COMMONWEALTH of VIRGINIA

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MEMORANDUM

TO: **BRIAN MCCORMICK**
Regulatory and Manual Section Manager
Department of Medical Assistance Services

FROM: **ELIZABETH A. MCDONALD** EAM
Special Counsel to DMAS

DATE: **September 18, 2009**

SUBJECT: **Emergency Regulations Regarding Coverage and Reimbursement of Early Intervention Services pursuant to Part C of the IDEA**

I have reviewed the attached emergency regulations that would create a new model for Medicaid coverage of Early Intervention ("EI") services for children under three (3) years of age who are eligible for services pursuant to Title 2.2, Chapter 53, of the Code of Virginia in accordance with Part C of the Individuals with Disabilities Education Act ("IDEA") (20 U.S.C. § 1400 *et seq.*).

Based on that review, it is this Office's view that the Director of the Department of Medical Assistance Services ("DMAS"), acting on behalf of the Board of Medical Assistance Services pursuant to Virginia Code § 32.1-324, has the authority to promulgate these regulations, subject to compliance with the provisions of Article 2 of the Administrative Process Act ("APA") and has not exceeded that authority.

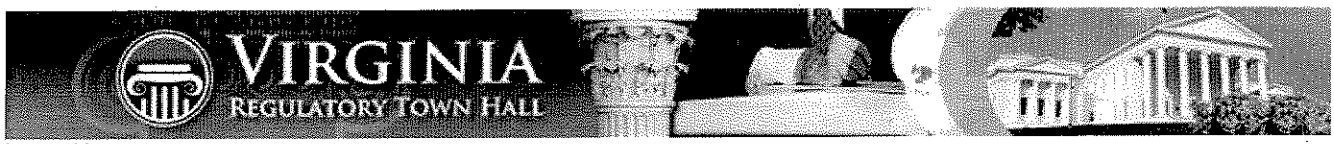
The authority for this emergency action is found in Virginia Code § 2.2-4011, which provides that an "emergency situation" is a "situation in which Virginia statutory law, the Virginia appropriations act, or federal law requires that a regulation shall be effective in 280 days or less from its enactment..." The amendments to the regulations

will enable the Director, in lieu of the Board of Medical Assistance Services, to comply with Item 306 TTT of the 2009 Appropriations Act.

Accordingly, with the prior approval of the Governor, these regulations will qualify for the "emergency" exemption from Article 2 requirements. Please be advised, however, that under Virginia Code §2.2-4011(A), the Department must state in writing the nature of and necessity for such emergency actions, and this appears to have been accomplished in the "Agency Background Document." In addition, the regulations shall be effective for no more than 12 months. As the Department intends to continue regulating the subject matter governed by this emergency regulation beyond 12 months, it will be necessary to replace these emergency regulations with regulations duly promulgated under Article 2 of the APA. A Notice of Intended Regulatory Action relating to the proposed replacement regulations must be filed with the Register within 60 days of the effective date of the emergency regulations. The proposed regulations must be filed with the Register within 180 days after the effective date of the emergency regulations.

If you have any questions or need any additional information, please feel free to contact me at 786-7363.

cc: Kim F. Piner
Senior Assistant Attorney General



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Emergency Text

Action: Coverage and Reimbursement of Early Intervention Services under ...

Stage: Emergency 9/3/09 10:39 AM [latest]

12VAC30-50-131. EPSDT and Early Intervention services.

A. Definitions. The following words and terms when used in these regulations shall have the following meanings unless the context clearly indicates otherwise:

"Early Intervention services" means services provided through Part C of the Individuals with Disabilities Education Act (20 U.S.C. § 1431 et seq.), as amended, and in accordance with 42CFR440.130(d), which are designed to meet the developmental needs of each child and the needs of the family related to enhancing the child's development, and are provided to children from birth to age three who have (i) a 25 percent developmental delay in one or more areas of development, (ii) atypical development, or (iii) a diagnosed physical or mental condition that has a high probability of resulting in a developmental delay.

"Individualized family service plan" or "IFSP" means a comprehensive and regularly updated statement specific to the child being treated containing, but not necessarily limited to, treatment or training needs, measurable outcomes expected to be achieved, services to be provided with the recommended frequency to achieve the outcomes, and estimated timetable for achieving the outcomes. The IFSP is developed by a multidisciplinary team which includes the family, under the auspices of the local lead agency.

"Local lead agency" means an agency under contract with the Department of Behavioral Health and Developmental Services to facilitate implementation of a local Early Intervention system as described in Chapter 53 of Title 2.2 (§ 2.2-5304.1) of the Code of Virginia.

"Primary care provider" means a practitioner who provides preventive and primary health care and is responsible for providing routine Early and Periodic Screening, Diagnosis and Treatment (EPSDT) screening and referral and coordination of other medical services needed by the child.

"DBHDS" means the Department of Behavioral Health and Developmental Services, the lead State agency for Early Intervention services appointed by the Governor in accordance with Chapter 53 of Title 2.2 (§ 2.2-5304) of the Code of Virginia.

B. Coverage for Early Intervention services.

1. Early Intervention services shall be reimbursed for individuals younger than 21 years of age who meet criteria for Early Intervention services established by DBHDS in accordance with Chapter 53 of Title 2.2 (§ 2.2-5304) of the Code of Virginia.

2. Early Intervention services shall be recommended by the child's primary care provider or other qualified EPSDT screening provider as necessary to correct or ameliorate a physical or mental condition.

3. Early Intervention services shall be provided in settings that are natural or normal for an infant or toddler without a disability, such as the home, unless there is justification for an atypical location.

4. Except for the initial and periodic assessments, Early Intervention services shall be described in an IFSP developed by the local lead agency and designed to prevent or ameliorate developmental delay within the context of the Early Intervention services system defined by Chapter 53 of Title 2.2 of the Code of Virginia.

5. Medical necessity for Early Intervention shall be defined by the IFSP. The IFSP shall describe service needs in terms of amount, duration, and scope. The IFSP shall be approved by the child's primary care provider.

6. Covered Early Intervention services include the following functions provided with the infant or toddler and the child's parent or other authorized caregiver by a certified Early Intervention professional:

a. Assessment, including consultation with the child's family and other service providers, to evaluate:

(1) the child's level of functioning in the following developmental areas: cognitive development; physical development, including vision and hearing; communication development; social or emotional development; and adaptive development;

(2) the family's capacity to meet the developmental needs of the child; and

(3) services needed to correct or ameliorate developmental conditions during the infant and toddler years.

b. Participation in a multidisciplinary team review of assessments to develop integrated, measurable outcomes for the IFSP.

c. The planning and design of activities, environments, and experiences to promote the normal development of an infant or toddler with a disability, consistent with the outcomes in the IFSP.

7. Covered Early Intervention services include the following functions when included in the IFSP and provided with an infant or toddler with a disability and the child's parent or other authorized caregiver by a certified Early Intervention professional or by a certified Early Intervention specialist under the supervision of a certified Early Intervention professional:

a. Providing families with information and training to enhance the development of the child.

b. Working with the child with a disability to promote normal development in one or more developmental domains.

c. Consulting with the child's family and other service providers to assess service needs, plan, coordinate, and evaluate services to ensure that services reflect the unique needs of the child in all developmental domains.

C. The following functions shall not be covered under this section:

1. Screening to determine if the child is suspected of having a disability. Screening is covered as an EPSDT service provided by the primary care provider and is not covered as an Early Intervention service under this section.

2. Administration and coordination activities related to the development, review, and evaluation of the IFSP and procedural safeguards required by Part C of the Individuals with Disabilities Education Act (20 U.S.C. § 1431 et seq.).

3. Services other than the initial and periodic assessments that are provided but are not documented in the child's IFSP or linked to a service in the IFSP.

4. Sessions that are conducted for family support, education, recreational, or custodial purposes, including respite or child care.

5. Services provided by a relative who is legally responsible for the child's care.

6. Services rendered in a clinic or provider's office without justification for the location.

7. Services provided in the absence of the child and a parent or other authorized caregiver identified in the IFSP with the exception of multidisciplinary team meetings, which need not include the child.

D. Qualifications of providers:

1. Individual practitioners of Early Intervention must be certified by DBHDS as a qualified Early Intervention professional or Early Intervention specialist.

2. Certified individuals and service agencies or groups who employ or contract with certified individuals may enroll with DMAS as Early Intervention providers. In accordance with 42CFR 431.51, recipients may obtain Early Intervention services from any willing and qualified Medicaid provider who participates in this service, or for individuals enrolled with a Managed Care Organization (MCO), from such providers available in their MCO network.

Statutory Authority

12VAC30-80-20. Services that 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 D 2 d. The upper limit for reimbursement shall be no higher than payments for Medicare patients on a facility by facility basis in accordance with 42 CFR 447.321 and 42 CFR 447.325. 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 uncovered as a component of the payment to the facility.

B. Reasonable costs will be determined from the filing of a uniform cost report by participating providers. The cost reports are due not later than 90 days after the

provider's fiscal year end. If a complete cost report is not received within 90 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. 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;

3. The provider's financial statements including, but not limited to, a balance sheet, a statement of income and expenses, a statement of retained earnings (or fund balance), and a statement of changes in financial position;

4. Schedules that reconcile financial statements and trial balance to expenses claimed in the cost report;

5. Depreciation schedule or summary;

6. Home office cost report, if applicable; and

7. Such other analytical information or supporting documents requested by DMAS when the cost reporting forms are sent to the provider.

C. Item 398 D of the 1987 Appropriation Act (as amended), effective April 8, 1987, eliminated reimbursement of return on equity capital to proprietary providers.

D. The services that are cost reimbursed are:

1. Inpatient hospital services to persons over 65 years of age in tuberculosis and mental disease hospitals.

2. Outpatient hospital services excluding laboratory.

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:

"All-inclusive" means all emergency department and ancillary service charges claimed in association with the emergency room visit, with the exception of laboratory services.

"DMAS" means the Department of Medical Assistance Services consistent with Chapter 10 (§et seq.) of Title 32.1 of the Code of Virginia.

"Emergency hospital services" means services that are necessary to prevent the death or serious impairment of the health of the recipient. The threat to the life or health of the recipient necessitates the use of the most accessible hospital available that is equipped to furnish the services.

"Recent injury" means an injury that has occurred less than 72 hours prior to the emergency department visit.

b. Scope. DMAS shall differentiate, as determined by the attending physician's diagnosis, the kinds of care routinely rendered in emergency departments and reimburse for nonemergency care rendered in emergency departments at a reduced rate.

(1) With the exception of laboratory services, DMAS shall reimburse at a reduced and all-inclusive reimbursement rate for all services, including those obstetric and pediatric procedures contained in 12VAC30-80-160, rendered in emergency departments that DMAS determines were nonemergency care.

(2) Services determined by the attending physician to be emergencies shall be reimbursed under the existing methodologies and at the existing rates.

(3) Services performed by the attending physician that may be emergencies shall be manually reviewed. If such services meet certain criteria, they shall be paid under the methodology for subdivision 2 b (2) of this subsection. Services not meeting certain criteria shall be paid under the methodology of subdivision 2 b (1) of this subsection. Such criteria shall include, but not be limited to:

(a) The initial treatment following a recent obvious injury.

(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 epilepticus, 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.

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

(5) DMAS shall review on an ongoing basis the effectiveness of this program in achieving its objectives and for its effect on recipients, physicians, and hospitals. Program components may be revised subject to achieving program intent, the accuracy and effectiveness of the ICD-9-CM code designations, and the impact on recipients and providers.

c. Limitation to 80% of allowable cost. Effective for services on and after July 1, 2003, reimbursement of Type Two hospitals for outpatient services shall be at 80% of allowable cost, with cost to be determined as provided in subsections A, B, and C of this section. For hospitals with fiscal years that do not begin on July 1, 2003, outpatient costs, both operating and capital, for the fiscal year in progress on that date shall be apportioned between the time period before and the time period after that date, based on the number of calendar months in the cost reporting period, falling before and after that date. Operating costs apportioned before that date shall be settled according to the principles in effect before that date, and those after at 80% of allowable cost. Capital costs apportioned before that date shall be settled according to the principles in effect before that date, and those after at 80% of allowable cost. Operating and capital costs of Type One hospitals shall continue to be reimbursed at 94.2% and 90% of cost respectively.

d. Outpatient reimbursement methodology prior to July 1, 2003. DMAS shall continue to reimburse for outpatient hospital services, with the exception of direct graduate medical education for interns and residents, at 100% of reasonable costs less a 10% reduction for allowable capital costs and a 5.8% reduction for allowable operating costs. This methodology shall continue to be in effect after July 1, 2003, for Type One hospitals.

e. Payment for direct medical education costs of nursing schools, paramedical programs and graduate medical education for interns and residents.

(1) Direct medical education costs of nursing schools and paramedical programs shall continue to be paid on an allowable cost basis.

(2) Effective with cost reporting periods beginning on or after July 1, 2002, direct

graduate medical education (GME) costs for interns and residents shall be reimbursed on a per-resident prospective basis. See 12VAC30-70-281 for prospective payment methodology for graduate medical education for interns and residents.

~~3. Rehabilitation agencies operated by community services boards. For reimbursement methodology applicable to other rehabilitation agencies, see 12VAC30-80-200. Reimbursement for physical therapy, occupational therapy, and speech-language therapy services shall not be provided for any sums that the rehabilitation provider collects, or is entitled to collect, from the NF or any other available source, and provided further, that this amendment shall in no way diminish any obligation of the NF to DMAS to provide its residents such services, as set forth in any applicable provider agreement.~~

~~4.~~ Comprehensive outpatient rehabilitation facilities.

~~5~~ 4. Rehabilitation hospital outpatient services.

12VAC30-80-96. Fee-for-service: Early Intervention (under EPSDT).

A. Payment for Early Intervention services pursuant to Part C of the Individuals with Disabilities Education Act (IDEA) of 2004, as set forth in 12VAC30-50-131, for individuals younger than 21 years of age shall be the lower of the state agency fee schedule or actual charge (charge to the general public). All private and governmental fee-for-service providers are reimbursed according to the same methodology. The agency's rates were set as of October 1, 2009, and are effective for services on or after that date. Rates are published on the agency's website at www.dmas.virginia.gov.

B. There shall be separate fees for:

1. certified Early Intervention professionals who are also licensed as either a physical therapist, occupational therapist, speech pathologist, or registered nurse and certified Early Intervention specialists who are also licensed as either a physical therapy assistant or occupational therapy assistant and

2. all other certified Early Intervention professionals and certified Early Intervention specialists.

C. Provider travel time shall not be included in billable time for reimbursement.

12VAC30-80-200. Prospective reimbursement for rehabilitation agencies.

A. Effective for dates of service on and after July 1, 2003, rehabilitation agencies~~, excluding those operated by community services boards,~~ shall be reimbursed a prospective rate equal to the lesser of the agency's cost per visit for each type of rehabilitation service (physical therapy, occupational therapy, and speech therapy) or a statewide ceiling established for each type of service. The prospective ceiling for each type of service shall be equal to 112% of the median cost per visit, for such services, of rehabilitation agencies. The median shall be calculated using a base year to be determined by the department. Effective July 1, 2003, the median calculated and the resulting ceiling shall be applicable to all services beginning on and after July 1, 2003, and all services in provider fiscal years beginning in SFY2004.

B. In each provider fiscal year, each provider's prospective rate shall be determined based on the cost report from the previous year and the ceiling, calculated by DMAS, that is applicable to the state fiscal year in which the provider fiscal year begins.

C. For providers with fiscal years that do not begin on July 1, 2003, services for the fiscal year in progress on that date shall be apportioned between the time

period before and the time period after that date based on the number of calendar months before and after that date. Costs apportioned before that date shall be settled based on allowable costs, and those after shall be settled based on the prospective methodology.

D. Beginning with state fiscal years beginning on and after July 1, 2004, the ceiling and the provider specific cost per visit shall be adjusted for inflation, from the previous year to the prospective year, using the nursing facility inflation factor published for Virginia by DRI, applicable to the calendar year in progress at the start of the state fiscal year.

Part VI
Medallion II

12VAC30-120-360. Definitions.

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

"Action" means the denial or limited authorization of a requested service, including the type or level of service; the reduction, suspension, or termination of a previously authorized service; the denial, in whole or in part, of payment for a service; the failure to provide services in a timely manner, as defined by the state; or the failure of an MCO to act within the timeframes provided in 42 CFR 438.408 (b).

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

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

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

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

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

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

"DMAS" means the Department of Medical Assistance Services.

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

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

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

1. Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,

2. Serious impairment to bodily functions, or

3. Serious dysfunction of any bodily organ or part.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

12VAC30-120-380. Medallion II MCO responsibilities.

A. The MCO shall provide, at a minimum, all medically necessary covered services provided under the State Plan for Medical Assistance and further defined by written DMAS regulations, policies and instructions, except as otherwise modified or excluded in this part.

1. Nonemergency services provided by hospital emergency departments shall be covered by MCOs in accordance with rates negotiated between the MCOs and the emergency departments.

2. Services that shall be provided outside the MCO network shall include, but are not limited to, those services identified and defined by the contract between DMAS and the MCO. Services reimbursed by DMAS include dental and orthodontic services for children up to age 21; for all others, dental services (as described in 12VAC30-50-190), school health services (as defined in 12VAC30-120-360), community mental health services (rehabilitative, targeted case management and substance abuse services) and long-term care services provided under the § 1915 (c) home-based and community-based waivers including related transportation to such authorized waiver services.

3. The MCOs shall pay for emergency services and family planning services and supplies whether they are provided inside or outside the MCO network.

B. EPSDT services shall be covered by the MCO. These services shall include EPSDT Early Intervention services provided pursuant to Part C of the Individuals with Disabilities Education Act (IDEA) of 2004, as set forth in 12VAC30-50-131, as identified and defined by the contracts between DMAS and the MCOs. The MCO shall have the authority to determine the provider of service for EPSDT screenings.

C. The MCOs shall report data to DMAS under the contract requirements, which may include data reports, report cards for clients, and ad hoc quality studies performed by the MCO or third parties.

D. Documentation requirements.

1. The MCO shall maintain records as required by federal and state law and regulation and by DMAS policy. The MCO shall furnish such required information to DMAS, the Attorney General of Virginia or his authorized representatives, or the State Medicaid Fraud Control Unit on request and in the form requested.

2. Each MCO shall have written policies regarding enrollee rights and shall comply with any applicable federal and state laws that pertain to enrollee rights and shall ensure that its staff and affiliated providers take those rights into account when furnishing services to enrollees in accordance with 42 CFR 438.100.

E. The MCO shall ensure that the health care provided to its clients meets all applicable federal and state mandates, community standards for quality, and standards developed pursuant to the DMAS managed care quality program.

F. The MCOs shall promptly provide or arrange for the provision of all required services as specified in the contract between the state and the contractor. Medical evaluations shall be available within 48 hours for urgent care and within 30 calendar days for routine care. On-call clinicians shall be available 24 hours per day, seven days per week.

G. The MCOs must meet standards specified by DMAS for sufficiency of provider networks as specified in the contract between the state and the contractor.

H. Each MCO and its subcontractors shall have in place, and follow, written policies and procedures for processing requests for initial and continuing authorizations of service. Each MCO and its subcontractors shall ensure that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, be made by a health care professional who has appropriate clinical expertise in treating the enrollee's condition or disease. Each MCO and its subcontractors shall have in effect mechanisms to ensure consistent application of review criteria for authorization decisions and shall consult with the requesting provider when appropriate.

I. In accordance with 42 CFR 447.50 through 42 CFR 447.60, MCOs shall not impose any cost sharing obligations on enrollees except as set forth in 12VAC30-20-150 and 12VAC30-20-160.

J. An MCO may not prohibit, or otherwise restrict, a health care professional acting within the lawful scope of practice, from advising or advocating on behalf of an enrollee who is his patient in accordance with 42 CFR 438.102.

K. An MCO that would otherwise be required to reimburse for or provide coverage of a counseling or referral service is not required to do so if the MCO objects to the service on moral or religious grounds and furnishes information about the service it does not cover in accordance with 42 CFR 438.102.

12VAC30-120-396. Payment for Early Intervention.

Payment for Early Intervention services provided pursuant to Part C of the Individuals with Disabilities Education Act (IDEA) of 2004, as set forth in 12VAC30-50-131, and as identified and defined by the contracts between DMAS and the MCOs, to an enrollee of an MCO by a nonparticipating provider shall be the lesser of the provider's charges or the Medicaid fee schedule. This shall be considered payment in full to the provider of Early Intervention services.