PUBLIC COMMENT OPPOSING ALL EIGHT PROPOSED HCBS WAIVER AMENDMENTS

Virginia Regulatory Town Hall • General Notice 3470 • CCC+, CL and FIS Waivers • October 2026

Executive summary and opening position

I strongly oppose all eight proposed amendments to Virginia's Community Living (CL), Family and Individual Supports (FIS), and Commonwealth Coordinated Care Plus (CCC+) Medicaid waivers and request their withdrawal. These objections concern the substance of the changes, not simply missing explanations. I separately request reconsideration of the live-in caregiver Electronic Visit Verification (EVV) mandate, a meaningful public-comment process, and a minimum six-month implementation period after that process is completed, with continuity protections while Virginia reviews the legal and operational conflicts. This comment addresses the proposals individually and cumulatively because a person receiving services experiences the actual combination of changes, not eight separate administrative files. *[Sources:* Virginia Town Hall, General Notice 3470; DMAS, summary of proposed waiver amendments; DMAS bulletin dated September 9, 2026] The fiscal record also merits individual-level scrutiny: the proposed 56-hour restriction was projected to reduce the Commonwealth General Fund by $44,846,032 over FY2027–FY2028, averaging $2,127.52 per authorized CL/FIS slot over those two years if spread across every slot. This is not the actual reduction to a participant whose hours are cut. Virginia's 2025 median nursing-home prices were $123,005 annually for a semi-private room and $140,160 for a private room. Market prices are not Medicaid reimbursement rates, but the comparison highlights the need to establish whether restricting community support will shift costs to institutional services rather than generate net savings.

Fiscal sources: Virginia Executive Biennial Budget (DMAS, FY2027–2028) | Virginia appropriation: authorized CL/FIS waiver slots | CareScout 2025 Virginia median cost table

Introduction

I am submitting this public comment in opposition to all eight proposed amendments to Virginia's Community Living (CL), Family and Individual Supports (FIS), and Commonwealth Coordinated Care Plus (CCC Plus) waivers. I am the parent of waiver service recipients, a caregiver, and a longtime disability advocate with firsthand experience navigating Medicaid waivers, consumer-directed attendant care, services facilitation, and the practical realities of supporting people with significant disabilities in their homes and communities. I am not an attorney, and I offer the legal and regulatory references in this comment as my good-faith understanding as a layperson so that DMAS and other readers can review the underlying sources directly. The eight proposed changes are described in the Virginia Regulatory Town Hall notice. *[Sources:* Virginia Town Hall, General Notice 3470]

I want to be equally clear about what I am requesting. I am not asking DMAS merely to explain these changes more fully, improve its guidance, or describe additional safeguards. I am asking that all eight proposed changes be reconsidered and withdrawn. Where I ask a question, identify an implementation problem, or describe a safeguard that might reduce harm, that should not be interpreted as agreement that the underlying change is appropriate. An answer to a question does not

resolve the objection that caused the question, and a mechanism intended to reduce the consequences of a policy does not necessarily make the policy itself acceptable.

My concerns are grounded primarily in what these policies mean when they leave an administrative document and enter a person's home. A reduction in paid assistance does not reduce the number of times someone needs help eating, bathing, transferring, communicating, using the restroom, or remaining safe. Eliminating an established provider does not create a qualified replacement. Moving a responsibility from one organization to another does not automatically transfer years of knowledge about a person. Removing a review does not prevent an erroneous decision. And reducing paid family-caregiver hours does not transform the remaining disability-related care into an unlimited supply of free family labor. These consequences affect not only Virginians with disabilities, but also their caregivers and families, attendants and providers, MCOs, DBHDS and other public agencies, hospitals and institutions, employers, and the communities in which they live.

These proposals also cannot be evaluated as though each will occur independently. The same Virginian may encounter a 56-hour personal-assistance threshold, loss of an established Services Facilitator, changed Employer-of-Record responsibilities, restrictions involving a current caregiver or transportation provider, reduced review protections, changed quality oversight, and the separately implemented live-in caregiver EVV requirement within the same period. The cumulative impact therefore matters just as much as the stated purpose of each individual amendment, particularly when determining whether these changes preserve continuity of care, prevent destabilization of existing community-based supports, and allow people with disabilities to remain safely supported in their homes and communities. Federal Medicaid HCBS rules themselves center person-centered planning on the individual's assessed needs, strengths, preferences, goals, and paid and unpaid supports. ***[****Sources:* 42 C.F.R. § 441.301(c)**]***

I also recognize that the federal legal landscape concerning disability integration has recently changed. In Texas v. Kennedy, formerly Texas v. Becerra, the federal district court vacated specified community-integration provisions contained in HHS's 2024 Section 504 regulations. I do not rely on those vacated regulatory provisions as though they remain in effect. My lay understanding, however, is that the decision did not repeal Section 504, amend the Americans with Disabilities Act, overturn the Supreme Court's decision in Olmstead v. L.C., or vacate CMS's separate Medicaid HCBS regulations. The concerns raised in this comment therefore do not depend upon the validity of the vacated 2024 Section 504 provisions. They include separate Medicaid requirements, Virginia's own program rules, applicable procedural and employment protections, and the practical consequences of whether necessary services actually remain available. ***[****Sources:* Texas v. Kennedy, No. 5:24-cv-00225-H, final judgment (Sept. 23, 2026); Olmstead v. L.C., 527 U.S. 581 (1999); 42 C.F.R. § 441.301(c)**]***

Throughout this comment, I therefore ask that the proposals be considered from the perspective of the people who must live with their combined consequences. Will the person continue receiving the care that their disability actually requires? Will existing supports remain stable while administrative systems change? Will the person retain meaningful choice and the ability to live and participate in the community? And if a service, caregiver, review, or support is removed, is there an actual replacement available before it disappears? For the reasons that follow, I strongly oppose all eight proposed changes and respectfully request that they be withdrawn.

1. Proposed 56-hour weekly threshold for personal assistance (CL and FIS)

What DMAS proposes and why I oppose it

DMAS proposes a 56-hour weekly "soft cap" for personal care/assistance in the CL and FIS developmental disability waivers, modeled on the existing CCC+ framework, with an exception procedure for requests above that amount. The 2026 Appropriation Act directs DMAS to seek federal authority for this change. I acknowledge that the proposal contains exceptions, but my objection is to creating the numerical threshold as the default in the first place. Fifty-six hours is an administrative number, not a determination of the particular hours required to help an individual eat, bathe, dress, use the restroom, transfer, communicate, manage disability-related health needs, and remain safe. An exception process does not remove the presumption that someone with more extensive needs must separately prove why care above the chosen number should continue. *[Sources:* Virginia Town Hall, General Notice 3470; 2026 Virginia Appropriation Act, Item 291; DMAS, summary of proposed waiver amendments; 12VAC30-120-924, CCC Plus covered services]

Care needs are also not evenly distributed in eight-hour blocks. They may be concentrated during mornings and evenings, repeated through the night, or triggered by seizures, changes in mobility, eating and swallowing difficulties, developmental or communication needs, and emergencies. A person who needs assistance at unpredictable intervals cannot simply defer those needs until a paid shift becomes available. If an assessment establishes a need for 70 or 90 hours each week, cutting an authorization to 56 does not make the other hours disappear. The remaining need still exists, and the policy must account for who will actually provide the care. Federal person-centered planning expressly addresses assessed functional needs, identified goals, risk factors, backup plans, and paid and unpaid supports. *[Sources:* 42 C.F.R. § 441.301(c)]

Paid family caregivers, voluntary supports and wage protections

The proposal is particularly troubling for families in which a parent, spouse, sibling, or other relative is also a lawful paid attendant. Federal Medicaid and Virginia program arrangements permit qualifying family members to be paid for covered services under specified conditions. The fact that the employee is related to the member does not establish that the member's paid personal-care needs are merely ordinary unpaid family chores. Nor does a reduced authorization change an existing need into voluntary labor. Federal HCBS regulations define natural supports as unpaid supports provided voluntarily, and CMS explained in the 2014 rulemaking that the planning process must not compel unpaid services. *[Sources:* 42 C.F.R. § 441.301(c); CMS HCBS final rule, 79 Fed. Reg. 2948 (2014); 12VAC30-122-150, consumer-directed model; DMAS, summary of proposed waiver amendments]

I recognize that families voluntarily help one another, and I am not asserting that all parental, spousal, or familial assistance is compensable employment. But there is an important distinction between ordinary voluntary family support and work performed within an employment relationship for covered attendant services. The Fair Labor Standards Act generally establishes minimum-wage and overtime protections for covered compensable work, subject to the applicable employer, worker classification, and home-care exemptions. DMAS should not treat a family caregiver's relationship to the member as a blanket justification for presuming that previously authorized paid work will be performed without compensation. The effect of a service cut cannot be evaluated by quietly converting missing paid hours into assumed free family labor. *[Sources:* 29 U.S.C. § 206, minimum-wage

requirements; 29 U.S.C. § 207, overtime requirements; U.S. Department of Labor, home-care employment guidance; 42 C.F.R. § 441.301(c)]

That assumption is also unsustainable for families caring for multiple people with disabilities, for aging parents, for caregivers with their own medical needs, and for households with employment, school, and other responsibilities. It can cause a family caregiver to stop outside employment or reduce work hours; it can also make the paid caregiving position economically unviable. Providers may struggle to recruit attendants for fragmented or reduced schedules, leaving both the participant and the paid-care workforce worse off. These are foreseeable practical consequences, not claims that every family will experience the same outcome.

Consequences for agencies, providers and public finances

The Commonwealth's 2026–2028 executive budget projected General Fund reductions of $21,038,424 in FY2027 and $23,807,608 in FY2028 for standardizing HCBS hourly limits, a combined $44,846,032 over two years; it also identified corresponding nongeneral-fund reductions. Those numbers are projected budget effects, not evidence that net Commonwealth and MCO costs will actually fall by the same amount. A meaningful analysis must include participants presently authorized above 56 hours, the criteria and expected approval rates for exceptions, clinician documentation, administrative staffing, appeals, provider availability, family employment loss, missed care, hospital admissions, and institutional costs. *[Sources:* 2026–2028 Executive Biennial Budget, DMAS decision packages; 2026 Virginia Appropriation Act, Item 291]

The proposal can shift administrative work rather than remove it. DMAS, DBHDS-related service coordination, clinicians, MCOs where responsible, support coordinators, providers, and appeals staff may face exception requests, additional assessments, urgent calls, disrupted staffing, and disputed denials. Hospitals may face delayed discharge when a safe care plan cannot be staffed. If a person's community placement fails, a budget saving attributed to personal assistance may simply reappear as higher expenditure on another service or in another agency's budget.

What the proposed savings amount to per waiver slot

The 2026–2028 Executive Biennial Budget projects the following reductions from standardizing personal-assistance hours. The enacted Virginia budget separately authorizes 12,520 Community Living slots and 8,559 Family and Individual Supports slots as of July 1, 2026, a total of 21,079. Dividing the projected reductions by those slots provides a useful statewide benchmark, but not an estimate of the hours or dollars that any particular member will lose. An authorized slot is not proof of current enrollment, receipt of personal assistance, or authorization above 56 hours.

Measure	Projected budget reduction	Per authorized CL/FIS slot
FY2027, Commonwealth General Fund	$21,038,424	$998.08
FY2028, Commonwealth General Fund	$23,807,608	$1,129.45
FY2027–FY2028, Commonwealth General Fund	$44,846,032	$2,127.52
FY2027–FY2028, all Medicaid fund sources	$93,525,718	$4,436.91

The General Fund column measures the projected effect on state appropriations; the all-funds column includes projected nongeneral funding, principally Medicaid-related federal financing. These should

not be added together. Statewide averages dilute the concentration of changes among the smaller number of participants whose assessed needs currently exceed 56 hours.

How the impact changes when fewer members actually lose hours

DMAS should publish the actual number of participants with authorizations above 56 hours, expected reductions after exceptions, and the resulting distribution of per-member changes. Pending that disclosure, the same $44,846,032 two-year General Fund projection implies the following arithmetic only when divided among possible affected cohorts; these are not forecasts of the number affected.

Hypothetical members absorbing reductions	Projected GF savings per affected member, 2 years
2,000	$22,423.02
5,000	$8,969.21
10,000	$4,484.60

For a family, the gap created by a reduction is measured in meals, transfers, personal-care tasks, and hours when no paid caregiver is available, not by the average calculated across all waiver slots. If the projected savings depend on eliminating necessary delivered care, DMAS must identify who will provide that care and at what real economic cost.

Direct budget and slot-count sources: Virginia Executive Biennial Budget, DMAS decision packages, page 217 | 2026 Appropriation Act, Item 291, CL and FIS slots

Community integration

Personal assistance makes ordinary community life possible: attending school or work, going to appointments, shopping, maintaining relationships, participating in civic activities, and simply choosing where and how to live. Insufficient hands-on help can effectively confine a person to a bedroom or home even when no institutional admission occurs. The HCBS settings rule speaks directly to full access to the greater community. The Supreme Court recognized important limits on unnecessary segregation in Olmstead, and the Fourth Circuit addressed the risk of institutionalization associated with reductions in in-home personal care in Pashby v. Delia. Those cases have particular factual and legal contexts, and I cite them as relevant principles rather than a claim that every administrative threshold automatically violates them. *[Sources:* 42 C.F.R. § 441.301(c); Olmstead v. L.C., 527 U.S. 581 (1999); Pashby v. Delia, 709 F.3d 307 (4th Cir. 2013)]

Continuity of care and requested action

A person's eligibility remaining active is not continuity of care if an existing authorized service is reduced and the care is no longer delivered. A promised exception does not keep someone safe while records are requested, decisions are delayed, or a hearing is pending. Medicaid notice and hearing requirements, including continuation protections in specified circumstances, are relevant when actual service reductions occur; those protections are not universal automatic extensions regardless of timing and circumstances. I oppose the threshold itself and ask that the proposal be withdrawn, rather than treating an exception process as an adequate substitute for individualized care decisions. *[Sources:* 42 C.F.R. §§ 431.206, 431.210–431.214; 42 C.F.R. § 431.230, continuation of services]

2. Elimination of standalone Services Facilitation / Support Broker model (CL, FIS and CCC+)

The loss is more than an administrative position

DMAS proposes eliminating Services Facilitation as a standalone service and incorporating the functions into a statewide Support Broker model operating through the Fiscal/Employer Agent (F/EA) contract. The 2026 budget specifically directs this restructuring. DMAS identifies a regional rollout beginning March 1, 2027, and states that a participant cannot receive both services after transition in the region. I oppose eliminating the standalone service, not merely the details of the rollout. A trusted Services Facilitator may know a participant's history, communication needs, support arrangements, past assessment errors, medication and health changes, safety issues, and local resources. Moving a case file does not transfer that knowledge or the relationship built over years. *[Sources:* Virginia Town Hall, General Notice 3470; 2026 Virginia Appropriation Act, Item 295; DMAS, summary of proposed waiver amendments; 12VAC30-120-924, CCC Plus covered services]

I recognize that existing facilitation quality is not uniform. Some families encounter missed visits, inadequate communication, or administrative shortcomings. Those problems deserve enforceable standards, choice, supervision, and corrective action. They do not establish that eliminating the service category and transferring duties to an F/EA-linked broker will improve quality. A participant who cannot reliably describe a missed task, subtle health change, or mistreatment particularly benefits from consistent and knowledgeable contact with someone able to notice the difference.

Conflict of interest, ethics and participant choice

The organizational design raises an ethical problem separate from allegations of misconduct. A structure that combines fiscal administration, enrollment, planning-related assistance, authorization work, and dispute resolution can create conflicting responsibilities when the participant needs help challenging an error by that same system. Federal HCBS planning provisions include conflict-of-interest rules and, where allowed exceptions apply, safeguards such as functional separation and accessible dispute resolution. Existing Virginia CCC+ provisions also prevent a Services Facilitator from concurrently occupying certain roles, including the EOR employing the attendant. I do not claim that every Support Broker arrangement is automatically forbidden by those provisions, but those protections show why independence matters. *[Sources:* 42 C.F.R. § 441.301(c); 12VAC30-120-924, CCC Plus covered services]

Being told that two departments operate separately within one contractor does not automatically give a participant independent assistance. A person who disputes a payroll denial, insufficient plan, unprocessed authorization, or inaccurate assessment needs someone whose duty is to support the participant's interests, with an accessible avenue beyond the entity being challenged. A statewide model can also diminish participant choice if qualified independent facilitators are excluded or if broker assignment is effectively mandatory. Consumer direction should provide meaningful control over service relationships, not merely a different title for the person assigned by a large administrative system.

The restructuring should not assume that families will absorb whatever time the broker model cannot provide. A family member may willingly participate in meetings and solve urgent problems. That does not mean the state may convert an existing funded navigation service into unpaid family

administrative work without considering availability and the voluntary nature of natural supports. *[Sources:* 42 C.F.R. § 441.301(c); CMS HCBS final rule, 79 Fed. Reg. 2948 (2014)]

Consequences for agencies, providers and public finances

The change requires a large-scale transfer of records, assessments, pending authorizations, visit schedules, employer training, case notes, and participant-specific history. It creates staffing and procurement questions for DMAS and F/EAs, workforce implications for existing facilitators, potential workload for MCOs and DBHDS-related support coordination, and risks of delayed authorizations and lost contact. The published regional schedule may reduce simultaneous conversion pressures, but it does not itself establish that each replacement can deliver the same quality of help when needed. *[Sources:* DMAS, summary of proposed waiver amendments]

The 2026–2028 executive budget projected $2,130,903 in FY2027 General Fund savings and $2,228,737 in FY2028 from streamlining facilitation, totaling $4,359,640 for the biennium, plus nongeneral-fund reductions. These are projected direct savings. They do not establish net savings after transitional staffing, contractor administration, missed service requests, complaint handling, delayed care, family work losses, or replacement services. I request disclosure of the assumptions and contract methodology, but that request is not permission to proceed once the figures have been supplied. *[Sources:* 2026–2028 Executive Biennial Budget, DMAS decision packages; 2026 Virginia Appropriation Act, Item 295]

Community integration

A knowledgeable facilitator can help someone obtain services needed for employment, safe transportation, health care, and participation in the community. Losing that independent help may narrow the person's practical choices, even where the list of formally authorized services remains unchanged. HCBS planning emphasizes individual preferences, meaningful choice and supports that make community participation possible. *[Sources:* 42 C.F.R. § 441.301(c)]

Continuity of care and requested action

I do not regard a 90-day administrative bridge or a newly assigned Support Broker as necessarily equivalent to continuity with an effective existing facilitator. Continuity requires a qualified available person, transferred information, reliable contact, resolved pending matters, effective advocacy, and no gap in authorized and delivered services. Because the model removes a distinct support and may compromise independent assistance and consumer choice, I request that the proposal to eliminate standalone Services Facilitation be withdrawn. *[Sources:* DMAS, summary of proposed waiver amendments; 42 C.F.R. § 438.62, managed-care transitions]

3. Employer of Record designation and delegation of duties (CL, FIS and CCC+)

Legal responsibility must not outpace functional ability

This proposal would allow the member receiving services to serve as the Employer of Record (EOR), with another individual designated to perform some or all duties. Budget Item 295.ZZ also addresses assignment of the Employer Identification Number to the member, with specified exceptions and possible limits on changes of designation. I recognize the stated goal of separating a member's legal employer identity from day-to-day help. My objection is that the proposal can assign formal

responsibility without demonstrating that a person has the disability accommodations, supported decision-making, and ongoing administrative help necessary to use that responsibility safely. *[Sources:* Virginia Town Hall, General Notice 3470; 2026 Virginia Appropriation Act, Item 295; DMAS, summary of proposed waiver amendments; 12VAC30-122-150, consumer-directed model]

For a person with significant cognitive, communication, physical, or visual disabilities, managing employment taxes, hiring records, payroll approvals, EVV corrections, schedules, urgent staff replacements, and disputed records may be unrealistic without another trusted person. Delegation can support autonomy, but it may not answer who is liable for a mistake, who may sign which document, what happens when the delegate becomes unavailable, how authority is withdrawn or transferred, or whether an agency accepts the participant's own supported decisions. These are substantive changes in responsibility, not merely clearer paperwork.

Ethical and administrative consequences

There is an ethical concern when the same person or organization advising the participant also controls information, payroll corrections, or other decisions affecting an attendant or the participant's representative. Conflicts may arise if a paid attendant, EOR, Support Broker, and F/EA have overlapping financial and decision-making interests. Federal HCBS planning and Virginia's current consumer-direction structure distinguish important roles. They do not necessarily ban every contemplated delegation, but they are reasons to resist a restructuring that could obscure accountability. *[Sources:* 42 C.F.R. § 441.301(c); 12VAC30-122-150, consumer-directed model; 12VAC30-120-924, CCC Plus covered services]

DMAS, F/EAs, MCOs and facilitators or brokers may face additional disputes over EIN assignment, tax filings, employer status, representative changes, inaccurate EVV approvals, and caregiver wages. The costs can fall on attendants waiting for pay and families unable to recruit replacements. No separate verified statewide savings estimate was established for this particular amendment in the research reviewed for this comment.

Community integration

Consumer direction should increase the person's choices about how and by whom care is provided, in settings that support participation in ordinary community life. It should not make continued community support conditional on successfully navigating an employer administrative system that the individual cannot use without assistance. Person-centered planning is intended to reflect the individual's own needs and preferences. *[Sources:* 42 C.F.R. § 441.301(c)]

Continuity of care and requested action

An established attendant should not disappear or go unpaid when employer paperwork, delegation, or EIN assignments change. Continuity is affected when approvals or hiring processes are frozen, even while Medicaid eligibility remains active. I oppose the restructuring as proposed and request withdrawal, rather than accepting the availability of a delegate as proof that the responsibilities can be carried out reliably.

4. Deletion of the Working Individuals with Disabilities eligibility-group language (CL and FIS)

A purported technical correction still merits scrutiny

DMAS describes deletion of the specified Working Individuals with Disabilities who buy into Medicaid (TWWIIA Basic Coverage Group) concurrent waiver eligibility language as correction of a provision included in error and never made operational. I recognize that statement and do not claim that DMAS proposes to abolish Medicaid Works generally or immediately terminate existing recipients solely by deleting the disputed provision. I nevertheless oppose removing the text without a showing that the deletion cannot narrow present or future access or leave people with confusing or inconsistent eligibility pathways. *[Sources:* Virginia Town Hall, General Notice 3470; DMAS, summary of proposed waiver amendments]

People with autism and/or developmental disabilities who wish to work need dependable information about how earnings, benefits, and eligibility interact. Ambiguous eligibility instructions can discourage accepting a job or increased hours for fear of losing the services that permit employment. Families, employers, benefits counselors, local eligibility workers, and providers should not have to infer the effect of deletion from a label such as “never implemented.”

Administrative and fiscal consequences

When eligibility language changes, local departments of social services, DMAS, MCOs where involved, and benefits advisers may issue inconsistent instructions, generate erroneous denials, or have to correct eligibility cases. Appeals and coverage reinstatements can create public expense, and interrupted community services can lead to medical costs borne elsewhere. I am not asserting that these costs will arise in every case, or that an active Medicaid Works entitlement has already been removed.

Community integration

Employment is an important means of participating in the larger community, and the HCBS settings framework expressly addresses opportunities to seek employment and work in competitive integrated settings. Policies should not unintentionally make work less attainable by creating uncertainty about continued disability supports. *[Sources:* 42 C.F.R. § 441.301(c)]

Continuity of care and requested action

A genuinely technical correction should be demonstrated to preserve all lawful current and future pathways, not assumed harmless from the agency’s description. Eligibility and care should not be interrupted by confusion during implementation. I request withdrawal of the deletion as proposed; requesting documentation of its effect is not an agreement that documentation alone makes removal appropriate.

5. Removal of legally responsible individuals as Employment and Community Transportation providers (CL and FIS)

An option can matter even if DMAS says it was not operationalized

DMAS describes the listed Legally Responsible Individual (LRI) provider category for Employment and Community Transportation as an erroneous selection that was never put into operation. I acknowledge

that description; I am not claiming all existing paid transportation arrangements are being terminated or that LRIs are being barred from every waiver service. My concern is that removing an expressly identified future provider possibility without an individualized availability analysis can reduce flexibility for people whose transportation needs are unusually complex. *[Sources:* Virginia Town Hall, General Notice 3470; DMAS, summary of proposed waiver amendments]

A wheelchair-accessible vehicle is not by itself enough for every participant. Some people need a provider familiar with communication, transfers, seizure precautions, sensory or behavioral support, medical equipment, remote locations, nonstandard work hours, or other disability-related needs. A company's name in a provider directory does not prove that the company can deliver the specific trip safely. If a qualified relative is the only workable transportation option, eliminating reimbursement eligibility or flexibility can shift costs and labor to the family, or leave the person unable to travel.

Consequences for providers and public systems

Missed employment transportation can undermine an employer's ability to retain a worker. Missed medical transportation can mean delayed treatment or preventable acute care. CSBs, support coordinators, DBHDS-related providers, clinics, MCOs, day programs, hospitals and community organizations may have to spend additional time replacing what was assumed to be an available ride. Even if this amendment is a correction rather than an existing service cut, that foreseeable need should inform the decision to eliminate the provider option.

Community integration

The ability to leave home for employment, medical care, education, recreation, relationships, and community services is central to community integration. A transportation service is only meaningful if it is actually accessible at the required time and place. Federal HCBS rules require community access in relevant settings and person-centered consideration of needs and preferences. *[Sources:* 42 C.F.R. § 441.301(c)]

Continuity of care and requested action

A promise of replacement transportation is not continuity unless a suitable provider agrees and can perform the trip. I oppose removing the category as proposed and request withdrawal rather than a statement that another provider might theoretically be available.

6. Corrections to enrollment requirements for paid legally responsible caregivers (CL and FIS)

The word "technical" does not remove the stakes

DMAS describes this amendment as correcting references to an outdated or incorrect enhanced enrollment agreement that has been incorporated into the normal Fiscal/Employer Agent enrollment packet. It is not described as a blanket ban on payment to legally responsible caregivers. I acknowledge that distinction. My objection is to adopting a correction in a form that could nevertheless alter responsibilities, disrupt payment, or produce contradictory instructions across DMAS, F/EAs and providers. *[Sources:* Virginia Town Hall, General Notice 3470; DMAS, summary of proposed waiver amendments]

When a parent or other qualifying legally responsible individual has completed the forms supplied by Virginia or the fiscal agent, compliance should not become retrospectively questionable simply because the administrative forms have changed. A caregiver who lawfully delivered authorized care needs timely wages, and the person receiving care needs that worker to remain available. The participant's disability does not lessen during a payroll dispute.

Providers, labor and fiscal consequences

Corrected forms, enrollment rework, employer training, or disputes over the proper packet can generate unpaid administrative time, delayed paychecks, claims corrections, and attendant attrition. Families may then be forced to seek replacement workers or absorb care that does not stop because payment has stopped. Applicable labor-law obligations must be considered according to the actual employment relationship and compensable hours, rather than assuming family members can automatically work for free. *[Sources:* U.S. Department of Labor, home-care employment guidance; 29 U.S.C. § 206, minimum-wage requirements; 29 U.S.C. § 207, overtime requirements]

Community integration

For many people with autism and/or developmental disabilities, a paid family caregiver may provide reliable assistance with health, safety and community participation that cannot promptly be replaced by an unfamiliar worker. An administrative change should not destabilize the arrangements supporting daily life in the community. *[Sources:* 42 C.F.R. § 441.301(c)]

Continuity of care and requested action

Correctable administrative issues should not interrupt already authorized, delivered services or make a qualified existing caregiver unavailable. Applicable notice and fair-hearing rights matter if Medicaid benefits or covered services are adversely affected, although those procedures do not automatically resolve every private payroll dispute. I oppose adoption of this amendment as proposed and request withdrawal, without treating a new form or corrected explanation as the end of the concern. *[Sources:* 42 C.F.R. §§ 431.206, 431.210–431.214]

7. Removal of higher-level DMAS review after a negative level-of-care determination (CCC+)

Preventive review matters before care is lost

DMAS proposes removing the requirement for a higher-level DMAS nurse review after a Level of Care Review (LOCERI) finds that a person no longer meets CCC+ waiver criteria. I oppose the removal of that internal checkpoint. An adverse determination can affect the assistance with bathing, eating, mobility, medical routines, safety, and daily functioning that supports a person's life at home. An error discovered only after care has stopped can have very different consequences from an error caught before termination. *[Sources:* Virginia Town Hall, General Notice 3470; DMAS, summary of proposed waiver amendments]

Complex genetic, neurological, developmental, mobility, behavioral, and other medical conditions may require a reviewer with appropriate experience and attention to treating-clinician evidence, prior service history, environmental circumstances, and the assistance that currently keeps the person stable. A person who remains clean, nourished, medically stable, or free from injury while receiving

services has not thereby proved the services unnecessary. The stability may be evidence that the supports are working.

Clinical, administrative, institutional and fiscal consequences

Removing one review step may save administrative work at DMAS while causing greater workload in appeals, emergency MCO care coordination, hospital discharge planning, home-health or agency staffing, and institutional-placement processes. If a mistaken termination produces avoidable emergency care or makes a return home unsafe, the public expense may exceed the cost of the internal review. Appropriate expertise and access to relevant evidence are essential to preventing those failures.

Community integration

A negative level-of-care error can place a person at serious risk of losing a sustainable home and community arrangement. Olmstead and Fourth Circuit precedent discuss unnecessary segregation and the consequences of lost in-home personal assistance within their respective legal standards. Virginia's separate permanent injunction in United States v. Commonwealth of Virginia also demonstrates the Commonwealth's continuing community-services obligations for the population covered by that case; I do not imply the injunction automatically applies to every CCC+ member. *[Sources:* Olmstead v. L.C., 527 U.S. 581 (1999); Pashby v. Delia, 709 F.3d 307 (4th Cir. 2013); United States v. Virginia, Permanent Injunction (Jan. 15, 2025)]

Continuity of care and requested action

Medicaid's notice, hearing, and, in specified circumstances, continuation provisions are important, but an appeal after an erroneous review does not necessarily recreate the care or prevent harm. The right to contest an action should not be used to justify discarding a checkpoint intended to detect problems sooner. I request withdrawal of the proposed removal and retention of meaningful pretermination clinical review. *[Sources:* 42 C.F.R. §§ 431.206, 431.210–431.214; 42 C.F.R. § 431.230, continuation of services]

8. Removal of MCO service-plan quality reviews and related LOCERI oversight (CCC+)

What is being removed, and why I oppose it

I strongly oppose Item 8. The Town Hall notice identifies a change to Appendix D of the CCC+ waiver removing managed care organizations (MCOs) as reviewers of specified service-plan quality measures. DMAS's accompanying summary also identifies removal of references to higher-level reviews following adverse Level of Care Review Instrument (LOCERI) findings. Both parts belong in this discussion; describing the proposal only as a change in who reviews service plans understates the connected loss of oversight. [Sources: Virginia Town Hall, General Notice 3470, Item 8; DMAS, summary of proposed amendments, Items 7 and 8]

The application says the State will perform the service-plan measure reviews. It separately describes revising the LOC4 measure and removing LOC5, the measure tracking whether higher-level reviews occur after adverse LOCERI findings. Those level-of-care measures concern Appendix B; the service-plan measures concern Appendix D. I am not claiming that all quality review ends or that every MCO responsibility disappears. My objection is to removing an existing assigned reviewer and a preventive

review checkpoint together with its related monitoring measure. [Sources: CCC+ amendment application, p. 3 and Appendices B and D; CCC+ amendment application, Appendix D, pp. 120–121]

Individualized care and participant accountability

A completed service plan is not proof that the person has adequate care. Plans can omit important information, authorize too little support, rely on nonexistent providers, or remain inaccurate after medical or functional change. Families and caregivers frequently identify these problems first, but they should not become the only mechanism for detecting administrative failure. A participant who cannot reliably communicate that an attendant did not arrive is particularly dependent on competent independent oversight.

My understanding of the federal HCBS rule is that a person-centered plan must identify who monitors it and must be reviewed and revised as appropriate following reassessment, significant changes in needs or circumstances, or a request from the individual. These duties do not establish that any particular MCO review must remain unchanged forever. They do demonstrate why service-plan monitoring is substantive protection, not dispensable paperwork. [Sources: 42 C.F.R. § 441.301(c)(2)(viii) and (c)(3), plan monitoring and review]

Effects on people with disabilities, families and caregivers

People with autism and/or developmental disabilities, and other people receiving CCC+ services, may need substantial help recognizing, reporting, or challenging an inadequate plan. Removing a review role can leave a family repeating the same history to several agencies while necessary assistance remains unavailable. Families should not have to wait for an injury, caregiver loss, hospitalization, or a threat to housing before the system recognizes that a plan is failing. This is a foreseeable implementation concern, not a claim that every participant will experience those outcomes.

Consequences for DMAS, MCOs, providers and institutions

Moving review responsibility to the State does not eliminate the underlying work. DMAS needs staff, records, timely escalation, and the capacity to correct problems before harm occurs. MCO care coordinators, clinicians, providers, hospital discharge teams, and other community services still depend on accurate plans and clear responsibility for missed care. If handoffs fail, complaints, appeals, urgent discharge planning, and crisis coordination can become substitutes for preventive oversight.

Federal managed-care rules continue to require quality-improvement programs, mechanisms to identify underuse and overuse, and attention to the quality of care for members with special health care needs. States also maintain managed-care quality strategies. Those continuing obligations are important, but their existence does not prove that removing the specific review responsibilities in this proposal will leave participants equally protected. [Sources: 42 C.F.R. § 438.330(b), quality assessment and performance improvement; 42 C.F.R. § 438.340, state managed-care quality strategy]

Financial consequences for the Commonwealth and MCOs

Any administrative savings must be weighed against the potential cost of undetected service gaps, repeated assessments, appeals, preventable emergency treatment, hospitalization, delayed discharge, and institutional care. No proposal-specific net savings figure has been established in the materials relied upon in this comment. I therefore do not assign a dollar amount to this risk. The point is that

removing an early opportunity to detect a problem may move the expense elsewhere rather than eliminate it.

To evaluate fiscal effects, Virginia should distinguish authorized service hours from delivered hours and monitor unfilled shifts, late authorizations, provider vacancies, repeated complaints, missed reviews, corrective-action completion, preventable admissions, and difficulty maintaining community placement. Savings within one administrative budget cannot be treated as net public savings when unmet needs generate greater expenditure for the Commonwealth, MCOs, providers, or families elsewhere.

Community integration

Quality should be measured partly by whether people receive the support necessary to live, work, pursue education, obtain healthcare, maintain relationships, and participate in community life. Correct paperwork is not enough when an inadequate plan leaves someone unable to leave home or sustain a community-living arrangement. The federal HCBS settings rule identifies full community access, and Olmstead addresses unnecessary segregation under the ADA within the standards established by that decision. My earlier discussion of the separate Texas v. Kennedy litigation applies here as well; I do not rely on vacated regulatory provisions. [Sources: 42 C.F.R. § 441.301(c)(4)(i), community access; Olmstead v. L.C., 527 U.S. 581 (1999)]

Continuity of delivered care

Sixty authorized hours are not sixty delivered hours if the participant can recruit assistance for only thirty-five. Continuity requires discovering and correcting service gaps before health, safety, caregiver availability, or housing is destabilized. Review should examine whether care was actually provided, whether a replacement provider truly exists, and whether corrective action restored services. An active authorization or completed review form is not a substitute for assistance reaching the individual.

Connection to Item 7 and my requested action

Item 7 removes the required higher-level DMAS review after an adverse level-of-care finding. The related quality changes revise or remove measures referring to that review. Together, the proposals affect both an opportunity to correct an individual determination and the reporting mechanism used to track that protection. They should be evaluated together without treating the two numbered amendments, or their different waiver appendices, as identical. [Sources: DMAS, summary of proposed amendments, Items 7 and 8; CCC+ amendment application, p. 3 and Appendices B and D]

I respectfully request withdrawal of Item 8 and preservation of meaningful oversight of service-plan adequacy, assessment accuracy, and delivered services. I also maintain my separate objection to Item 7. Assigning review to the State, describing remaining monitoring, or promising future corrective action does not withdraw my objection to removing these established protections. Community integration and continuity of care require effective oversight before necessary support is lost, not reassurance after a preventable disruption.

Separate issue: live-in caregiver EVV, regulatory conflict and public comment

The federal requirement and Virginia's existing exemption are not the same

Live-in EVV is not one of these eight waiver amendments. DMAS announced on September 9, 2026, that beginning October 1 all covered agency and consumer-directed attendants, including live-in caregivers, would have to use an EVV-compliant method. The bulletin cites Item 291.NNNNN of the 2026 Appropriation Act and states that CMS confirmed Virginia could make the change without a 1915(c) waiver amendment. I acknowledge that statement and that the budget directs removal of the exemption. My objection is not based on a claim that CMS necessarily prohibits a state from requiring EVV of live-in caregivers. *[Sources:* Virginia Town Hall, General Notice 3470; DMAS bulletin dated September 9, 2026; 2026 Virginia Appropriation Act, Item 291]

Two existing bodies of authority nevertheless make the implementation chronology require substantial scrutiny. First, the federal EVV statute, 42 U.S.C. § 1396b(l), addresses EVV for services involving in-home visits and calls for minimal burden, consultation and stakeholder input. CMS explained in its August 2019 guidance that services provided by a caregiver who lives with the beneficiary do not constitute an "in-home visit" requiring EVV under the federal mandate, while states may choose to apply EVV anyway. Thus, federal law and CMS policy do not require Virginia to impose this added live-in obligation as a condition of avoiding the federal EVV reduction; the additional obligation is a state policy choice requiring its own justification. *[Sources:* 42 U.S.C. § 1396b(l), EVV provisions; CMS August 8, 2019, live-in caregiver EVV guidance]

Second, Virginia's published regulation, 12VAC30-60-65(C)(4), expressly lists "live-in caregivers" among the persons exempt from EVV. The developmental disability waiver regulation, 12VAC30-122-125, incorporates 12VAC30-60-65 for relevant services. Virginia's own November 2023 EVV FAQ also describes the live-in exemption. These sources must be reconciled with the October 1 implementation directive. They are not all separate statutes, and a later appropriation may authorize action before completion of ordinary regulatory processes under specified conditions; nevertheless, a bulletin alone does not explain to the public precisely how the agency reconciled the directive with the text people are still instructed to read. *[Sources:* 12VAC30-60-65, Virginia EVV regulation; 12VAC30-122-125, DD waiver EVV rule; DMAS EVV FAQ, November 16, 2023; 2026 Virginia Appropriation Act, Item 291]

There is an additional documented discrepancy. As of October 12, the Town Hall page for EVV Action 6412 showed the proposed regulatory stage still in Attorney General review, with no publication date or effective date listed. Its October 7 proposed text also continued to list live-in caregivers among the exempt categories. I do not treat a draft regulation or its procedural status alone as conclusive proof that DMAS lacks authority. I do, however, believe this contradiction warrants a publicly accessible explanation of the complete enacted authority, federal correspondence, emergency-rule record, approvals and intended operative language, before a statewide implementation is treated as settled. *[Sources:* Town Hall EVV Action 6412, Stage 10246; October 7 EVV proposed regulatory text; 12VAC30-60-65, Virginia EVV regulation; 2026 Virginia Appropriation Act, Item 291]

Operational reality and caregiver payment

Live-in care is not ordinarily a single, uninterrupted visit by a stranger arriving at a separate workplace. Covered disability-related assistance may be provided in short periods throughout a day alongside unpaid family activities, overnight emergencies, multiple care recipients, medical

treatments, school schedules, meals, and sleep. If the new EVV process incorrectly equates continuous clock time with reimbursable care, or requires frequent clock changes that caregivers cannot reliably perform in emergencies, it may create inaccurate time records without improving accountability. The policy must distinguish compensable covered services from unpaid family tasks without demanding that either be misrepresented.

Technology reliability and accessibility matter. Some attendants or employers of record cannot easily use a smartphone or telephone interface because of visual, cognitive, motor, communication, broadband, cellular or other limitations. The current Virginia EVV regulation expressly describes requirements for 24-hour access, backups, multiple shifts, multiple attendants and recipients, and correction of time entries. Training immediately before implementation does not demonstrate that those requirements have been tested under real household conditions for all affected groups. *[Sources:* 12VAC30-60-65, Virginia EVV regulation; DMAS bulletin dated September 9, 2026]

Technical errors may become financial and service-access crises if the only available caregiver goes unpaid, is found noncompliant, or leaves the program. A consumer can retain full Medicaid eligibility and a printed authorization while losing usable care. Replacing a trusted live-in caregiver may be impossible in the short term, especially where specialized care, rural recruitment, or extensive hands-on help is required. MCOs, F/EAs, DMAS, employers of record, providers, hospital discharge planners and CSBs may face new emergency work and costs. A cost-saving policy should not be measured only by the software or claim line; it must include those consequences.

Community integration and continuity of delivered care

The loss of a live-in caregiver can limit employment, education, participation, social relationships and access to healthcare, or make it impossible to continue living safely in an ordinary home. Federal HCBS planning and community-access principles remain relevant regardless of the September 2026 judgment about specified HHS Section 504 regulatory text. A state implementation that destabilizes caregiver availability can undermine the very community services the waivers are intended to provide. *[Sources:* 42 C.F.R. § 441.301(c); Texas v. Kennedy, No. 5:24-cv-00225-H, final judgment (Sept. 23, 2026)]

Continuity must mean actual support and timely lawful wages, not only an undisturbed authorization record. DMAS should publicly report payment rejections, missed visit records, correction turnaround, help-desk resolution, caregiver departures, available replacement workers, access accommodations, and any resulting service interruptions. Those outcomes are necessary to determine whether the policy protects consumers as well as the agency's administrative records.

Specific request: meaningful comment and at least six months for responsible implementation

I respectfully request that Virginia suspend or defer enforcement of the October 1 live-in EVV requirement while it reconciles the published exemption, the separate DD waiver cross-reference, the 2026 appropriation language, the regulatory action and the CMS correspondence. I request a distinct and meaningful public-comment opportunity with publication of the governing documents, concrete examples of intermittent extraordinary care, written answers to substantive public questions, accessible participation, privacy and technical analyses, and a process capable of influencing the policy rather than merely explaining it after the fact. *[Sources:* 12VAC30-60-65, Virginia EVV regulation;

12VAC30-122-125, DD waiver EVV rule; 2026 Virginia Appropriation Act, Item 291; Town Hall EVV Action 6412, Stage 10246; 42 U.S.C. § 1396b(l), EVV provisions]

Any resumed statewide implementation should follow completion of that comment and analysis process with a minimum six-month preparation and transition period, not a six-month period counted retroactively from the October 1 announcement. This requested six-month period is a policy safeguard, not a claim that the federal EVV statute itself prescribes six months. It should allow genuine system testing, accommodations, correction-policy publication, caregiver and employer training, fiscal-agent readiness, privacy disclosures and an independent check on consumer continuity. During the review and transition, there should be clear protection against loss of lawful payment or consumer-directed services solely because of unresolved implementation defects, with accessible correction and dispute procedures and preservation of care while legitimate records are resolved.

The public should also know whether DMAS has examined alternatives that preserve existing live-in exemptions or use less burdensome oversight, particularly since CMS does not mandate EVV for live-in caregivers as a federal minimum requirement. Any selected alternative must preserve accountability without making the person receiving services bear the consequences of a technology problem or a procedural conflict. *[Sources:* CMS August 8, 2019, live-in caregiver EVV guidance; 42 U.S.C. § 1396b(l), EVV provisions]

Cumulative effects, fiscal responsibility and community living

These actions should be evaluated together. The same household may face a reduction in paid hours, loss of an experienced facilitator, changes to who is legally responsible for employer paperwork, changed quality reviews, and live-in EVV requirements. Each change could be described separately as administrative streamlining. Together they may shift paperwork, uncompensated labor, financing and risk onto families and frontline providers who already have too few hours and too few workers. The relevant question is whether actual delivered services remain sufficient, accessible and sustainable.

The Executive Biennial Budget gives the public a starting point for assessing expected savings. For the 56-hour change, it projected a two-year General Fund reduction of $44,846,032; for Services Facilitation, $4,359,640; and for strengthened personal-care oversight associated with live-in EVV, $2,247,019. These figures come from executive budget decision packages and must not be presented as net realized savings, or as final audited results. They also cannot be summed and assumed to represent the full Commonwealth impact without assessing program changes, federal matching funds, administrative expenses, exception approvals, provider shortages, appeals, emergency medicine, caregiver employment and institutional services. *[Sources:* 2026–2028 Executive Biennial Budget, DMAS decision packages]

What community care saves compared with institutional care

The immediate cost difference is substantial. In Virginia, the 2025 median price of nonmedical help at home was $80,080 per year for 44 hours each week. The median price of one year in a nursing home was $123,005 for a semi-private room and $140,160 for a private room. The table below makes that comparison visible. These are surveyed provider prices, not Virginia Medicaid payment rates. Forty-four hours of home care are also not enough for every person, and a nursing facility may not be an appropriate setting for people with autism and/or developmental disabilities.

Virginia care setting (2025 survey)	Median annual price	Basis
Nonmedical home caregiver	$80,080	44 hours/week × 52 weeks
Nursing home, semi-private room	$123,005	365 days
Nursing home, private room	$140,160	365 days

In ordinary terms, the semi-private nursing-home median is $42,925 more per year, approximately 54% higher than the 44-hour home-care benchmark. The private-room median is $60,080 more per year, approximately 75% higher. For two years, the differences would be $85,850 or $120,160 for one person. These comparisons show why a community placement lost can be expensive; they do not establish actual Medicaid savings, because the benefits, hours, clinical needs and reimbursement methods differ.

Market-price source: CareScout, 2025 State Annual Median Costs, Virginia row

Medicaid itself was designed around a less expensive alternative

There is an even more relevant comparison than private nursing-home prices. In federal training published in 2021, CMS reported that national Medicaid waiver-program estimates as of June 2020 averaged $54,232 per person for first-year home- and community-based services and other covered care, compared with $141,503 for the institutional alternative for similar waiver populations. That is a projected difference of $87,271 per person per year, with the community alternative costing about 62% less. These were historical national waiver estimates, not present-day Virginia rates or proof that every individual costs less at home. They do show that the financial advantage of HCBS is grounded in Medicaid's own cost-neutrality analysis. Under Section 1915(c), states must demonstrate that the average cost of waiver services does not exceed the institutional alternative for the corresponding population.

Federal sources: CMS, 1915(c) Waiver Financing and Payment Trends, 2021, page 6 | CMS, Section 1915(c) cost-neutrality guidance | CMS, HCBS waiver requirements

The long-term loss is not limited to the cost of a bed

Hospitalization disrupts the ordinary ability to attend school, work, training, appointments and community activities. Longer-term institutional placement may also limit access to integrated education, employment, relationships and everyday choices available to a person living in the community. The financial effect can last well beyond the immediate medical bill. Community supports may enable a person to practice mobility, communication, self-care, travel, workplace and other functional skills in the places where those skills will actually be used. For some people, growing confidence and functional skills may reduce particular support needs over time. For others, intensive services will remain essential. Neither possibility justifies withdrawing needed care; both require an individualized plan and genuine opportunities.

Education, supported employment and participation in ordinary community life can also have an economic return. A person who is able and chooses to work may earn income, pay applicable income and payroll taxes, purchase goods and services, and contribute toward eligible health-coverage costs through lawful premiums or cost-sharing arrangements where those actually apply. Virginia's Medicaid Works program explicitly supports employment while retaining Medicaid coverage for qualifying individuals. This should not be misread as a claim that every waiver recipient must work, that all waiver members owe copayments, or that Medicaid Works automatically guarantees

concurrent waiver eligibility. Participation, autonomy and dignity matter regardless of employment. But when Virginia removes supports that allow people to learn, work or remain engaged, it risks losing potential future earnings, tax revenue, skill development and opportunities for greater independence in addition to assuming greater public care costs.

Employment and community integration sources: CMS, Employment and HCBS | Virginia DBHDS, DD Waiver Services | Virginia DMAS, Medicaid Works | CMS, waiver cost-sharing framework, 2021 | 42 C.F.R. § 441.301(c), integrated community settings

What an additional institutional placement could cost the Commonwealth

The Commonwealth's true budget question is straightforward: if cutting a person's waiver assistance makes living at home unsustainable, how much more will Virginia spend for that person's care elsewhere? To calculate actual General Fund costs, DMAS must compare the Medicaid-funded services that would have been delivered in the community with the institutional and other services that would be paid instead, accounting for federal matching funds, member contributions where applicable, hospital care and administrative expenses. The private nursing-home median cannot be substituted for that actual Medicaid calculation.

Assumed extra net Virginia GF cost per placement / year	Additional continuous 2-year placements that would offset the $44.85M projected GF reduction
$20,000	1,122
$40,000	561
$60,000	374

Here is a simple illustration, not a forecast: suppose the extra cost to Virginia's General Fund after an institutional placement is $40,000 per person per year. One hundred people remaining in institutions for two years would add $8 million; five hundred would add $40 million. That would consume nearly all of the $44.85 million in two-year General Fund savings projected for the personal-assistance changes. The actual additional cost could be higher or lower; DMAS should publish it using Virginia Medicaid and MCO data.

I therefore ask DMAS to show actual participant-level comparisons across CL, FIS, CCC+, hospitals, nursing facilities, ICF/IID facilities and other relevant services; how many people may be at risk of losing a sustainable home placement; and the effects on total state spending, federal matching funds and long-term community participation. A reduction in one Medicaid budget category is not a saving to the Commonwealth if it triggers larger expenses or lost opportunities elsewhere.

State reimbursement and background: DMAS nursing facility rate announcement | DMAS annual costs of new DD waiver slots, FY2025

What the projected savings do and do not include

The executive budget separately projects $4,359,640 in biennial General Fund reductions associated with the Services Facilitation change and $2,247,019 connected with strengthened oversight of personal-care services, including live-in EVV. Unlike the 56-hour change, both proposals affect service populations and functions for which the documents cited here do not establish a reliable common denominator of actual affected participants; presenting a precise dollar saving "per waiver participant" for those two measures would invent a population count. Their net fiscal effects must also be tested for caregiver turnover, broker staffing, denied or delayed payments, provider transitions,

appeals, and institutional or acute-care consequences. I oppose using unverified savings estimates as a substitute for evidence that actual care will continue.

Fiscal source: 2026–2028 Executive Biennial Budget, DMAS decision packages

Federal person-centered planning still requires attention to the individual's functional needs and services and to voluntary natural supports. Applicable fair-hearing protections remain important. For eligible children under age twenty-one, Medicaid's EPSDT provisions provide additional protections concerning medically necessary covered services, although they do not automatically make every waiver-only service an EPSDT entitlement. Virginia's own long-running integration litigation and permanent injunction concern a defined population and set of requirements; they are not proof that every proposed change is unlawful for every Medicaid member. They are, however, reminders of the importance of maintaining meaningful community-support systems. *[Sources:* 42 C.F.R. § 441.301(c); 42 C.F.R. §§ 431.206, 431.210–431.214; 42 U.S.C. § 1396d(r), EPSDT; United States v. Virginia, Permanent Injunction (Jan. 15, 2025); Independent Reviewer, 28th report (June 13, 2026)]

Conclusion: withdrawal of all eight amendments and separate EVV action

I respectfully request that DMAS withdraw all eight proposed CL, FIS and CCC+ waiver amendments. The fact that an amendment originated in a budget item, is described as a technical correction, or includes an exception or new contractor does not eliminate its potential effect on an individual's independence or right to receive necessary services. Questions about implementation, requests for records, and proposed harm-reduction measures should not be treated as acceptance of the policies themselves. I further request that DMAS refrain from representing savings in one administrative line item as net savings to the Commonwealth until the actual per-member effects, institutional alternatives, federal-state financing, and continuity-related downstream costs have been measured and published.

I separately request that DMAS reconcile the live-in EVV mandate with the federal guidance and existing Virginia regulatory exemption, provide a dedicated and meaningful public-comment process, and allow no less than six months after completion of that process for responsible analysis, training, system testing, accommodations and transition before resuming the requirement. Consumer access to services and caregiver payment must be protected against interruption caused by unresolved administrative or technological changes.

What happens in a government office does not stay in a government office. A lost service hour becomes an hour someone still needs assistance. A trusted provider replaced on paper is still a relationship that cannot be recreated by assignment. A review eliminated from a workflow does not eliminate the error it might have caught. An attendant who cannot be paid or retained through an unfamiliar system is not replaced by an authorization number. For Virginians with disabilities, community integration and continuity of care must be judged by the care actually delivered and the ability to live safely with dignity and meaningful choice in their homes and communities. An authorization on paper is not delivered care. The longer-term costs of losing opportunities for learning, work, skills and participation also belong in the Commonwealth's fiscal accounting, not outside it.