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https://dmas.virginia.gov

MEDICAID BULLETIN

Last Updated: 03/31/2026

Updates on Continuity of Care from the Commonwealth Coordinated Care Plus (CCC Plus) Waiver to a Developmental Disabilities Waiver

The purpose of this bulletin is to provide additional clarification to the continuity of care process outlined in the Medicaid Memo "Transitioning from the Commonwealth Coordinated Care Plus (CCC Plus) Waiver to a Developmental Disabilities Waiver" last updated 07/28/2022.

This guidance affects individuals who are transitioning from specific services in the Commonwealth Coordinated Care Plus (CCC Plus) Waiver to like services in a Developmental Disabilities (DD) Waiver, which includes the Community Living (CL), Family and Individual Supports (FIS) and the Building Independence (BI) Waivers. It remains essential that Support Coordinators work with the assigned MCO Care Manager and/or current provider for a seamless transition between the two waivers to mitigate service interruption and conclude service authorizations under the CCC Plus for the day prior to the proposed start date of the DD Waiver.

NOTE: When an individual transitions from CCC Plus Waiver to one of the DD waivers (regardless of the type of services), the Support Coordinator must ensure that services for DD waivers start on the 1st of the month following the "accepted status" assignment described below. DD Services for individuals transitioning waivers CANNOT start Mid-Month.

The continuity of care service authorization (SA) process will now be **extended** to services beyond Agency Directed and Consumer Directed Personal Assistance (PA) to include the following:

- Agency Directed and Consumer Directed Respite
- Personal Emergency Response System Service (PERS) and
- Private Duty Nursing (RN and LPN, including PDN from EPSDT)

The following services are **not eligible** for the continuity of care authorization process and instead need to be submitted meeting medical necessity requirements for the new eligibility

program (DD Waiver):

- Assistive Technology
- Environmental Modification
- Transition Services
- Services that exist in DD waivers but not CCC plus waiver.

Services that exist in CCC Plus waiver but not in DD waivers are not eligible for a continuity of care authorization under the DD waivers. Those services would be terminated by the MCO and appeal rights issued.

The DD Waiver Enrollment Process

The DD waiver enrollment process begins when an individual currently enrolled in CCC Plus Waiver has accepted a DD waiver slot and is moved to "accepted status" in the Waiver Management System (WaMS). The first Service Authorization (SA) is submitted to DBHDS or "Pending PA staff review" in WaMS. Upon review, DBHDS will ensure the individual meets functional eligibility requirements such as meeting the Virginia Individual Developmental Disabilities Eligibility Survey (VIDES), completed no more than 6 months prior to enrollment, and a Medical Examination, completed no earlier than 12 months prior to the initiation of waiver services.

DD waiver enrollment (to include the start date of services) cannot begin earlier than the first day of the month following the DD waiver slot being moved to accepted status. Upon the approval of a continuity request of the first authorization in WaMS, the Level of Care (LOC) or waiver line will be updated in WaMS and transmitted to MES, the DMAS system for DD Waiver, and the CCC Plus waiver LOC will be ended the day prior.

For example: An individual currently enrolled in CCC Plus Waiver has accepted a DD waiver slot. The individual is moved to accepted status in WaMS by the Support Coordinator on December 10th. The earliest that any DD Waiver services may be authorized to begin is January 1st. The period for continuity of care service authorizations remains 30 calendar days (January 1st-January 30th).

For services to be continued after 30 calendar days, it is paramount that providers submit a new SA that meets the DD Waiver Service Authorization requirements noted in Appendix D of the Provider Manual Title: Developmental Disabilities Waivers (BI, FIS, CL) prior to the end of 30 calendar days.

Continuity of Care Authorizations Requirements

When a continuity of care SA request is submitted, the provider should type into the justification field for the SA in WaMS "continuity of care service authorization request."

Once the provider submits the request, the Support Coordinator verifies the hours or units with the MCO Care Manager. If accurate, the Support Coordinator submits the continuity of care service authorization request to DBHDS.

DBHDS service authorization staff will approve the 30-day service authorization for respite, personal assistance, PERS, and/or private duty nursing for the same number of hours or units currently authorized by the CCC Plus health plan at the time the individual transitions to the DD waiver.

The provider completes and submits to DBHDS all required assessments and documentation for DD Waiver service authorization by the 20th of the month that the continuity of care authorization is in effect. DD waiver service authorization requests received after the 30-day continuity of care period will result in a start date of the date the request is received, which will result in a lapse in service authorization and payment for services rendered. DMAS has sole discretion to extend the continuity of care period timeframe.

Documentation Requirements for Continuity of Care

The provider must submit the **most recent version** of the following forms for any continuity of care authorization:

Respite and personal assistance services:

- CCC Plus Waiver plan of care (DMAS 97A/B) and
- DMAS 99 Form

NOTE: Respite hours do not reset upon transitioning to the DD waivers. The total amount either by agency or consumer directed respite (or both) remains 480 hours and resets each fiscal year. (July 1)

Private duty nursing:

- Home Health Certification and Plan of Care form (CMS-485 form) (signed and dated by the physician) that was used by CCC Plus Waiver or EPSDT for nursing services.
- DMAS-62 form that was used by EPSDT for nursing services.

PERS:

- PERS CCC Plus Waiver Plan of Care (DMAS-100A or copy of current DMAS approved electronic request).
- Installation of the PERS device shall not be included in the continuity of care service authorization request.
- PERS cannot be the only waiver service utilized by the individual.
- PERS continuity of care SA will not be approved or will be terminated if the individual receives an incompatible DD waiver service (Group Home Residential, Sponsored Residential, or Supported Living Residential).

ADDITIONAL INFORMATION ON THE MEDICAID WAIVERS:

DBHDS website: Waiver Services - Virginia Department of Behavioral Health and Developmental Services (DBHDS)

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