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MEDICAID BULLETIN

Last Updated: 08/27/2025

Consumer-Directed (CD) Services Facilitation (SF) Requirements and Reminders

The purpose of this bulletin is to remind Services Facilitators of requirements and responsibilities as Medicaid providers. The Department of Medical Assistance (DMAS) has been made aware of actions that are not in compliance with the expectations of a Medicaid enrolled Services Facilitator. DMAS reminds Services Facilitators that any actions that are out of compliance with rules and regulations may result in negative consequences, including retraction of Medicaid payments. Of concern are the topic areas below:

Face-to-Face Visits

As stated in regulations, manuals, and in the December 28, 2022 Bulletin "Face-to-Face Supervisory, Services Facilitation and ID/DD Case Management Visits 1/1/2023", Consumer-Directed Services Facilitators were required to resume face-to-face visits. This includes all visits with the exception of the Employer Management Training (S5109) for the Community Living and Family and Individual Supports Waivers (12VAC30-122-500.B.2.d; 12VAC30-122-500.B.3). All visits for members in the Commonwealth Coordinated Care (CCC) Plus Waiver must be face-to-face (12VAC30-120-935.G.4.d.(3); 12VAC30-120-935.G.4.d.(4); 12VAC30-120-935.G.4.d.(5); 12VAC30-120-935.G.4.d.(7).(c). Conducting visits with the member and/or Employer of Record (EOR) via a virtual or telephonic method and billing the visit as though it were performed face-to-face is not allowed. As stated in provider manuals, if the member and/or EOR is not available at the date, time, and location of the visit, the visit must be rescheduled within 15 days (CCC Plus Waiver Provider Manual, Chapter IV, Page 14). When any assessment is performed, the member must be present.

The signature by the member/EOR and the Services Facilitator is not only an attestation of the member's understanding of what is included on the documentation but also serves as confirmation that the visit was conducted in accordance with rules and regulations. The practice of obtaining signatures via a "courier" or "traveling notary" type staff after visits have been conducted is not permitted. Signatures by the Services Facilitator who conducted the visit and the member/EOR must be received at the conclusion of the visit in the face-to-face setting; no Services Facilitator may use a "Signature on File" for their own signature nor may the person who conducts the visit use another person's signature as the Services Facilitator. Additional electronic signature requirements are outlined in Chapter VI of the CCC Plus Waiver Provider Manual.

Role of the Services Facilitator

Services Facilitators are required to report changes that may affect eligibility, including

admission or discharge from services, using the DMAS-225. Service Facilitators are required to submit the DMAS-225 to the local Departments of Social Services, other providers, and managed care organizations as documented in the CCC Plus Waiver Provider Manual (Chapter IV, "Long Term Care Communication Form (DMAS-225)".

Services Facilitators work with the member/EOR to develop the Plan of Care/Plan for Supports and submit it to the appropriate service authorization entity. The Plan of Care and supporting documentation is the method by which the Services Facilitator identifies the appropriate number of hours based on the member's person-centered needs. Services Facilitators are required to submit authorization requests within the necessary timeframe to the authorizing entity. Failure to do this means that the member's attendant will not be paid for services rendered prior to the receipt of the authorization. Repeated failures to complete timely service authorization requests are seen as an inability to meet a basic requirement to remain an enrolled provider. If a Services Facilitator is unable to meet the program requirements for the members on their caseload, they will need to reduce the number of members they serve. The Services Facilitator must adhere to the member disenrollment requirements for each program.

Further, DMAS and the Department of Behavioral Health and Developmental Services have received numerous complaints from members, EORs, and attendants regarding the lack of communication from their Services Facilitator, and many report missed visits by Services Facilitators. Services Facilitators are responsible for conducting quarterly visits as well as responding to inquiries in a timely manner.

Electronic Visit Verification (EVV)

Per the January 7, 2021 Medicaid Bulletin titled "Electronic Visit Verification Live-In Caregiver Exemption and Consumer-Directed Personal Care Overtime" and 12VAC30-60-65, EVV is required for all attendants except attendants who reside in the same home as the member receiving services. Attendants who do not live with the Medicaid member must use the Fiscal-employer agent's mobile EVV application or the Interactive Verification Response (IVR) system to enter shifts. The web portal is not an approved method for non-live in attendants. Exception methods to submit work shift entries for non-live-in attendants should only be used when necessary and are not to be the standard method of submission. Part of the Services Facilitator's role is to ensure that requirements of the program are met. This also includes ensuring that the documented tasks being entered at the end of each shift by the attendant align with the member's Plan of Care. If the Services Facilitator identifies that the documented tasks being entered do not align with the member's Plan of Care, the Services Facilitator should determine if the current Plan of Care adequately addresses the member's needs and educate the member/EOR that tasks performed outside of the Plan of Care are not permitted. Therefore, it is the responsibility of the Services Facilitator to educate the member/EOR on these requirements.

DMAS is required to report EVV compliance to the Centers for Medicare and Medicaid

Services. Fiscal-Employer Agents (F/EAs) provide DMAS with a report on frequent and repeat offenders who have failed or refused to use EVV to submit work shift entries. In June 2025, the F/EAs sent communication blasts to EORs and attendants reminding them of their requirement to adhere to EVV compliance.

Repeat offenders who do not use EVV for consumer-directed services will be escalated for review. When resolution cannot be accomplished, these members may be contacted by DMAS or their MCO and may be removed from the consumer-directed model of service delivery. Services Facilitators should remind members and EORs of the importance of meeting consumer directed requirements, which includes compliance with EVV. If members or EORs indicate a refusal to adhere to EVV requirements, the consumer-directed model of service delivery is not appropriate, and the Services Facilitator must refer the member to agency-directed services pursuant to 12VAC30-120-924.B and 12VAC30-122-160.

Nursing Services vs Consumer Directed Services

It is vital that members receive the appropriate services to meet their needs. DMAS is aware of requests for family members to provide nursing activities and being reimbursed under the auspices of consumed directed personal care. While trained family members can provide nursing services for their family member, these services cannot be reimbursed as personal care. DMAS is aware of activities that occur among the nursing agency, the Services Facilitator, and the member/family in order to allow this practice. When DMAS becomes aware of these occurrences, they will be discontinued. Services Facilitators need to ensure that families understand their choices and the appropriate service to meet the member's needs.

Mandated Reporting

Providers of Medicaid services are mandated reporters; this includes Services Facilitators (12VAC30-120-930.B.17 and 12VAC30-122-120.A.16). Services Facilitators are required to report any actual or suspected instances of abuse, neglect, or exploitation. A report is not an accusation against any party, but rather such reports are necessary to ensure that members have proper support. Information on filing reports of suspected or actual instances of abuse, neglect, or exploitation can be found in the CCC Plus Waiver and DD Waiver Provider Manuals.

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