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MEDICAID BULLETIN

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Revised Update to Pending 1915(c) Home and Community-Based Services (HCBS) Waivers Amendments—Approvals and Procedure Changes to Legally Responsible Individuals Effective July 1, 2025

The purpose of this bulletin is to provide an update to the Medicaid Bulletin "Update to Pending 1915(c) Home and Community-Based Services (HCBS) Waivers Amendments" dated December 20, 2024. DMAS submitted waiver amendments on September 20, 2024, for its four HCBS waivers: Building Independence (BI), Community Living (CL), Family and Individual Supports (FIS), and Commonwealth Coordinated Care Plus (CCC+). In its December 20, 2024, Medicaid Bulletin, DMAS informed providers that the Centers for Medicare and Medicaid Services (CMS) had paused approval on these amendments.

On April 17, 2025, DMAS received approval from CMS regarding these amendments.

1. Effective September 1, 2025, combining the annual service limits for Assistive Technology and Electronic Home-Based Services into an annual calendar year $10,000 limit to be shared, according to the member's needs, between the two services. (BI, CL, FIS)

Additional details to be provided from DMAS and the Department of Behavioral Health and Developmental Services soon.

2. Effective July 1, 2025, removing educational requirements for providers of Consumer-Directed Services Facilitation. (CL, FIS, CCC+)

SF providers are not required to have either an Associate's Degree or higher from an accredited college in a health or human services field.

SFs are still required to complete the SF modules with at least an 80% passing grade for each module at hire and every 5 years thereafter. Work experience requirements remain in effect. All new SFs must have a minimum of two years of satisfactory direct care experience supporting individuals with disabilities or older adults. Such experience must be verified through reference checks prior to hire and may not include any instances of abuse, neglect, or exploitation.

3. Effective July 1, 2025, finalizing rules regarding when a Legally Responsible Individual (LRI) is the paid aide/attendant for the personal care service. (CL, FIS, CCC+)

Reimbursing Legally Responsible Individuals (LRIs)

Legally responsible individuals are defined as parents or legal guardians of minors or the participant's spouse. Personal care/assistance services provided by a legally responsible individual must be extraordinary in nature, which is above and beyond what they are obligated to provide. Personal care/assistance may only be used to meet the extraordinary needs of the member under the age of 18 due to their disability, and it is above and beyond the typical basic care for a child that all families with children of the same age may experience. For members younger than 18 years of age, the LRI must meet the needs of the participant, including the need for assistance and supervision typically required for children at various stages of growth and development.

Reimbursement may be made to LRIs for up to 40 hours per week. When the LRI is reimbursed for providing assistance to multiple children, they may be reimbursed for up to 40 hours per week for each child.

The LRI must also meet the same requirements as other personal care aides or attendants. All services rendered by a paid LRI must be within the scope of the personal care service and are limited to support with Activities of Daily Living (ADLs). Instrumental Activities of Daily Living (IADLs) and general supervision are not considered extraordinary care and are, therefore, not allowable. Respite services are not available when there is a paid LRI providing personal care/assistance.

The RN agency supervisor/SF and MCO care manager/CSB support coordinator must monitor services at least every 90 days to ensure that the individual's growth towards independence is not hindered by having a LRI as a paid support person and that the LRI remains aware of the different relationship that exists once they become a paid employee supporting the individual.

Consumer Direction

When the consumer-direction model is used, the Employer of Record (EOR), who is responsible for the direct oversight of services and approves all attendant work shifts for payment, may be another LRI, including a parent or step-parent. Under consumer direction, the following requirements must be met to ensure the services are in the best interest of the participant and to ensure payments are made only for services rendered:

1. Individuals must choose a SF;

2. The DMAS-95B ("Consumer-Direction Services Management Questionnaire") must be completed once for each EOR; reviewed by the SF to determine if the EOR can appropriately manage CD services before the next service authorization request is submitted; and stored by the SF in the individual's records. This document is not required for service authorization;

3. The LRI must document all tasks for each shift through a DMAS-approved method.

Extraordinary Care and Person-Centered Plan Development

DMAS had extensive discussions with CMS regarding extraordinary care requirements. CMS requires states to have a method for determining and documenting that care provided by an LRI is extraordinary in nature. These waiver amendments were delayed as CMS stated that existing procedures have not been sufficient. They required DMAS to implement additional procedures to ensure this provision is being followed as a condition of approval.

Effective July 1, 2025, providers are required to document the need for extraordinary care during the person-centered planning process. The nurse supervisor or SF must identify the individual's extraordinary support needs in relation to ADLs with the member, family, EOR, and any other parties as the member desires. This information can be documented on the existing Agency or Consumer Direction Provider Plan of Care (DMAS-97AB) and the Community-Based Care Member Assessment (DMAS-99)

The extraordinary care documentation requirements include:

- The types of ADL tasks requiring support (DMAS-97AB)
- The time to complete each task per day (DMAS-97AB)
- Evidence that the task is not typical care based on the age and development of the individual. (DMAS-99)

Tasks that are not extraordinary in nature will not be approved or reimbursed. LRI caregivers will not be reimbursed for providing instrumental ADLs or supervision. To assist providers in determining whether care is extraordinary, DMAS has developed a guide based on the chronological age of the individual and needs that are beyond those typically required. This guide provides support and guidance to ensure that the care provided meets the necessary criteria for reimbursement. See Attachment A for more details.

When there is a need for an additional attendant/aide who is not an LRI, a second Plan of Care will be developed. The development of the non-LRI Plan of Care and LRI Plan of Care is a collaborative process, working in tandem to address the waiver individual's daily needs. This collaborative approach ensures that all aspects of the waiver individual's care are considered. To receive service authorization, the personal care agency/Services Facilitator must submit both the plans together.

Additionally, to ensure the waiver individual's desires and needs are expressed and met, to the extent practical, the provider shall document the individual's choice of provider. The provider must also document that services by a legally responsible individual is in the best interest of the waiver participant, and in instances when the legally responsible individual has decision-making authority over the selection of providers of waiver services, they must attest that they are using "substituted judgement" on behalf of the individual (i.e., makes decisions based on an understanding of what the individual would want).

DMAS is in the process of developing updates to existing program manuals and forms to incorporate extraordinary care requirements. These documents will be used during the service authorization process to ensure requirements are met.

LRIs and Signatures

The paid LRI for a minor may sign the DMAS-99 and DMAS-97A/B as they remain the legal representative of the member.

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
Humana Healthy Horizons Provider Services Call Center	1-844-881-4482 (TTY: 711) https://provider.humana.com/medicaid/virginia-medicaid
Sentara Community Plan	1-800-881-2166 https://www.sentarahealthplans.com/providers
United Healthcare	www.uhcprovider.com/ 1-844-284-0146
Acentra Health Behavioral Health and Medical Service Authorizations	https://vamedicaid.dmas.virginia.gov/sa 1-804-622-8900
Dental Provider DentaQuest	1-888-912-3456
Fee-for-Service (POS) Prime Therapeutics	https://www.virginiamedicaidpharmacyservices.com/ 1-800-932-6648