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accomplished.

Personal Assistance Services will always be fee-for-service, whereas all other Medicaid-covered services shall be through one of three models: Fee-for-service, Primary Care Case Management or through Managed Care Organizations.

Personal assistance services are described only on pages 51 and 52 of Attachment 3.1-C, the benchmark, as these services are only available as state plan services in the benchmark plan. These services are limited by medical necessity and are provided in accordance with 42 CFR 440.167(a)(2). Personal care services will not be provided by a family member. Family members for this purpose mean a legally responsible relative. PAS workers are required to maintain documentation of the hours worked, and what services were provided so that payment may be made by the Commonwealth based upon documented work.

Personal assistance services are the same as personal care services. The attending physician must participate in the approval of the initial assessment. For agency-directed personal care services, an RN conducts the initial assessment. For consumer directed services, a Service Facilitator conducts the initial assessment. An RN supervises the plan of care.

An agency refers to a home health agency, whereas individual refers to the personal care assistant who actually provides the service to the enrollee. DMAS has qualifications and standards that agencies and individuals must meet in order to be reimbursed for these services.

D. Additional Assurances

a. X / The State assures that individuals will have access, through benchmark coverage, benchmark-equivalent coverage, or otherwise, to Rural Health Clinic (RHC) services and Federally Qualified Health Center (FQHC) services as defined in subparagraphs (B) and (C) of section 1905(a)(2).

b. X / The State assures that payment for RHC and FQHC services is made in accordance with the requirements of section 1902(bb).

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E. Cost Effectiveness of Plans

_X_ / Benchmark or benchmark-equivalent coverage and any additional benefits must be provided in accordance with economy and efficiency principles.

F. Compliance with the Law

_X_ / The State will continue to comply with all other provisions of the Social Security Act in the administration of the State plan under this title.

G. Implementation Date

_X_ / The State will implement this State Plan amendment on 12/31/2011.

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§2. Services which are reimbursed on a cost basis.

A. Payments for services listed below shall be on the basis of reasonable cost following the standards and principles applicable to the Title XVIII Program with the exception provided for in subdivision 2c of subsection D below. The upper limit for reimbursement shall be no higher than payments for Medicare patients in accordance with 42 CFR 447.321. In no instance, however, shall charges for beneficiaries of the program be in excess of charges for private patients receiving services from the provider. The professional component for emergency room physicians shall continue to be noncovered as a component of payment to the facility.

B. Reasonable costs will be determined from the filing of a uniform CMS-approved cost report by participating providers. The cost reports are due not later than 150 days after the provider's fiscal year end. If a complete cost report is not received within 150 days after the end of the provider's fiscal year, the Program shall take action in accordance with its policies to assure that an overpayment is not being made. All cost reports shall be reviewed and reconciled to final costs within 180 days of the receipt of a completed cost report. The cost report will be judged complete when DMAS has all of the following:

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

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

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1. Supplemental Payments for FQHCs/RHCs selecting the PPS methodology. FQHCs/RHCs that provide services under a contract with a Medicaid Managed Care Entity (MCE) will receive quarterly state supplemental payments for the cost of furnishing such services that are an estimate of the difference between the payments the FQHC/RHC receives from MCEs and the payments the FQHC/RHC would have received under the BIPA PPS methodology. At the end of each FQHCs/RHCs fiscal year, the total amount of supplemental and MCE payments received by the FQHC/RHC will be reviewed against the amount that the actual number of visits provided under the FQHCs/RHCs contract with MCE would have yielded under the PPS. If the PPS amount exceeds the total amount of supplemental and MCE payments, the FQHC/RHC will be paid the difference between the PPS amount calculated using the actual number of visits and the total amount of supplemental and MCE payments received by the FQHC/RHC. If the PPS amount is less than the total amount of supplemental and MCE payments, the FQHC/RHC will refund to DMAS the difference between the PPS amount calculated using the actual number of visits, and the total amount of supplemental and MCE payments received by the FQHC/RHC.

D. These providers shall be subject to the same cost reporting submission requirements as specified in 12VAC30-80-20 for cost-based reimbursed providers.

§6. Fee-for-service providers. (12 VAC 30-80-30)

A. Payment for the following services shall be the lower of the State agency fee schedule (Supplement 4 has information about the State agency fee schedule except as specified below) or actual charge (charge to the general public). Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private individual practitioners. Fee schedules and any annual/periodic adjustments to the fee schedule are published on the DMAS website at the following web address: http://www.dmas.virginia.gov/pr-fee_files.htm.

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

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

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(b) Treatment related to an injury sustained more than 72 hours prior to the visit with the deterioration of the symptoms to the point of requiring medical treatment for stabilization.
(c) The initial treatment for medical emergencies including indications of severe chest pain, dyspnea, gastrointestinal hemorrhage, spontaneous abortion, loss of consciousness, status epilipticus, or other conditions considered life threatening.
(d) A visit in which the recipient's condition requires immediate hospital admission or the transfer to another facility for further treatment or a visit in which the recipient dies.
(e) Services provided for acute vital sign changes as specified in the provider manual.
(f) Services provided for severe pain when combined with one or more of the other guidelines.

§6.A.1.b. (4) Payment shall be determined based on ICD-9-CM diagnosis codes and necessary supporting documentation.

§6.A. 2. Dentists' services: the agency's rate was set as of July 1, 2010, October 1, 2010, and July 1`, 2011, and is effective for services on or after that date, respectively. Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private individual practitioners.

§6.A. 3. Mental health services including: Community mental health services. (The agency's rates were set as of July 1, 2011 or earlier and are effective for services on or after that date.) Services of a licensed clinical psychologist; mental health services provided by a physician

a. Services provided by licensed clinical psychologists shall be reimbursed at 90% of the reimbursement rate for psychiatrists.
b. Services provided by independently enrolled licensed clinical social workers, licensed professional counselors, licensed clinical nurse specialists-psychiatric, or licensed marriage and family therapists shall be reimbursed at 75% of the reimbursement rate for licensed clinical psychologists.

3.1. Intensive In-Home Services: The agency's hourly rates were set as of February 1, 2010, and are effective for services on or after that date.

These services are provided by Qualified Mental Health Professionals or other licensed professional. The Medicaid hourly fee is paid directly to an individual practitioner or billed on behalf of the practitioner through an employment arrangement.

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§6 A Fee for service providers. Durable Medical Equipment (continued)

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

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

7. Local health services, including services paid to local school districts
8. Laboratory services (Other than inpatient hospital) (The agency's rates for clinical laboratory services were set as of February 1, 2010, and are effective for services on or after that date.)
9. Payments to physicians who handle laboratory specimens, but do not perform laboratory analysis (limited to payment for handling)
10. X-Ray services.
11. Optometry services
12. Reserved.
13. Home health services: Effective June 30, 1991, cost reimbursement for home health services is eliminated. A rate per visit by discipline shall be established as set forth by Supplement 3. (12 VAC30-80-180)
14. Physical therapy, occupational therapy, and speech, hearing, language disorders services when rendered to non-institutionalized recipients. Physical therapy, occupational therapy, and speech-language therapy services furnished by state rehabilitation agencies are paid on a cost basis (see sec. 2D, page 4.1). All other services under this section furnished by rehabilitation agencies are paid rates established by Supplement 5.
15. Clinic services, as defined under 42 CFR 440.90.
16. Supplemental payments to state government-owned or operated clinics.
(Repealed effective July 1, 2005)

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16 **Reimbursement for personal assistance services (PAS): Fee-for-Service Providers (12 VAC30-80-30 and 42 CFR 447, Subpart F)** All governmental and private PAS providers are reimbursed according to the same published fee schedule, located on the Agency's website at the following address: http://www.dmas.virginia.gov./pr-fee files.htm. The agency's rates, based upon one-hour increments, were set as of July 1, 2011, and shall be reset as of October 1, 2011, and shall be effective for services on or after that date.

B. Hospice services payments must be no lower than the amounts using the same methodology used Under Part A of Title XVIII and take into account the room and board furnished by the facility, equal to at least 95 percent of the rate that would have been paid by the state under the plan for facility services in that facility for that individual. Hospice services shall be paid according to the location of the service delivery and not the location of the agency's home office.