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State/Territory Name: **District of Columbia**

State Plan Amendment (SPA) #: **20-0001**

This file contains the following documents in the order listed:

- 1) Approval Letter
- 2) CMS 179 Form/Summary Form (with 179-like data)
- 3) Approved SPA Pages

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850



June 5, 2020

Melisa Byrd
Medicaid Director
Department of Health Care Finance
441 4th Street, N.W., 9th floor, South
Washington, D.C. 20001

Re: District of Columbia State Plan Amendment (SPA) 20-0001

Dear Director Byrd:

We have reviewed the proposed amendment to add section 7.5 Medicaid Disaster Relief for the COVID-19 National Emergency to your Medicaid state plan, as submitted under transmittal number (TN) DC-20-001. This amendment proposes to implement temporary policies, which are different from those policies and procedures otherwise applied under your Medicaid state plan, during the period of the Presidential and Secretarial emergency declarations related to the COVID-19 outbreak (or any renewals thereof).

On March 13, 2020, the President of the United States issued a proclamation that the COVID-19 outbreak in the United States constitutes a national emergency by the authorities vested in him by the Constitution and the laws of the United States, including sections 201 and 301 of the National Emergencies Act (50 U.S.C. 1601 *et seq.*), and consistent with section 1135 of the Social Security Act (Act). On March 13, 2020, pursuant to section 1135(b) of the Act, the Secretary of the United States Department of Health and Human Services invoked his authority to waive or modify certain requirements of titles XVIII, XIX, and XXI of the Act as a result of the consequences of the COVID-19 pandemic, to the extent necessary, as determined by the Centers for Medicare & Medicaid Services (CMS), to ensure that sufficient health care items and services are available to meet the needs of individuals enrolled in the respective programs and to ensure that health care providers that furnish such items and services in good faith, but are unable to comply with one or more of such requirements as a result of the COVID-19 pandemic, may be reimbursed for such items and services and exempted from sanctions for such noncompliance, absent any determination of fraud or abuse. This authority took effect as of 6PM Eastern Standard Time on March 15, 2020, with a retroactive effective date of March 1, 2020. The emergency period will terminate, and this state plan provision will no longer be in effect, upon termination of the public health emergency, including any extensions.

Pursuant to section 1135(b)(5) of the Act, for the period of the public health emergency, CMS is modifying the requirement at 42 C.F.R. 430.20 that the state submit SPAs related to the COVID-19 public health emergency by the final day of the quarter, to obtain a SPA effective date during the quarter, enabling SPAs submitted after the last day of the quarter to have an effective date in a previous quarter, but no earlier than the effective date of the public health emergency.

The District of Columbia requested a waiver of public notice requirements applicable to the SPA submission process. Pursuant to section 1135(b)(1)(C) of the Act, CMS is waiving public notice requirements applicable to the SPA submission process. Public notice for SPAs is required under 42 C.F.R. §447.205 for changes in statewide methods and standards for setting Medicaid payment rates, 42 C.F.R. §447.57 for changes to premiums and cost sharing, and 42 C.F.R. §440.386 for changes to Alternative Benefit Plans (ABPs). Pursuant to section 1135(b)(1)(C) (to waive) and/or 1135(b)(5) (to modify) of the Act, CMS is approving the state's request to waive these notice requirements otherwise applicable to SPA submissions.

These waivers or modifications of the requirements related to SPA submission timelines, public notice, and tribal consultation apply only with respect to SPAs that meet the following criteria: (1) the SPA provides or increases beneficiary access to items and services related to COVID-19 (such as by waiving or eliminating cost sharing, increasing payment rates or amending ABPs to add services or providers); (2) the SPA does not restrict or limit payment or services or otherwise burden beneficiaries and providers; and (3) the SPA is temporary, with a specified sunset date that is not later than the last day of the declared COVID-19 public health emergency (or any extension thereof). We nonetheless encourage states to make all relevant information about the SPA available to the public so they are aware of the changes.

We conducted our review of your submittal according to the statutory requirements at section 1902(a) of the Act and implementing regulations. This letter is to inform you that the District of Columbia Medicaid SPA Transmittal Number DC-20-001 is approved effective March 11, 2020.

Enclosed is a copy of the CMS-179 summary form and the approved state plan pages.

Please contact LCDR Frankeena McGuire at 215-861-4754 or by email at Frankeena.McGuire@cms.hhs.gov if you have any questions about this approval. We appreciate the efforts of you and your staff in responding to the needs of the residents of the District of Columbia and the health care community.

Sincerely,



Anne Marie Costello
Deputy Director
Center for Medicaid & CHIP Services

Enclosures

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL	1. TRANSMITTAL NUMBER: 20-001	2. STATE: District of Columbia
	3. PROGRAM IDENTIFICATION: Title XIX of the Social Security Act	

TO: Regional Administrator Centers for Medicare & Medicaid Services Department of Health and Human Services	4. PROPOSED EFFECTIVE DATE: March 11, 2020
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5. TYPE OF PLAN MATERIAL (Check One):

- NEW STATE PLAN AMENDMENT TO BE CONSIDERED AS NEW PLAN AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)

6. FEDERAL STATUTE/REGULATION CITATION: 1915(i) Social Security Act 42 CFR 441 42 CFR 447 Title XIX of the SSA	7. FEDERAL BUDGET IMPACT: FFY20: \$ 30,579,739 FFY21: <u>N/A</u>
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8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Section 7.5: pp 1-14	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable): New
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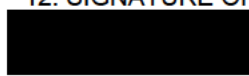
10. SUBJECT OF AMENDMENT:

COVID-19 Emergency State Plan Amendment

11. GOVERNOR'S REVIEW (Check One)

- GOVERNOR'S OFFICE REPORTED NO COMMENT
 COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
 NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL


OTHER, AS SPECIFIED:
D.C. Act: 22-434

12. SIGNATURE OF STATE AGENCY OFFICIAL 	16. RETURN TO Melisa Byrd Senior Deputy Director/Medicaid Director Department of Health Care Finance 441 4 th Street, NW, 9 th Floor, South Washington, DC 20001
13. TYPED NAME Melisa Byrd	
14. TITLE Senior Deputy Director/Medicaid Director	
15. DATE SUBMITTED Apr 30, 2020	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED 04/30/2020	18. DATE APPROVED 06/05/2020
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PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL 03/11/2020	20. SIGNATURE 
21. TYPED NAME Anne Marie Costello	22. TITLE Deputy Director Center for Medicaid & CHIP Services

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Section 7 – General Provisions

7.5. Medicaid Disaster Relief for the COVID-19 National Emergency

On March 13, 2020, the President of the United States issued a proclamation that the COVID-19 outbreak in the United States constitutes a national emergency by the authorities vested in him by the Constitution and the laws of the United States, including sections 201 and 301 of the National Emergencies Act (50 U.S.C. 1601 et seq.), and consistent with section 1135 of the Social Security Act (Act). On March 13, 2020, pursuant to section 1135(b) of the Act, the Secretary of the United States Department of Health and Human Services invoked his authority to waive or modify certain requirements of titles XVIII, XIX, and XXI of the Act as a result of the consequences COVID-19 pandemic, to the extent necessary, as determined by the Centers for Medicare & Medicaid Services (CMS), to ensure that sufficient health care items and services are available to meet the needs of individuals enrolled in the respective programs and to ensure that health care providers that furnish such items and services in good faith, but are unable to comply with one or more of such requirements as a result of the COVID-19 pandemic, may be reimbursed for such items and services and exempted from sanctions for such noncompliance, absent any determination of fraud or abuse. This authority took effect as of 6PM Eastern Standard Time on March 15, 2020, with a retroactive effective date of March 1, 2020. The emergency period will terminate, and waivers will no longer be available, upon termination of the public health emergency, including any extensions.

The State Medicaid agency (agency) seeks to implement the policies and procedures described below, which are different than the policies and procedures otherwise applied under the Medicaid state plan, during the period of the Presidential and Secretarial emergency declarations related to the COVID-19 outbreak (or any renewals thereof), or for any shorter period described below:

March 11, 2020 until the end of the public health emergency.

NOTE: States may not elect a period longer than the Presidential or Secretarial emergency declaration (or any renewal thereof). States may not propose changes on this template that restrict or limit payment, services, or eligibility, or otherwise burden beneficiaries and providers.

Request for Waivers under Section 1135

X The agency seeks the following under section 1135(b)(1)(C) and/or section 1135(b)(5) of the Act:

The District received initial authority to waive section 1135(b)(1)(C) SPA submission and section 1135(b)(5) public notice requirements from CMS on April 3, 2020. The District reiterates its intent to utilize that flexibility with regard to this SPA submission by highlighting them below.

- a. X SPA submission requirements – the agency requests modification of the requirement to submit the SPA by March 31, 2020, to obtain a SPA effective date during the first calendar quarter of 2020, pursuant to 42 CFR 430.20.
- b. X Public notice requirements – the agency requests waiver of public notice requirements that would otherwise be applicable to this SPA submission. These requirements may include those specified in 42 CFR 440.386 (Alternative Benefit Plans),

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42 CFR 447.57(c) (premiums and cost sharing), and 42 CFR 447.205 (public notice of changes in statewide methods and standards for setting payment rates).

- c. ____ Tribal consultation requirements – the agency requests modification of tribal consultation timelines specified in [insert name of state] Medicaid state plan, as described below:

Please describe the modifications to the timeline.

Section A – Eligibility

1. ____ The agency furnishes medical assistance to the following optional groups of individuals described in section 1902(a)(10)(A)(ii) or 1902(a)(10)(c) of the Act. This may include the new optional group described at section 1902(a)(10)(A)(ii)(XXIII) and 1902(ss) of the Act providing coverage for uninsured individuals.

Include name of the optional eligibility group and applicable income and resource standard.

2. ____ The agency furnishes medical assistance to the following populations of individuals described in section 1902(a)(10)(A)(ii)(XX) of the Act and 42 CFR 435.218:

- a. ____ All individuals who are described in section 1905(a)(10)(A)(ii)(XX)

Income standard: _____

-or-

- b. ____ Individuals described in the following categorical populations in section 1905(a) of the Act:

Income standard: _____

3. ____ The agency applies less restrictive financial methodologies to individuals excepted from financial methodologies based on modified adjusted gross income (MAGI) as follows.

Less restrictive income methodologies:

Less restrictive resource methodologies:

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4. ____ The agency considers individuals who are evacuated from the state, who leave the state for medical reasons related to the disaster or public health emergency, or who are otherwise absent from the state due to the disaster or public health emergency and who intend to return to the state, to continue to be residents of the state under 42 CFR 435.403(j)(3).
5. ____ The agency provides Medicaid coverage to the following individuals living in the state, who are non-residents:
6. ____ The agency provides for an extension of the reasonable opportunity period for non-citizens declaring to be in a satisfactory immigration status, if the non-citizen is making a good faith effort to resolve any inconsistencies or obtain any necessary documentation, or the agency is unable to complete the verification process within the 90-day reasonable opportunity period due to the disaster or public health emergency.

Section B – Enrollment

1. ____ The agency elects to allow hospitals to make presumptive eligibility determinations for the following additional state plan populations, or for populations in an approved section 1115 demonstration, in accordance with section 1902(a)(47)(B) of the Act and 42 CFR 435.1110, provided that the agency has determined that the hospital is capable of making such determinations.

Please describe the applicable eligibility groups/populations and any changes to reasonable limitations, performance standards or other factors.

2. ____ The agency designates itself as a qualified entity for purposes of making presumptive eligibility determinations described below in accordance with sections 1920, 1920A, 1920B, and 1920C of the Act and 42 CFR Part 435 Subpart L.

Please describe any limitations related to the populations included or the number of allowable PE periods.

3. ____ The agency designates the following entities as qualified entities for purposes of making presumptive eligibility determinations or adds additional populations as described below in accordance with sections 1920, 1920A, 1920B, and 1920C of the Act and 42 CFR Part 435 Subpart L. Indicate if any designated entities are permitted to make presumptive eligibility determinations only for specified populations.

Please describe the designated entities or additional populations and any limitations related to the specified populations or number of allowable PE periods.

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4. ____ The agency adopts a total of ____ months (not to exceed 12 months) continuous eligibility for children under age enter age ____ (not to exceed age 19) regardless of changes in circumstances in accordance with section 1902(e)(12) of the Act and [42 CFR 435.926](#).
5. ____ The agency conducts redeterminations of eligibility for individuals excepted from MAGI-based financial methodologies under 42 CFR 435.603(j) once every ____ months (not to exceed 12 months) in accordance with 42 CFR 435.916(b).
6. ____ The agency uses the following simplified application(s) to support enrollment in affected areas or for affected individuals (a copy of the simplified application(s) has been submitted to CMS).
 - a. ____ The agency uses a simplified paper application.
 - b. ____ The agency uses a simplified online application.
 - c. ____ The simplified paper or online application is made available for use in call-centers or other telephone applications in affected areas.

Section C – Premiums and Cost Sharing

1. ____ The agency suspends deductibles, copayments, coinsurance, and other cost sharing charges as follows:

<p><i>Please describe whether the state suspends all cost sharing or suspends only specified deductibles, copayments, coinsurance, or other cost sharing charges for specified items and services or for specified eligibility groups consistent with 42 CFR 447.52(d) or for specified income levels consistent with 42 CFR 447.52(g).</i></p>

2. ____ The agency suspends enrollment fees, premiums and similar charges for:
 - a. ____ All beneficiaries
 - b. ____ The following eligibility groups or categorical populations:

<p><i>Please list the applicable eligibility groups or populations.</i></p>

3. ____ The agency allows waiver of payment of the enrollment fee, premiums and similar charges for undue hardship.

<p><i>Please specify the standard(s) and/or criteria that the state will use to determine undue hardship.</i></p>

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Section D – Benefits

Benefits:

1. The agency adds the following optional benefits in its state plan (include service descriptions, provider qualifications, and limitations on amount, duration or scope of the benefit):

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2. The agency makes the following adjustments to benefits currently covered in the state plan:

1915(i): Adult Day Health Program Services:

Temporarily expand 1915(i) HCBS Adult Day Health Program (AHDP) services to include wellness checks provided via video conferencing/other electronic modality (e.g., Skype, FaceTime) or telephone for the duration of the public health emergency, in accordance with HIPAA requirements. A qualifying wellness check includes inquiries/reminders on the following:

- Overall health status, including emotional well-being, need for care, and any signs or symptoms of illness
- Meals, routines, and medication adherence
- Social isolation and self-quarantine, including the availability/use of informal supports and access to groceries or emergency supplies

Temporarily expand 1915(i) HCBS Adult Day Health Program Services to include the following services, when delivered via video conferencing/other electronic modality (e.g., Skype, FaceTime) or telephone for the duration of the public health emergency, in accordance with HIPAA requirements:

- Remote therapeutic activities conducted individually or in groups by a licensed therapist
- Remote nursing services conducted individually by a licensed nurse

Temporarily expand 1915(i) HCBS Adult Day Health Program Services to include delivery of meals that are already included in the currently approved service definition, when delivered at the beneficiary's permanent or temporary residence:

- Meal or food delivery to the beneficiary's permanent or temporary residence

The District assures that meals provided as part of these services shall not constitute a full nutritional regimen (no more than 2 meals a day).

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3. The agency assures that newly added benefits or adjustments to benefits comply with all applicable statutory requirements, including the statewideness requirements found at 1902(a)(1), comparability requirements found at 1902(a)(10)(B), and free choice of provider requirements found at 1902(a)(23).
4. Application to Alternative Benefit Plans (ABP). The state adheres to all ABP provisions in 42 CFR Part 440, Subpart C. This section only applies to states that have an approved ABP(s).
 - a. The agency assures that these newly added and/or adjusted benefits will be made available to individuals receiving services under ABPs.
 - b. Individuals receiving services under ABPs will not receive these newly added and/or adjusted benefits, or will only receive the following subset:

<i>Please describe.</i>

Telehealth:

5. The agency utilizes telehealth in the following manner, which may be different than outlined in the state's approved state plan:

1915(i) Eligibility Evaluations and 1915(i) Independent Assessments for Home and Community-Based Services authorized under the State Plan

Temporarily allow 1915(i) eligibility evaluation and 1915(i) face to face independent assessment requirement using telehealth/telemedicine. The District assures that 1915(i) independent assessments will be performed in accordance with requirements set forth at 42 CFR §441.720.

Drug Benefit:

6. The agency makes the following adjustments to the day supply or quantity limit for covered outpatient drugs. The agency should only make this modification if its current state plan pages have limits on the amount of medication dispensed.

Temporarily adjust day supply limits to allow and reimburse for dispensing of a 90-day supply of maintenance medications identified at http://www.dc-pbm.com/external/medicaid/dc/doc/en-us/DcRx_maintenance_medications.pdf.

7. Prior authorization for medications is expanded by automatic renewal without clinical review, or time/quantity extensions.
8. The agency makes the following payment adjustment to the professional dispensing fee when additional costs are incurred by the providers for delivery. States will need to supply documentation to justify the additional fees.

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Please describe the manner in which professional dispensing fees are adjusted.

9. The agency makes exceptions to their published Preferred Drug List if drug shortages occur. This would include options for covering a brand name drug product that is a multi-source drug if a generic drug option is not available.

Section E – Payments

Optional benefits described in Section D:

1. Newly added benefits described in Section D are paid using the following methodology:
- a. Published fee schedules –
- Effective date (enter date of change): _____
- Location (list published location): _____
- b. Other:

Describe methodology here.

Increases to state plan payment methodologies:

2. The agency increases payment rates for the following services:

Home Health: Personal Care Aide Services
Home Health: Skilled Nursing and Private Duty Nursing Services
Nursing Facility Services
Intermediate Care Facility Services for Individuals with Intellectual Disabilities
Laboratory and X-Ray Services

- a. Payment increases are targeted based on the following criteria:

Rates are increased to support increased staff cost, as well as ongoing or increased fixed cost related to the continued provision of services to vulnerable Medicaid beneficiaries during the public health emergency. To ensure support for Medicaid providers across the benefit, changes to reimbursement for Home Health services align with similar emergency changes to services provided under the District's 1915(c) Home and Community Based Waivers.

- b. Payments are increased through:

- i. A supplemental payment or add-on within applicable upper payment

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limits:

Please describe.

- ii. X An increase to rates as described below.

Rates are increased:

X Uniformly by the following percentage: 20% for Nursing Facilities; 15% for ICF/IIDs

Nursing Facility Services -

Temporarily increase reimbursement to Nursing Facilities by 20% to all facility rate components (i.e., Nursing Care Price, Routine and Support Care Price, and Capital Rate)

Rates are increased to support increased staff cost, as well as ongoing or increased fixed cost related to the public health emergency.

Intermediate Care Facility Services for Individuals with Intellectual Disabilities

Temporarily increase the reimbursement rates to ICF/IIDs by a 15% increase to the Direct Service cost center; which is comprised of the direct support professional (DSP), certified nursing assistant (CNA), licensed professional nurse (LPN), registered nurse (RN), qualified intellectual disabilities professional (QIDP), and the house managers' costs. In line with the ICF/IID rate methodology, enhancements in the Direct service cost center also result in increases in other components of the per-diem rate including all other healthcare services, administration, active treatment, and Stevie Sellows cost centers.

The overall increase in the per-diem rate will apply across all acuity levels (i.e., Base through Acuity Level: C12).

Rates are increased to support increased staff cost, as well as other increased cost related to the public health emergency.

 Through a modification to published fee schedules –

Effective date (enter date of change): _____

Location (list published location): _____

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X Up to the Medicare payments for equivalent services.

Laboratory and X-Ray Services

Temporarily increase Medicaid reimbursement of laboratory services related to the diagnostic testing of COVID-19 from 80% of the Medicare reimbursement rate to 100% of the Medicare rate.

X By the following factors:

Home Health: Personal Care Aide Services

Temporarily increase reimbursement rates to home health agencies (HHAs) to support increased costs associated with services provided by personal care aides (PCAs) because HHAs, due to a reduction in total available workforce, utilize staffing agencies charging a rate higher than that reimbursed by DHCF. Reimbursement for services provided by such staff may vary, but shall reflect the reasonable, additional costs to the HHA provider. To receive the increased rate, an HHA will be required to: 1) identify the NPI of the staffing agency in the original claim; and 2) submit an invoice for reimbursement that includes the invoice from the staffing agency showing the amount charged. Maximum reimbursement for services provided by PCAs hired through a staffing agency shall not exceed the standard PCA rate by more than 50%. Maximum overtime reimbursement for services provided by PCAs hired through a staffing agency shall not exceed the standard PCA rate by more than 100%.

Temporarily increase reimbursement rates to HHAs for PCA services to accommodate additional costs associated with the need to pay overtime compensation to individual staff who, due to a reduction in total available workforce, will work over 40 hours per hours a week. Maximum overtime reimbursement for services provided by PCAs shall not exceed \$32 per hour (\$8/per 15min).

Temporarily increase reimbursement rates to HHAs to support costs associated with PCAs working with persons who have been medically quarantined. The District will reimburse for a quarantine period not to exceed to 14 consecutive days. PCAs will be paid an increased rate for the first 40 hours worked; and will then be paid an overtime rate for any hours worked over 40 hours. For the first 40 hours worked, maximum reimbursement for services provided by PCAs working with persons who have been medically quarantined shall not exceed \$32 per hour (\$8/per 15min). For any work over 40 hours, the overtime rate for PCAs working with persons who have been medically quarantined shall not exceed \$48 per hour (\$12/per 15min).

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Home Health: Skilled Nursing and Private Duty Nursing Services

Temporarily increase reimbursement rates to home health agencies (HHAs) to support increased costs associated with services provided by skilled nursing (SN) and private duty nursing (PDN) staff because HHAs, due to a reduction in total available workforce, utilize staffing agencies charging a rate higher than that reimbursed by DHCF. Reimbursement for services provided by such staff may vary, but shall reflect the reasonable, additional costs to the HHA provider. To receive the increased rate, an HHA will be required to: 1) identify the NPI of the staffing agency in the original claim; and 2) submit an invoice for reimbursement that includes the invoice from the staffing agency showing the amount charged. Maximum reimbursement for services provided by SN and PDN staff hired through a staffing agency shall not exceed the standard rate by more than 50%. Maximum overtime reimbursement for services provided by SN and PDN staff hired through a staffing agency shall not exceed the standard SN and PDN rate by more than 100%.

Temporarily increase reimbursement rates to HHAs for SN and PDN services to accommodate additional costs associated with the need to pay overtime compensation to individual staff who, due to a reduction in total available workforce, will work over 40 hours per hours a week. Maximum overtime reimbursement for services provided by RNs shall not exceed \$90 per hour (\$22.5/per 15min). Maximum overtime reimbursement for services provided by LPNs shall not exceed \$75 per hour (\$18.75/per 15min).

Temporarily increase reimbursement rates to HHAs to support costs associated with SN and PDN staff working with persons who have been medically quarantined. The District will reimburse for a quarantine period not to exceed to 14 consecutive days. HHAs will be reimbursed an increased rate for the first 40 hours worked; and will then be reimbursed an overtime rate for any hours worked over 40 hours. For the first 40 hours worked per week, maximum reimbursement to HHA for services provided by RNs working with persons who have been medically quarantined shall not exceed \$90 per hour (\$22.5/per 15min). Maximum reimbursement to HHA for services provided by LPNs working with persons who have been medically quarantined shall not exceed \$75 per hour (\$18.75/per 15min). For any work over 40 hours a week, the overtime reimbursement rate to HHA for services provided by RNs working with persons who have been medically quarantined shall not exceed \$120 per hour (\$30/per 15min). Maximum reimbursement to HHA for services provided by LPNs working with persons who have been medically quarantined shall not exceed \$100 per hour (\$25/per 15min).

The reimbursement rate for supervisory nursing visits will remain unchanged.

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Payment for services delivered via telehealth:

3. For the duration of the emergency, the state authorizes payments for telehealth services that:
- a. Are not otherwise paid under the Medicaid state plan;
 - b. Differ from payments for the same services when provided face to face;

1915(i): Adult Day Health Program Services:

Temporarily allow payments equal to 75% of the fee-for-service per diem rate to Adult Day Health Programs (AHDPs) for wellness checks provided via video conferencing/other electronic modality (e.g., Skype, FaceTime) or telephone for the duration of the public health emergency, in accordance with HIPAA requirements. A qualifying wellness check includes inquiries/reminders on the following:

- Overall health status, including emotional well-being, need for care, and any signs or symptoms of illness
- Meals, routines, and medication adherence
- Social isolation and self-quarantine, including the availability/use of informal supports and access to groceries or emergency supplies

AHDPs shall document all wellness checks in the District's case management system, DC Care Connect. Reimbursement is not available for wellness checks provided simultaneously while a supervisory nurse is present with the beneficiary or the beneficiary is receiving similar services from another Medicaid provider.

Temporarily allow payments equal to 100% of the FFS per diem rate to Adult Day Health Program providers who 1) conduct a wellness check; and 2) Provide one of the following services in the same day:

- Remote therapeutic activities conducted individually or in groups by a licensed therapist in accordance with HIPAA requirements
- Remote nursing services conducted individually by a licensed nurse in accordance with HIPAA requirements
- Meal or food delivery to the beneficiary's permanent or temporary residence

- c. Differ from current state plan provisions governing reimbursement for telehealth;

Describe telehealth payment variation.

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- d. ___ Include payment for ancillary costs associated with the delivery of covered services via telehealth, (if applicable), as follows:
- i. ___ Ancillary cost associated with the originating site for telehealth is incorporated into fee-for-service rates.
 - ii. ___ Ancillary cost associated with the originating site for telehealth is separately reimbursed as an administrative cost by the state when a Medicaid service is delivered.

Other:

4. ___ Other payment changes:

Section F – Post-Eligibility Treatment of Income

1. ___ The state elects to modify the basic personal needs allowance for institutionalized individuals. The basic personal needs allowance is equal to one of the following amounts:
 - a. ___ The individual's total income
 - b. ___ 300 percent of the SSI federal benefit rate
 - c. ___ Other reasonable amount: _____
2. ___ The state elects a new variance to the basic personal needs allowance. (Note: Election of this option is not dependent on a state electing the option described the option in F.1. above.)

The state protects amounts exceeding the basic personal needs allowance for individuals who have the following greater personal needs:

Please describe the group or groups of individuals with greater needs and the amount(s) protected for each group or groups.

Section G – Other Policies and Procedures Differing from Approved Medicaid State Plan /Additional Information

Prescription Order Form

Initial request for LTCSS assessment and request for re-assessment will not require physician or APRN authorization for the duration of the emergency period.

Health Homes as authorized under 1945 of SSA

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My Health GPS Health Home Program and Services

Effective April 1, 2020 modify the *My Health GPS* health home program to eliminate acuity tiers, face-to-face requirements, and update care team staffing requirements during the public health emergency.

Proposed changes include:

- Temporary enrollment of *My Health GPS* beneficiaries into a single acuity tier, replacing the current Acuity Levels 1 and 2.
- Changing the *My Health GPS* acuity-based staffing model set forth under the State Plan to instead allow for the following staff participation ratios per 400 enrolled beneficiaries: Health Home Director (0.5 FTE), Nurse Care Manager (2 FTE), Social Worker (1 FTE), and Community Health Worker (1 FTE)
- Removing the in-person requirements for the initial and annual a biopsychosocial assessment to allow *My Health GPS* providers to complete the required initial and annual biopsychosocial assessments via video conferencing or other electronic modality or telephone, in accordance with HIPAA requirements.

DHCF is also proposing reimbursement changes described below corresponding to the programmatic changes set forth above.

My Health GPS Reimbursement and Pay-for-Performance Program

In order to align with the programmatic changes set forth above, DHCF is proposing establishment of a new reimbursement methodology for *My Health GPS* providers during the public health emergency, including:

- A new PMPM rate and frequency. In place of the currently approved two PMPM rates based on different acuity levels, DHCF is proposing a single combined rate, that will be reimbursable quarterly to providers who provide at least one authorized *My Health GPS* activity per quarter. The quarterly reimbursement rate to *My Health GPS* providers will be increased to \$304.98.
- Temporarily delayed implementation of *My Health GPS* pay-for-performance and quality reporting requirements set forth in the State Plan until fiscal year 2022 in order to decrease the administrative burden on *My Health GPS* providers due to the public health emergency.

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148 (Expires 03/31/2021). The time required to complete this information collection is estimated to average 1 to 2 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. Your response is required to receive a waiver under Section 1135 of the Social Security Act. All responses are public and will be made available on the CMS web site. If you have

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