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State/Territory Name: District of Columbia

State Plan Amendment (SPA) #: 23-0003

This file contains the following documents in the order listed:

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

May 11, 2023

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

Re: District of Columbia State Plan Amendment (SPA) 23-0003

Dear Director Byrd:

We have reviewed the proposed amendment and accompanying section 1135 waivers to add section 7.5 Medicaid Disaster Relief for the COVID-19 National Emergency to your Medicaid state plan, as submitted on April 4, 2023 under transmittal number (TN) 23-0003. 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 also 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) of the Act, CMS is approving the state's request to waive these notice requirements otherwise applicable to SPA submissions.

These waivers of the requirements related to SPA submission timelines and public notice 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's Medicaid SPA Transmittal Number 23-0003 is approved effective May 1, 2022. This SPA is in addition to all previous approved Disaster Relief SPAs, and does not supersede anything approved in those SPAs.

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

Please contact Dan Belnap at (215)861-4273 or by email at Dan.Belnap@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,

Alissa M. Deboy -S

Digitally signed by Alissa M. Deboy -S
Date: 2023.05.11 08:23:16 -04'00'

Alissa Mooney DeBoy
On Behalf of Anne Marie Costello, Deputy Director
Center for Medicaid and CHIP Services

Enclosures

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: ~~23-003~~ 23-0003

2. STATE: **District of Columbia**

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT

TO: CENTER DIRECTOR
CENTERS FOR MEDICARE & MEDICAID SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE:
May 1, 2022

5. FEDERAL STATUTE/REGULATION CITATION:
Section 1905(a) Social Security Act
Title XIX of the SSA
Section 1915(i) Social Security Act

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars):
a. FFY 2023 18,713,000.00
b. FFY 2024 18,713,000.00

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Section 7.5: pp 85-94

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
N/A

9. SUBJECT OF AMENDMENT:
1915(i) Housing Supportive Services Evaluation and ARPA 9817 Direct Care Worker Supplemental Payment

10. 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

[redacted] OFFICIAL

12. TYPED NAME
Melissa Byrd

13. TITLE
Senior Deputy Director/Medicaid Director

14. DATE SUBMITTED
April 4, 2023

15. RETURN TO
Melissa Byrd
Senior Deputy Director/Medicaid Director
Department of Health Care Finance
441 4th Street, NW, 9th Floor, South
Washington, DC 20001

FOR CMS USE ONLY

16. DATE RECEIVED
April 4, 2023

17. DATE APPROVED
May 11, 2023

PLAN APPROVED – ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL
May 1, 2022

19. SIGNATURE OF APPROVING OFFICIAL
Alissa M. Deboy -S
Digitally signed by Alissa M. Deboy -S
Date: 2023.05.11 08:23:58 -04'00'

20. TYPED NAME OF APPROVING OFFICIAL
Alissa Mooney DeBoy, on Behalf of Anne Marie Costello

21. TITLE OF APPROVING OFFICIAL
Deputy Director, Center for Medicaid and CHIP Services

22. REMARKS

Boxes 1, 5, and 14: State authorized pen and ink change on 05/08/2023

State/Territory: District of Columbia

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:

Except for the modifications under Section G pertaining to the process of evaluation and re-evaluation of 1915(i) eligibility, the provisions of the emergency State Plan Amendment shall be effective May 1, 2022 through the end of the federal public health emergency. The provisions under Section G shall be effective May 8, 2023, through the end of the PHE.

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:

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),

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:

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 inconsistences 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.

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:

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).

2. _____ The agency suspends enrollment fees, premiums and similar charges for:

    a. _____ All beneficiaries

    b. _____ The following eligibility groups or categorical populations:

Please list the applicable eligibility groups or populations.

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

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

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):

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

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:

Please describe.

Telehealth:

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

Please describe.

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.

Please describe the change in days or quantities that are allowed for the emergency period and for which drugs.

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.

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.

State/Territory: District of Columbia

Increases to state plan payment methodologies:

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

Please list all that apply.

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

Please describe criteria.

b. Payments are increased through:

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

Please describe.

ii. ____ An increase to rates as described below.

Rates are increased:

_____ Uniformly by the following percentage: _____

_____ Through a modification to published fee schedules –

Effective date (enter date of change): _____

Location (list published location): _____

_____ Up to the Medicare payments for equivalent services.

_____ By the following factors:

Please describe.

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;

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

Describe telehealth payment variation.

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. __X__ Other payment changes:

ARPA 9817 Direct Care Worker Supplemental Payment

(a) Beginning state fiscal year 2023 and for the duration of the federal COVID-19 Public Health Emergency, DHCF will make supplemental payments to strengthen the direct service workforce and to increase the pay of direct support professionals who are likely to be paid at or near the minimum/living wage for delivering the following State Plan services:

• 1905(a) Home Health Agency – Personal Care Aides; Home Health Aides
• 1915(i) Adult Day Health Providers – Personal Care Aides employed as Direct Care Support staff
• 1905(a) Rehabilitation: Behavioral Health (e.g. Mental Health Rehabilitation Services; Adult Substance Use Rehabilitation Services) – Certified Peer Specialists
• 1915(i) Supported Employment Providers - Certified Peer Specialists

Supplemental payments will be disbursed to provider agencies in annual, lump sum allotments.

(b) To qualify for a supplemental payment, a provider agency must submit cost and employment data (e.g., a schedule of direct support professionals, their wages paid, hours worked, hire dates, and vacancy rates), at the request of the District, and must demonstrate that supplemental allotments are used (in their entirety) to pay direct support professional staff a benchmark wage rate, set above the District of Columbia's living/minimum wage rate.

(c) Effective January 1, 2023, eligible Medicaid State Plan service providers will receive an annual supplemental payment that takes into account the increased costs associated with paying

Medicaid direct care workers, for provision of HCBS services to Medicaid beneficiaries, at a rate that is 10% above the effective DC Living Wage rate. To determine this payment, DHCF will project the CY 2023 Medicaid-related expenditures for salary, wages, fringe benefits, and administration associated with paying their direct care workforce at 10% above the target wage rate, based on the current rate methodology applicable to the eligible Medicaid service provider.

(d) Eligible provider agencies retain 100% of the total computable expenditure claims by the District to CMS. The District may recoup supplemental payments from provider agencies which fail to submit the required cost data or pay direct supports professionals an average wage below the benchmark wage rate. The federal share for any recouped payments is returned through an adjustment to the CMS 64 Report.

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

1915(i) Housing Supportive Services

Process for Performing Evaluation/Reevaluation

DC's Coordinated Entry Process, known as Coordinated Assessment and Housing Placement (CAHP), shall be used to complete the independent evaluation of an individual's eligibility for HSS. This process begins with homeless service agency outreach and shelter workers (workers) engaging

individuals who are either experiencing homelessness or at risk of homelessness. These workers use the Vulnerability Index-Service Prioritization Decision Assistance Tool (VI-SPDAT) to interview and assess the needs of the individual. DHS staff performs the independent evaluation of eligibility by reviewing the results of the assessment, as well as additional information obtained from the individual and/or their current service providers (this includes clinical documentation of the individual's disability), to determine whether the individual has a need for assistance getting or maintaining house because of their disabilities or functional impairments and is eligible for the 1915(i) benefit.
After the evaluation and determination of eligibility is complete, DHS notifies the individual if they meet the HSS eligibility criteria. If any individual is found not to meet the eligibility criteria, the individual has the right to request a reconsideration and/or fair hearing.

The reevaluation process is conducted every 12 months. **Effective May 8, 2023, the individual's HSS provider will complete the HSS Biopsychosocial Reassessment, which is a standardized tool in DC's web-based case note platform, Housing the Homelessness. (HTH). DHS staff performs the independent evaluation of eligibility by reviewing the results of the HSS Biopsychosocial Reassessment, as well as additional information obtained from the individual and/or their current service providers (this includes clinical documentation of the individual's disability), to determine whether the individual has a continued need for assistance getting or maintaining house because of their disabilities or functional impairments and is eligible for the 1915(i) benefit.**

If a participant is determined no longer ineligible for this 1915(i) benefit or will experience a reduction in amount, duration or scope of services as a result of using the HSS Biopsychosocial Reassessment, DHS will re-assess the participant using the VI-SPADT.

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 comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. ***CMS Disclosure*** Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact the Centers for Medicaid & CHIP Services at 410-786-3870.