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MEDICAID BULLETIN

Last Updated: 12/09/2024

Consumer-Directed Work Shift Submission Requirements, Effective January 1, 2025

The purpose of this bulletin is to inform providers that that Chapter VII of the Commonwealth Coordinated Care Plus Waiver Provider Manual is being updated to include changes impacting the consumer-directed (CD) model of care. The manual will reflect that the changes are effective January 1, 2025. CD attendants will be required to document the tasks they complete daily. Attendants must also submit worked time to the appropriate Fiscal/Employer Agent (F/EA) within 30 days of the date of service to be eligible for payment. These changes apply to all services delivered through consumer direction, including personal care, respite, and companion services.

CD Documentation

In 2019, CMS conducted an audit that included services delivered through consumer-direction. Their audit findings concluded that due to a lack of documentation, they were unable to verify that the services billed through consumer direction were delivered in accordance with the individual's person-centered plan of care. To respond to the finding, effective January 1, 2025, DMAS will require all consumer-directed attendants to document the tasks they completed during each shift. Documentation is required regardless of live-in status.

The F/EAs have configured their mobile apps, web portals, and Interactive Voice Response (IVR) systems to provide a method for attendants to document tasks during each shift. Attendants must follow the plan of care when providing services and document what tasks are completed each shift. The tasks must align with the member's approved plan of care. If a task that is identified on the plan of care was not performed, the attendant must use the open-text field to explain the reason. Attendants may also use this optional field to provide comments on the individual's condition or response to services.

DMAS reminds Services Facilitators (SFs) that a copy of the plan of care must be left in the member's home. SFs should review the documented tasks to ensure the attendant is following the plan of care. This information should also be used to determine if the Plan of Care continues to meet the member's needs. SFs should reiterate to the Employer of Record (EOR) that tasks performed outside of the plan of care are not permitted.

Timely Submission

The attendant is responsible for submitting shifts timely in accordance with the payroll calendar provided by the F/EA. If an attendant does not submit shifts timely, payment may

be delayed or denied. Shifts must be submitted within 30 calendar days of the service being provided. Shifts submitted after 30 calendar days may be denied unless the shift(s) meet one of the following four (4) exceptions:

a. **Background Check Delay (Criminal History Record Name Search Request and/or Child Abuse and Neglect Central Registry Records Check if caring for a minor under the age of 18)**: Attendants can work temporarily for up to 30 days pending background check results. If the criminal background results pend beyond 30 days, upon receipt of a passed criminal background check the attendant may submit shifts older than 30 calendar days for reimbursement.

b. Medicaid **Eligibility**: Medicaid eligibility is required for shift reimbursement. If there is an issue with the members eligibility, the attendant may submit shifts worked older than 30 calendar days for reimbursement once the members eligibility has been reinstated.

c. F/EA **Enrollment Delay**: Attendants must enroll with the Fiscal Employer/Agent for reimbursement. If the attendant is unable to submit shifts due to delays with the enrollment process, the attendant may submit shifts worked older than 30 calendar days for reimbursement once enrollment has been completed.

d. **Service Authorization Delay**: A service authorization is required for shift submission. If the attendant is unable to submit shifts due to delays with the member's service authorization, the attendant may submit eligible shifts older than 30 calendar days for reimbursement once the service authorization is successfully loaded into the Fiscal Employer/Agent (F/EA) portal.

In all of these cases, the shifts must be submitted within 30 days of the resolution of the issue.

The EOR has a responsibility to ensure their employees are compensated timely for their work. Failure to adhere to EOR requirements, which includes timely submission and approval of work shifts, could result in involuntary disenrollment from consumer direction if a pattern of discrepancies is determined.

Employers of Record (EORs) and CD attendants have been notified of these changes by DMAS, the managed care organizations, and Fiscal-Employer Agents (F/EA) through a series of email blasts and trainings. For additional information, EORs and attendants can contact their respective F/EA.

To avoid disruption to claims payment through FFS and the MCOs providers must periodically check the DMAS provider portal, also known as the Provider Services Solution (PRSS), to ensure that the provider's enrollment, contact information, and license information is up to date, for all of the provider's respective service locations. Under federal rules, MCOs and DMAS are prohibited from paying claims to network providers who are not enrolled in PRSS. Additional information is provided on the MCO Provider Network Resources webpage and includes links to resources, tutorials and contact information to reach Gainwell with any provider enrollment or revalidation related questions. Dental providers should continue to enroll directly through the DMAS Dental Benefits Administrator, DentaQuest.

PROVIDER CONTACT INFORMATION & RESOURCES

Virginia Medicaid Web Portal **Automated Response System (ARS)** Member eligibility, claims status, payment status, service limits, service authorization status, and remittance advice.	https://vamedicaid.dmas.virginia.gov/
Medicall (Audio Response System) Member eligibility, claims status, payment status, service limits, service authorization status, and remittance advice.	1-800-884-9730 or 1-800-772-9996
Provider Appeals DMAS launched an appeals portal in 2021. You can use this portal to file appeals and track the status of your appeals. Visit the website listed for appeal resources and to register for the portal.	https://www.dmas.virginia.gov/appeals/

Managed Care Programs

Cardinal Care Managed Care and Program of All-Inclusive Care for the Elderly (PACE). In order to be reimbursed for services provided to a managed care enrolled individual, providers must follow their respective contract with the managed care plan/PACE provider. The managed care plan may utilize different guidelines than those described for Medicaid fee-for-service individuals.

Cardinal Care Managed Care	https://www.dmas.virginia.gov/for-providers/managed-care/cardinal-care-managed-care/
PACE	Program of All-inclusive Care (virginia.gov)
Provider Enrollment	In-State: 804-270-5105 Out of State Toll Free: 888-829-5373 Email: VAMedicaidProviderEnrollment@gainwelltechnologies.com
Provider HELPLINE Monday–Friday 8:00 a.m.-5:00 p.m. For provider use only, have Medicaid Provider ID Number available.	1-804-786-6273 1-800-552-8627

Aetna Better Health of Virginia	https://www.aetnabetterhealth.com/virginia/providers/index.html 1-800-279-1878
Anthem HealthKeepers Plus	http://www.anthem.com/ 1-800-901-0020
Molina Complete Care	1-800-424-4524 https://www.molinahealthcare.com/providers/va/medicaid/home.aspx
Sentara Community Plan	1-800-881-2166 https://www.sentarahealthplans.com/providers
United Healthcare	www.uhcprovider.com/ 1-844-284-0149
Dental Provider DentaQuest	1-888-912-3456
Fee-for-Service (POS) Prime Therapeutics	https://www.virginiamedicaidpharmacyservices.com/ 1-800-424-4046
Acentra Health Behavioral Health and Medical Service Authorizations	https://vamedicaid.dmas.virginia.gov/sa 1-804-622-8900