose of this action is to make corrections in the current regulation for consistency with 18VAC60-20 before it was divided into four separate chapters. The regulatory changes will ensure that mobile clinics and portable dental operations that often serve children in underserved school districts will be able to continue renewing their permits and continue offering dental services that protect health and welfare of the public.

Rationale for Using Fast-Track Rulemaking Process: The proposed amendments are appropriate for the fast-track rulemaking process because they are consistent with previously adopted fees or are less costly for reactivation of an inactive license; therefore, the amendments are not expected to be controversial.

Substance: A renewal fee for a mobile clinic or portable dental operation was inadvertently omitted from 18VAC60-20-40 B before 18VAC60-20 was divided into four separate chapters and 18VAC60-21 was promulgated in 2015. The application fee for mobile clinic or portable dental operations was included in 18VAC60-21-40 A, and the renewal fee for those entities was included in 18VAC60-21-40 H, which set out a renewal fee reduction for 2016. Subsequently, those entities were also included in the renewal fee reduction for 2018. There has been no change in the renewal fee for those entities, but a correction of the error, by including them on the list found in 18VAC60-21-40 B for renewals and in 18VAC60-21-40 C for late renewal fees is necessary. Additionally, the renewal date for mobile clinics or portable operations was omitted from 18VAC60-21-240, and is added by this action. Additionally, the application fee for temporary dental permits issued pursuant to § 54.1-2715 of the Code of Virginia was omitted in the adoption of 18VAC60-21. Currently, there are no dentists who hold such a permit, but the fee needs to be included should the board receive an application. Additional information is added in parentheses to provide further explanation and identification of current fees. Finally, the fee reactivation of an inactive license is reduced from the cost of renewing an active license ($285) to the difference between the renewal of an inactive license ($145) and an active license. The end result is a dentist could reactivate an inactive license for the fee of $140.

Issues: The primary advantage of the amendments to the public is the ability of mobile dental clinics or portable dental operations to be able to renew their permits. There are no disadvantages of the amendments to the public. There are no advantages or disadvantages associated with the amendments 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 Dentistry (Board) proposes to (i) reintroduce fees for temporary dental permit applications, temporary dental permit renewals, mobile clinic/portable operation renewals, and mobile clinic/portable operation late renewals; and (ii) introduce new fees for moderate sedation permit reinstatements and deep sedation/general anesthesia permit reinstatements. The Board also proposes to reduce the fee for reactivating an inactive dental license.

Background. Prior to December of 2015, all fees were in 18VAC60-20, Regulations Governing Dental Practice. Action 3252[1] repealed 18VAC60-20, and created four new regulations that covered the subject matter that had been addressed in that regulation. 18VAC60-15, Regulations Governing the Disciplinary Process; 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, were promulgated. 18VAC60-21 includes standard application, renewal, late, and reinstatement fees for various dental licenses, registrations, certifications, and permits. This new regulation also includes reduced renewal fees only for the year 2016. The four new regulations became effective and the old regulation was officially repealed on December 2, 2015. By regulation, the renewal fees were at the higher standard levels in 2017.[2] Action 4974,[3] which became effective on February 21, 2018, established reduced renewal fees only for the year 2018.

The following three fees were in 18VAC60-20, and thus far have not been in 18VAC60-21: (i) temporary dental permit application, (ii) temporary dental permit renewal, and (iii) mobile dental clinic/portable dental operation late fee. The Board proposes to insert these fees into 18VAC60-21 at their respective 2015 levels from 18VAC60-20. See Table 1.

Table 1

FEE TYPE	2015	2016	2017	2018	2019	Proposed
Temporary dental permit application	$400	$0	$0	$0	$0	$400
Temporary dental permit renewal	$285	$0	$0	$0	$0	$285
Mobile clinic/portable operation late fee	$50	$0	$0	$0	$0	$50
Mobile clinic/portable operation renewal	$150	$110	$0	$75	$0	$150
Moderate sedation permit reinstatement	$0	$0	$0	$0	$0	$150
Deep sedation/general anesthesia permit reinstatement	$0	$0	$0	$0	$0	$150
Reactivating an inactive dental license	$145	$285	$285	$285	$285	$140

The fee for mobile dental clinic/portable dental operation renewal was included in the only 2016 and only 2018 subsections, but not in the standard fee section. This produced no fee for 2017, 2019, and going forward. The Board also proposes to insert this fee into 18VAC60-21 at its 2015 level from 18VAC60-20.

There currently exist reinstatement fees for lapsed dental licenses and lapsed oral maxillofacial surgeon registrations, but no such fees have been in effect for lapsed sedation permits. The Board proposes $150 fees for reinstatement of lapsed moderate sedation permits and lapsed deep sedation/general anesthesia permits. In the current regulation the reactivation fee for an inactive dental license is $285. The Board proposes to instead charge "the difference between the current renewal fee for inactive licensure and the current renewal fee for active licensure," (i.e., $140).

Estimated Benefits and Costs. Department of Health Professions (DHP) operations are funded through fees charged to those regulated. As of the third quarter of fiscal year 2019, the Board's cash balance was $4,628,752.[4]

As described, the proposed amendments in this action would not substantially affect that balance.

Pursuant to § 54.1-2715 of the Code of Virginia, the Board may issue a temporary dental permit to individuals who (i) have a D.D.S. or D.M.D. degree and are otherwise qualified, (ii) are not licensed to practice dentistry in Virginia, and (iii) have not failed an examination for a license to practice dentistry in the

Commonwealth. Also, such temporary permits may be issued only to those who serve as clinicians in dental clinics operated by (a) the Virginia Department of Corrections, (b) the Virginia Department of Health, (c) the Virginia Department of Behavioral Health and Developmental Services, or (d) a Virginia charitable corporation granted tax-exempt status under § 501(c)(3) of the Internal Revenue Code and operating as a clinic for the indigent and uninsured that is organized for the delivery of primary health care services. The proposed $400 fee for temporary dental permit application is equal to the existing $400 fee for dental license application. Likewise, the proposed $285 temporary dental permit renewal fee is equal to the existing $285 dental license renewal fee. There have been no temporary dental permits since 2014. Thus the proposed reintroduction of the temporary dental permit renewal fee would have no initial affect. Though it is possible that the reintroduction of the application fee for the temporary dental permit might discourage some applications, given the lack of activity over the years when there was no fee, this proposal would not likely have a substantial impact.

Mobile dental clinics are self-contained units in which dentistry is practiced that are not confined to a single building and can be transported from one location to another. Portable dental operations are non-facilities in which dental equipment used in the practice of dentistry is transported to and utilized on a temporary basis at an out-of-office location, including patients' homes, schools, nursing homes, or other institutions. According to DHP, there are 28 registered mobile dental clinics/portable dental operations. Without the proposal to reintroduce the mobile clinic/portable operation renewal fee of $150, these entities would not by regulation pay a renewal fee. If all 28 would choose to renew their registration with the proposed $150 fee, that would increase Board revenue by $4,200. It is not known how many of the 28 would be late in paying their renewal fee. Nevertheless, proposed reintroduction of the $50 late fee would likely have negligible impact on revenue. Though it may increase the likelihood that regulants pay their renewal fee on time.

18VAC60-21-240 states that "Any person whose license or permit has expired for more than one year or whose license or permit has been revoked or suspended and who wishes to reinstate such license or permit shall submit a reinstatement application and the reinstatement fee." The current regulation does not include specified reinstatement fees for lapsed sedation permits. According to DHP, "It is unknown how many sedation/anesthesia permit holders would be affected; the Board has had requested from a couple of dentists to reinstate lapsed permits." Thus the Board's proposal to introduce a $150 fee for both moderate sedation permit and deep sedation/general anesthesia permit would likely have minimal revenue impact. Given the earnings of dentists,[5] the proposed fee amount would not likely discourage reinstatement.

Any dentist who holds a current, unrestricted license in Virginia may, upon a request on the renewal application and submission of a $145 fee, be issued an inactive license. With the exception of practice with a current restricted volunteer license, the holder of an inactive license may not perform any act requiring a license to practice dentistry in Virginia. The Board proposes to reduce the fee for reactivation of an inactive license from $285 to $140. Given the earnings of dentists,[6] the proposed fee reduction would not likely materially affect decisions on whether or not to reactivate inactive dental licenses. There are currently 299 inactive dental licenses.[7] Typically seven or eight licenses are reactivated each year.[8] If there are on average 7.5 reactivations annually, the $145 reduction in fee revenue received per reactivation would reduce the Board's cash balance by $1,087.50 annually.

Businesses and Other Entities Affected. The proposed amendments affect mobile dental clinics/portable dental operations, and potentially some dental practices. There are 28 registered mobile dental clinics/portable dental operations[9] and 3,267 offices of dentists[10] in the Commonwealth. All of the mobile dental clinics/portable dental operations and dental practices with dentists who have lapsed moderate sedation permits or lapsed deep sedation/general anesthesia permits that they may wish to reinstate would be particularly affected.

Since temporary permits may be issued to those who serve as clinicians in dental clinics operated by (i) the Virginia Department of Corrections, (ii) the Virginia Department of Health, (iii) the Virginia Department of Behavioral Health and Developmental Services, or (iv) a Virginia charitable corporation granted tax-exempt status under § 501(c)(3) of the Internal Revenue Code and operating as a clinic for the indigent and uninsured that is organized for the delivery of primary health care services, these entities could be affected by the proposed reintroduction of the temporary dental permit application and temporary dental permit renewal fees. Given the lack of activity over the years concerning the temporary permit, there would not likely be a substantial impact.

Localities[11] Affected.[12] The proposed amendments apply throughout the Commonwealth, and do not disproportionately affect particular localities. The proposed amendments do not introduce costs for local governments. Accordingly, no additional funds would be required.

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

Effects on the Use and Value of Private Property. The proposed amendments do not substantively affect the use and value of private property. The proposed amendments do not affect real estate development costs.

Adverse Effect on Small Businesses:[13]

Types and Estimated Number of Small Businesses Affected. The 28 registered mobile dental clinics/portable dental operations are likely small businesses or nonprofit organizations or part of such organizations. All 3,267 offices of dentists in the Commonwealth qualify as small businesses.[14]

Costs and Other Effects. The proposal to reintroduce the mobile clinic/portable operation renewal fee of $150 increases

costs for those entities that are or are part of small businesses by that amount annually. Dental practices with a dentist who has a lapsed moderate sedation permit or lapsed deep

Alternative Method that Minimizes Adverse Impact. There are no clear alternative methods that both reduce adverse impact and meet the intended policy goals.

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[1]See https://townhall.virginia.gov/L/ViewAction.cfm?actionid=3252.

[2]Renewal fees that were not included in 18VAC60-21 remained, of course, at $0.

[3]See https://townhall.virginia.gov/L/ViewAction.cfm?actionid=4974.

[4]See https://www.dhp.virginia.gov/about/stats/2019Q3/07BoardCashBalancesQ3FY2019.pdf.

[5]The mean annual wage for dentists in Virginia is $199,870. See https://www.bls.gov/oes/current/oes_va.htm.

[6]Ibid.

[7]Data source: Department of Health Professions.

[8]DHP reports that there were seven reactivations in 2016, seven reactivations in 2017, and eight reactivations in 2018. Through August 30, there have been four reactivations thus far in 2019.

[9]Data source: Department of Health Professions.

[10]Data source: Virginia Employment Commission.

[11]"Locality" can refer to either local governments or the locations in the Commonwealth where the activities relevant to the regulatory change are most likely to occur.

[12]Section 2.2-4007.04 of the Code of Virginia defines "particularly affected" as bearing disproportionate material impact.

[13]Pursuant to § 2.2-4007.04, 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."

[14]Data source: Virginia Employment Commission.

Agency's Response to Economic Impact Analysis: The board concurs with the economic impact analysis of the Department of Planning and Budget.

Summary:

The amendments (i) correct the displacement of the applicable renewal fee and late fee for mobile clinics or portable operations in 18VAC60-21-40 and the omission of that fee in 18VAC60-21-240; (ii) correct the omission of the application fee for temporary dental permits issued pursuant to § 54.1-2715 of the Code of Virginia; (iii) add information regarding certain fees; and (iv) reduce the fee for reactivation of an inactive license to the difference between the renewal of an inactive license and an active license, which is $140.

18VAC60-21-40. Required fees.

A. Application/registration fees.

1. Dental license by examination	$400
2. Dental license by credentials	$500
3. Dental restricted teaching license (pursuant to § 54.1-2714 of the Code of Virginia)	$285
4. Dental faculty license (pursuant to § 54.1-2713 of the Code of Virginia)	$400
5. Temporary dental permit (pursuant to § 54.1-2715 of the Code of Virginia)	$400
6. Dental temporary resident's license	$60
~~6.~~ 7. Restricted volunteer license	$25
~~7.~~ 8. Volunteer exemption registration	$10
~~8.~~ 9. Oral maxillofacial surgeon registration	$175
~~9.~~ 10. Cosmetic procedures certification	$225
~~10.~~ 11. Mobile clinic/portable operation	$250
~~11.~~ 12. Moderate sedation permit	$100
~~12.~~ 13. Deep sedation/general anesthesia permit	$100

B. Renewal fees.

1. Dental license - ~~active~~ (active, faculty, or temporary permit)	$285
2. Dental license - inactive	$145
3. Dental temporary resident's license	$35
4. Restricted volunteer license	$15
5. Oral maxillofacial surgeon registration	$175
6. Cosmetic procedures certification	$100
7. Moderate sedation permit	$100
8. Deep sedation/general anesthesia permit	$100
9. Mobile clinic/portable operation	$150

C. Late fees.

1. Dental license - active	$100
2. Dental license - inactive	$50
3. Dental temporary resident's license	$15
4. Oral maxillofacial surgeon registration	$55
5. Cosmetic procedures certification	$35
6. Moderate sedation permit	$35
7. Deep sedation/general anesthesia permit	$35
8. Mobile clinic/portable operation	$50

D. Reinstatement fees.

1. Dental license - expired	$500
2. Dental license - suspended	$750
3. Dental license - revoked	$1000
4. Oral maxillofacial surgeon registration	$350
5. Cosmetic procedures certification	$225
6. Moderate sedation permit	$150
7. Deep sedation/general anesthesia permit	$150

E. Document fees.

1. Duplicate wall certificate	$60

2. Duplicate license	$20
3. License certification	$35

F. Other fees.

1. Handling fee for returned check or dishonored credit or debit card	$50
2. Practice inspection fee	$350

G. No fee will be refunded or applied for any purpose other than the purpose for which the fee is submitted.

H. For the renewal of an active dental license in 2021, fees shall be prorated according to a licensee's birth month as follows:

January birth month	$150
February birth month	$165
March birth month	$180
April birth month	$195
May birth month	$210
June birth month	$225
July birth month	$240
August birth month	$255
September birth month	$270
October birth month	$285
November birth month	$300
December birth month	$315

18VAC60-21-220. Inactive license.

A. Any dentist who holds a current, unrestricted license in Virginia may, upon a request on the renewal application and submission of the required fee, be issued an inactive license. With the exception of practice with a current restricted volunteer license as provided in § 54.1-2712.1 of the Code, the holder of an inactive license shall not be entitled to perform any act requiring a license to practice dentistry in Virginia.

B. An inactive license may be reactivated upon submission of the required application, which includes evidence of continuing competence and payment of the difference between the current renewal fee for inactive licensure and the current renewal fee for active licensure. To evaluate continuing competence the board shall consider (i) hours of continuing education that meet the requirements of 18VAC60-21-250; (ii) evidence of active practice in another state or in federal service; (iii) current specialty board certification; (iv) recent passage of a clinical competency examination that is accepted by the board; or (v) a refresher program offered by a program accredited by the Commission on Dental Accreditation of the American Dental Association.

1. Continuing education hours equal to the requirement for the number of years in which the license has been inactive, not to exceed a total of 45 hours, must be included with the application. Of the required hours, at least 15 must be earned in the most recent 12 months and the remainder within the 36 months immediately preceding the application for activation.

2. The board reserves the right to deny a request for reactivation to any licensee who has been determined to have committed an act in violation of § 54.1-2706 of the Code or who is unable to demonstrate continuing competence.

18VAC60-21-240. License renewal and reinstatement.

A. The license or permit of any person who does not return the completed renewal form and fees by the deadline shall automatically expire and become invalid, and his practice of dentistry shall be illegal. With the exception of practice with a current, restricted volunteer license as provided in § 54.1-2712.1 of the Code practicing in Virginia with an expired license or permit may subject the licensee to disciplinary action by the board.

B. Prior to 2022, every person holding an active or inactive license and those holding a permit to administer moderate sedation, deep sedation, or general anesthesia shall annually, on or before March 31, renew his license or permit. Beginning in January 2022, every person holding an active or inactive license and those holding a permit to administer moderate sedation, deep sedation, or general anesthesia shall annually renew his license or permit in his birth month in accordance with fees set forth in 18VAC60-21-40.

C. Every person holding a faculty license, temporary resident's license, a restricted volunteer license, or a temporary permit shall, on or before June 30, request renewal of his license.

D. Every person holding a permit as a mobile clinic or portable dental operation shall renew annually by December 31.

E. Any person who does not return the completed form and fee by the deadline required in subsection B of this section shall be required to pay an additional late fee.

~~E.~~ F. The board shall renew a license or permit if the renewal form, renewal fee, and late fee are received within one year of the deadline required in subsection B of this section provided that no grounds exist to deny said renewal pursuant to § 54.1-2706 of the Code and Part II (18VAC60-21-50 et seq.) of this chapter.

~~F.~~ G. Reinstatement procedures.

1. Any person whose license or permit has expired for more than one year or whose license or permit has been revoked or suspended and who wishes to reinstate such license or permit shall submit a reinstatement application and the reinstatement fee. The application must include evidence of continuing competence.

2. To evaluate continuing competence, the board shall consider (i) hours of continuing education that meet the requirements of subsection H of 18VAC60-21-250; (ii) evidence of active practice in another state or in federal service; (iii) current specialty board certification; (iv) recent passage of a clinical competency examination accepted by the board; or (v) a refresher program offered by a program accredited by the Commission on Dental Accreditation of the American Dental Association.

3. The executive director may reinstate such expired license or permit provided that the applicant can demonstrate continuing competence, the applicant has paid the reinstatement fee and any fines or assessments, and no grounds exist to deny said reinstatement pursuant to § 54.1-2706 of the Code and Part II (18VAC60-21-50 et seq.) of this chapter.

VA.R. Doc. No. R23-5785; Filed November 3, 2022, 8:22 a.m.

BOARD OF SOCIAL WORK

Forms

Title of Regulation: **18VAC140-20. Regulations Governing the Practice of Social Work.**

Agency Contact: Erin Barrett, Regulatory Coordinator, Department of Health Professions, 9960 Mayland Drive, Suite 300, Henrico, VA 23233, telephone (804) 367-4688, FAX (804) 915-0382, or email erin.barrett@dhp.virginia.gov.

FORMS (18VAC140-20)

Verification of Clinical Supervision (rev. 8/2016)

Request for Termination of Supervision (rev. 2/2020)

~~Application for Initial and Add or Change Registration of Supervision toward LCSW licensure, online form available at https://www.dhp.virginia.gov/social/social_forms.htm~~

~~Application for Licensure by Examination and Endorsement as a Licensed Clinical Social Worker, online form available at https://www.dhp.virginia.gov/social/social_forms.htm~~

~~Application for Licensure by Examination and Endorsement as a Licensed Baccalaureate Social Worker, online form available at https://www.dhp.virginia.gov/social/social_forms.htm~~

Initial Application for Supervision for LCSW Licensure (rev. 4/2022)

Verification of Clinical Supervision (rev. 4/2022)

Add or Change Supervision (rev. 4/2022)

LCSW Application by Examination (rev. 4/2022)

LCSW Endorsement Online Instructions and Forms (rev. 11/2022)

LMSW Application by Examination (rev. 4/2022)

LMSW Endorsement Online Instructions and Forms (rev. 11/2022)

LBSW Application by Examination (rev. 4/2022)

LBSW Endorsement Online Instructions and Forms (rev. 11/2022)

LCSW Supervision Log (rev. 3/2020)

Application for Reinstatement of Licensure: Checklist Instructions (rev. 3/2020)

Application for Reinstatement Following Disciplinary Action: Checklist Instructions (rev. 3/2020)

Social Work Name/Address Change (rev. 2/2020)

Request for Change in Status of Virginia Social Work License (Current Active to Current Inactive) (rev. 3/2020)

Request for Change in Status of Virginia Social Work License (Current Inactive to Current Active) (rev. 3/2020)

Request for Verification of Virginia Social Work License (rev. 2/2020)

Request for Late Renewal Instructions (rev. 3/2020)

VA.R. Doc. No. R23-7425; Filed November 9, 2022, 9:00 a.m.

GUIDANCE DOCUMENTS

PUBLIC COMMENT OPPORTUNITY

Pursuant to § 2.2-4002.1 of the Code of Virginia, a certified guidance document is subject to a 30-day public comment period after publication in the Virginia Register of Regulations and prior to the guidance document's effective date. During the public comment period, comments may be made through the Virginia Regulatory Town Hall website (http://www.townhall.virginia.gov) or sent to the agency contact. Under subsection C of § 2.2-4002.1, the effective date of the guidance document may be delayed for an additional period. The guidance document may also be withdrawn.

The following guidance documents have been submitted for publication by the listed agencies for a public comment period. Online users of this issue of the Virginia Register of Regulations may click on the name of a guidance document to access it. Guidance documents are also available on the Virginia Regulatory Town Hall (http://www.townhall.virginia.gov) or from the agency contact or may be viewed at the Office of the Registrar of Regulations, 900 East Main Street, Richmond, Virginia 23219.

DEPARTMENT FOR AGING AND REHABILITATIVE SERVICES

Title of Document: Work Incentives Specialist Advocate Manual.

Public Comment Deadline: January 4, 2023.

Effective Date: January 5, 2023.

Agency Contact: Charlotte Arbogast, Senior Policy Analyst and Regulatory Coordinator, Department for Aging and Rehabilitative Services, 8004 Franklin Farms Drive, Richmond, VA 23229, telephone (804) 662-7093, or email charlotte.arbogast@dars.virginia.gov.

BOARD OF AUDIOLOGY AND SPEECH-LANGUAGE PATHOLOGY

BOARD OF COUNSELING

BOARD OF DENTISTRY

BOARD OF FUNERAL DIRECTORS AND EMBALMERS

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BOARD OF PHYSICAL THERAPY

BOARD OF PSYCHOLOGY

BOARD OF SOCIAL WORK

BOARD OF VETERINARY MEDICINE

DEPARTMENT OF HEALTH PROFESSIONS

Title of Document: Custodian of the Record.

Disciplinary Cases Involving Board Members.

Disciplinary Process for Cases Involving Noncompliance with § 54.1-2400.6 of the Code of Virginia.

Disclosure of Information to Health Practitioners Monitoring Program.

Disclosure of Noninvestigative Information.

Extension of Time for Active Duty Servicemembers and Spouses.

Principles for Establishment of Fees.

Procurement of Professional Services.

Publication of Notices and Orders.

Receipt and Investigation of Allegations of Misconduct.

Reporting Disciplinary Actions to the Data Bank.

Unlicensed Activity.

Public Comment Deadline: January 4, 2023.

Effective Date: January 5, 2023.

Agency Contact: Erin Barrett, Senior Policy Analyst, Department of Health Professions, Perimeter Center, 9960 Mayland Drive, Suite 300, Henrico, VA 23233, telephone (804) 367-4688, or email erin.barrett@dhp.virginia.gov.

STATE BOARD OF BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES

Title of Document: The Individual and Family Support Program Funding Guidelines.

Public Comment Deadline: January 4, 2023.

Effective Date: January 9, 2023.

Agency Contact: Heather Hines, Community Coordination Supervisor, Interim Program, Department of Behavioral Health and Developmental Services, Developmental Disability Division, 9th Floor, P.O. Box 1797, Richmond, VA 23218-1797, telephone (804) 259-1775, or email heather.hines@dbhds.virginia.gov.

BOARD OF JUVENILE JUSTICE

Title of Document: Guidelines for Determining the Length of Stay for Juveniles Indeterminately Committed to the Department of Juvenile Justice.

Public Comment Deadline: January 4, 2023.

Effective Date: January 5, 2023.

Agency Contact: Kristen Peterson, Regulatory Affairs Coordinator, Department of Juvenile Justice, Main Street Centre, 20th Floor, 600 East Main Street, Richmond, VA 23219, telephone (804) 773-0180, or email kristen.peterson@djj.virginia.gov.

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

Title of Document: Medicaid's Early and Periodic Screening, Diagnostic and Treatment Benefit How It Is Operationalized in Virginia Module 1.

Public Comment Deadline: January 4, 2023.

Effective Date: January 5, 2023.

Agency Contact: Meredith Lee, Policy, Regulations, and Manuals Supervisor, Department of Medical Assistance Services, 600 East Broad Street, Suite 1300, Richmond, VA 23219, telephone (804) 371-0552, or email meredith.lee@dmas.virginia.gov.

STATE BOARD OF BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES

State Human Rights Committee Decision on Variances to the Regulations to Assure the Rights of Individuals Receiving Services from Providers Licensed, Funded, or Operated by the Department of Behavioral Health and Developmental Services

Notice of action: The Department of Behavioral Health and Developmental Services (DBHDS), in accordance with Part VI, Variances (12VAC35-115-220), of the Regulations to Assure the Rights of Individuals Receiving Services from Providers Licensed, Funded, or Operated by the Department of Behavioral Health and Developmental Services (12VAC35-115), hereafter referred to as the "Human Rights Regulations," is announcing a decision on an application for variances to the Human Rights Regulations submitted to the State Human Rights Committee (SHRC). The purpose of the regulations is to ensure and protect the legal and human rights of individuals receiving services in facilities or programs operated, licensed, or funded by DBHDS.

Each variance application references the specific part of the Human Rights Regulations to which a variance is needed, the proposed wording of the substitute rule or procedure, and the justification for a variance. Such application also describes time limits and other conditions for duration and the circumstances that will end the applicability of the variance. After considering all available information, including comments, the SHRC intends to submit a written decision deferring, disapproving, modifying, or approving each variance application. All variances shall be approved for a specific time period. The decision and reasons for variances are described as follows:

Purpose of notice: After considering all available information, at its meeting on November 3, 2022, the SHRC voted to approve the application for variances to the Human Rights Regulations for DBHDS' Central State Hospital (CSH). Each variance was approved for a three-year period with quarterly reports to the local human rights committee (LHRC) and SHRC regarding the implemented variances.

I. Variance is requested to the following sections:

12VAC35-115-150, General Provisions

12VAC35-115-175, Human Rights Complaint Process

12VAC35-115-180, Local Human Rights Committee Hearing and Review Procedures

12VAC35-115-190, Special Procedures for Emergency Hearings by the LHRC

12VAC35-115-200, Special Procedures for LHRC Reviews Involving Consent and Authorization

12VAC35-115-210, State Human Rights Committee Appeals Procedure

Explanation: The CSH variances allow alternative procedures for addressing complaints by individuals in maximum security when the individual is not satisfied with the director's response so that the individual may appeal to the CSH Maximum Security Appeals Committee.

II. Variance requested to the following section:

12VAC35-115-100, Restrictions on Freedoms of Everyday Life, A 1 c, "freedom to have and spend personal money."

Explanation: Individuals who are receiving hospitalization under the civil admissions process in the maximum security perimeter may not keep any form of money on their person. The CSH variance to this regulation allows nonforensic patients to purchase items in a canteen and from external providers; however, individuals may not have money on their person.

III. Variance requested to the following sections:

12VAC35-115-20 A 2, Policy, "Each individual who receives services shall be assured respect for basic human dignity."

12VAC35-115-50 C 3 a, Dignity, "each individual has the right to … reasonable privacy…."

Explanation: CSH cannot fulfill its duty to provide a safe environment for individuals who are high-risk in a secure forensic program through less intrusive means than routine "pat downs" of fully clothed individuals and proactive searches of individuals' bedroom areas. The CSH variance to this provision allows for routine pat downs of nonforensic individuals in secure programs before and after group movement: within a secure perimeter; anytime an individual leaves the secure perimeter; any time an individual has physical access to a visitor who is not an employee of CSH; and allows proactive routine searches of individuals' bedrooms to identify contraband or breaches of safety and security.

IV. Variance requested to the following sections:

12VAC35-115-50, Dignity:

C 6, "each individual has the right to… communicate privately with any person by mail and have help in writing and reading mail, as needed."

C 6 a, "An individual's access to mail may be limited only if the provider has reasonable cause to believe that the mail contains illegal material or anything dangerous. If so, the director or his designee may open the mail, but not read it, in the presence of the individual."

C 7, "each individual has the right to… communicate privately with any person by telephone and have help in doing so."

C 7 a, "An individual's access to the telephone may be limited only if, in the judgment of a licensed professional,

communication with another person will result in demonstrable harm to the individual or significantly affect his treatment."

Explanation: The CSH variance to these provisions allows for staff to open but not read mail and packages in the presence of the individual in the maximum security program. CSH also seeks to restrict individuals in the maximum security forensic program from communicating with each other by mail or telephone.

Contact Information: Taneika Goldman, Director, Office of Human Rights, Department of Behavioral Health and Developmental Services, 1220 East Bank Street, P.O. Box 1797, Richmond, VA 23218-1797, telephone (804) 786-3988, FAX (833) 734-1241, or email taneika.goldman@dbhds.virginia.gov.

DEPARTMENT OF ENVIRONMENTAL QUALITY

Windsor PV1 LLC WITHDRAWAL of Notice of Intent for a Small Renewable Energy Project (Solar) – Isle of Wight County

Windsor PV1 LLC (applicant), has withdrawn its notice of intent to submit the necessary documentation for a permit by rule for a small renewable energy project (solar) in Isle of Wight County, Virginia. The original notice of intent was published in the Virginia Register on November 11, 2019.

Contact Information: Susan Tripp, Department of Environmental Quality, 1111 East Main Street, Richmond, VA 23219, telephone (804) 664-3470, or email susan.tripp@deq.virginia.gov.

Windsor Solar Notice of Intent for Small Renewable Energy Project (Solar) - Isle of Wight County

Windsor PV1 LLC (the applicant) has provided the Department of Environmental Quality a notice of intent to submit the necessary document for a permit by rule for a small renewable energy project (solar) in Isle of Wight County. Windsor Solar will be located in south-central Isle of Wight County, approximately 0.5 mile to the west of the Town of Windsor. Centroid latitude and longitude coordinates are 36.810514, -76.785867.

The project will have a maximum generating capacity of 85 megawatts alternating current across approximately 1,388 acres. The solar modules will be constructed on a single-axis tracker.

Contact Information: Susan Tripp, Department of Environmental Quality, 1111 East Main Street, Richmond, VA 23219, telephone (804) 664-3470, or email susan.tripp@deq.virginia.gov.

The Virginia Department of Environmental Quality Announces the Availability of the 2021 Fish Tissue Monitoring Data

Background: The Virginia Department of Environmental Quality (DEQ) conducts routine studies of fish tissue and sediment samples in state waters to assess the human health risks for individuals who may consume fish from state waters and to identify impaired aquatic ecosystems. Results are made available to the public each year on the agency's website.

In 2021, DEQ collected fish tissue samples primarily from sites located in the watersheds of the James River, New River, Roanoke River, and Tennessee River. DEQ also conducted special fish tissue monitoring studies in the Dan River and in Lovills Creek Lake (Carroll County), and these data are also available. Samples were analyzed for polychlorinated biphenyls and a suite of 17 metals, including mercury.

2021 monitoring results are available on the agency's website at https://www.deq.virginia.gov/water/water-quality/monitoring/fish-tissue-monitoring.

Additional information: The Virginia Department of Health (VDH) uses the data generated by DEQ's fish tissue monitoring program to determine the need for fish consumption advisories. More information on VDH fish consumption advisories is available at https://www.vdh.virginia.gov/environmental-health/public-health-toxicology/fish-consumption-advisory/.

Contacts for more information: Questions on DEQ's fish tissue monitoring program can be directed to Rick Browder at richard.browder@deq.virginia.gov, or Gabriel Darkwah at gabriel.darkwah@deq.virginia.gov. Additional information is also available on the VADEQ Water Quality Monitoring website at https://www.deq.virginia.gov/water/water-quality/monitoring.

Contact Information: Gabriel Darkwah, Water Quality Monitoring Specialist, Department of Environmental Quality, 1111 East Main Street, Suite 1400, Richmond, VA 23218, telephone (804) 659-2656, or email gabriel.darkwah@deq.virginia.gov.

FORENSIC SCIENCE BOARD

Additional Approved Field Tests for the Detection of Drugs

In accordance with 6VAC40-30, the Regulations for the Approval of Field Tests for Detection of Drugs, and under the authority of the Code of Virginia, the following field tests for the detection of drugs have been added to the list of approved field tests:

DETECTACHEM, INC.

120 INDUSTRIAL BOULEVARD

SUGAR LAND, TX 77478

MobileDetect

Drug or Drug Type:	Manufacturer's Field Test:
Fentanyl	MDT (Multi-Drug Test)
Heroin	MDT (Multi-Drug Test)
Methamphetamine	MDT (Multi-Drug Test)
Cocaine	MDT (Multi-Drug Test)
3,4-methylenedioxymethamphetamine (MDMA)	MDT (Multi-Drug Test)
Methamphetamine	DME (Meth/MDMA Test)
Cocaine	DCO (Cocaine Test)
Marijuana	DCT (CBD/THC Test)
Industrial hemp	DCT (CBD/THC Test)
Heroin	DHE (Heroin Test)
Fentanyl	FYL (Fentanyl Test Strips)
Buprenorphine	DSO (Special Opiates Test)

These field tests are additions to the list of approved field tests previously published by the Department of Forensic Science in the General Notices/Errata Section of the 32:13 VA.R. 2057-2067 February 22, 2016. Please note the new address for the manufacturer.

Contact Information: Amy Jenkins, Department Counsel, Department of Forensic Science, 700 North 5th Street, Richmond, VA 23219, telephone (804) 786-6848, FAX (804) 786-6857.

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

Draft Pharmacy Provider Manual

The draft Pharmacy Provider Manual Appendices D and E are now available on the Department of Medical Assistance Services website at https://www.dmas.virginia.gov/for-providers/general-information/medicaid-provider-manual-drafts/.

Contact Information: Meredith Lee, Policy, Regulations, and Manuals Supervisor, Department of Medical Assistance Services, 600 East Broad Street, Suite 1300, Richmond, VA 23219, telephone (804) 371-0552, or email meredith.lee@dmas.virginia.gov.

VIRGINIA CODE COMMISSION

Notice to State Agencies

Contact Information: *Mailing Address:* Virginia Code Commission, Pocahontas Building, 900 East Main Street, 8th Floor, Richmond, VA 23219; *Telephone:* (804) 698-1810; *Email:* varegs@dls.virginia.gov.

Meeting Notices: Section 2.2-3707 C of the Code of Virginia requires state agencies to post meeting notices on their websites and on the Commonwealth Calendar at 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.