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MEDICAID BULLETIN

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# Home and Community-Based Settings (HCBS) Rule Compliance Post December 31, 2025

On March 17, 2014 (CMS) issued the Home and Community Based Services (HCBS) Final Rule ("settings rules") 42 CFR 441.301. The rule defines home and community-based settings as a person-centered and home-like or community-based environment with the freedoms that should be characteristic of any home and community-based setting.

On December 31, 2025, Virginia successfully completed the initial compliance reviews of all services required to comply with the "settings rules," e.g. group homes, sponsored residential settings, supported living settings, group supported employment and group day services to ensure compliance with the Home and Community Based Settings (HCBS) Regulation (42 CFR 441.301(c)(4)). However, reaching compliance is not a one-time achievement and, as such, the system is moving into the ongoing monitoring process to ensure that providers maintain their compliance status.

Per 42 CFR §441.301(c)(6), states were required to develop a Statewide Transition Plan (STP) to describe how the state would ensure compliance with the HCBS Final Rule at both the state level and in their provider communities, providing transparency to stakeholders. Virginia's plan was approved by CMS on August 22, 2019.

Virginia's approved STP (as well as others) are available at https://www.medicaid.gov/medicaid/home-community-based-services/statewide-transition-plans/index.html

STPs included settings assessments, heightened scrutiny, remediation milestones, and associated timeframes. STPs are no longer in effect with the HCBS Final Rule Transition period ending, though the processes they described, especially for ongoing monitoring, will continue.

During the transition period, certain services ***were presumed to be compliant*** with the regulation. Specifically, services that take place in the individual's home or the community (examples- personal care, in-home support services). While this presumption remains true, Virginia will begin looking at training and policies of these providers to ensure that individuals utilizing these services have a community-based experience and that the presumed compliance is, in fact, true. The provisions of the HCBS Regulation have been embedded into multiple review processes including but not limited to Quality Management Reviews (QMR), Quality Service Reviews QSR, and specific HCBS reviews.

**All providers** must comply with 12VAC30-122-120 (A)(7):

*"Provide medically necessary services and supports for individuals in accordance with the ISP and in full compliance with 42 CFR 441.301, which provides for person-centered planning and other requirements for home and community-based settings including the additional requirements for provider-owned and controlled residential settings; Title VI of the Civil Rights Act of 1964, as amended (42 USC § 2000d et seq.), which prohibits discrimination on the grounds of race, color, or national origin; the Virginians with Disabilities Act (Title 51.5 (§ 51.5-1 et seq.) of the Code of Virginia); § 504 of the Rehabilitation Act of 1973, as amended (29 USC § 794), which prohibits discrimination on the basis of a disability; and the Americans with Disabilities Act, as amended (42 USC § 12101 et seq.)."*

This regulation is applicable to all developmental disability waiver providers. Providers must ensure that their policies and procedures are in alignment with the HCBS regulation and have educated their employees of the regulation. Further information is available in the DD Waiver manual chapter two (2) on pages 30-37 (https://vamedicaid.dmas.virginia.gov/sites/default/files/2025-07/DD%20Waivers%20Chapter%202%20%28updated%207.17.25%29_Final.pdf). The Department of Behavioral Health and Developmental Services (DBHDS) will include HCBS policy and training reviews during the Quality Service Review (QSR) process.

Group home, sponsored residential, supported living, group supported employment and group day providers will receive specific HCBS reviews using the new Home and Community Based Compliance Portal (outlined below). These reviews will consist of documentation reviews, individual interviews, staff interviews and a tour of the setting. These reviews are mandatory and failure to participate in the review process or remediate areas of non-compliance may result in termination of the service provider's Medicaid Provider Participation Agreement.

The Virginia Department of Medical Assistance Services (DMAS) is launching a new system and portal to manage the ongoing monitoring process. This process will streamline communications, reduce administrative burden on providers, and promote more consistency in the review process. The portal will be available starting February 7, 2026. The provider's primary account holder (PAH) in the Medicaid Enterprise System (MES) will be able to see the new portal under the Care Management tile and assign a designee, if needed. A user guide is available on the MES website (https://vamedicaid.dmas.virginia.gov/sites/default/files/2026-01/HCP_UserGuide.pdf) and DMAS will be holding a series of training sessions for providers during the month of February 2026. All training registration links will be sent via the DBHDS Provider Listserv.

As was outlined in the STP, the transition process was only available for providers who were enrolled to provide DD services prior to 2018. Any provider who is seeking to become a DMAS provider of group home, sponsored residential, supported living, group day services and group supported employment must enter the system in compliance. Compliance is

determined via a self-assessment and policy review for any provider who does not have a presumption of isolation. Any provider who is attempting to enroll with DMAS to provide DD services (group home, sponsored residential, supported living, group supported employment and group day) but does meet the criteria for potential isolation will be reviewed using the guidance from CMS that was published on August 2, 2019 which includes a review of individuals receiving services from the provider utilizing a funding source that is not Medicaid HCBS. A self-assessment is not required for providers who are enrolling to provide services that are presumed to be compliant as they take place in the community.

**For Questions, please refer to the contact information below.**

***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** | |
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| **Virginia Medicaid Web Portal**<br>**Automated Response System (ARS)**<br>Member eligibility, claims status, payment status, service limits, service authorization status, and remittance advice. | https://vamedicaid.dmas.virginia.gov/ |
| **Medicall (Audio Response System)**<br>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**<br>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.

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| **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<br>Out of State Toll Free: 888-829-5373<br>Email: VAMedicaidProviderEnrollment@gainwelltechnologies.com |
| **Provider HELPLINE**<br>Monday–Friday 8:00 a.m.-5:00 p.m. For provider use only, have Medicaid Provider ID Number available. | 1-804-786-6273<br>1-800-552-8627 |
| **Aetna Better Health of Virginia** | https://www.aetnabetterhealth.com/virginia/providers/index.html<br>1-800-279-1878 |
| **Anthem HealthKeepers Plus** | http://www.anthem.com/<br>1-800-901-0020 |
| **Humana Healthy Horizons**<br>Provider Services Call Center | 1-844-881-4482 (TTY: 711)<br>https://provider.humana.com/medicaid/virginia-medicaid |
| **Sentara Community Plan** | 1-800-881-2166 https://www.sentarahealthplans.com/providers |
| **United Healthcare** | www.uhcprovider.com/<br>1-844-284-0146 |
| **Acentra Health**<br>Behavioral Health and Medical Service Authorizations | https://vamedicaid.dmas.virginia.gov/sa<br>1-804-622-8900 |
| **Dental Provider**<br>DentaQuest | 1-888-912-3456 |
| **Fee-for-Service (POS)**<br>Prime Therapeutics | https://www.virginiamedicaidpharmacyservices.com/<br>1-800-932-6648 |