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State/Territory Name: DC

State Plan Amendment (SPA) #: 24-0005

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
Center for Medicaid & CHIP Services
230 South Dearborn
Chicago, Illinois 60604



Financial Management Group

May 24, 2024

Melisa Byrd
Senior Deputy Director/Medicaid Director
441 4th Street, NW, 9th Floor, South
Washington, DC 20001

RE: TN 24-0005

Dear Byrd:

The Centers for Medicare & Medicaid Services (CMS) has reviewed the proposed DC state plan amendment (SPA) to Attachment 4.19-B, 24-0005 which was submitted to CMS on April 12, 2024. This plan amendment will permit the District of Columbia Medicaid Program to continue to provide supplemental payments through March 31, 2025 to direct support professionals who are likely to be paid at or near the minimum/living wage for delivering the follow 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, 1915(i) Supported Employment Providers - Certified Peer Specialists.

We reviewed your SPA submission for compliance with statutory requirements including in sections 1902(a)(2), 1902(a)(13), 1902(a)(30), and 1903 as it relates to the identification of an adequate source for the non-federal share of expenditures under the plan, as required by 1902(a)(2), of the Social Security Act and the applicable implementing Federal regulations.

Based upon the information provided by the State, we have approved the amendment with an effective date of May 12, 2024. We are enclosing the approved CMS-179 and a copy of the new state plan pages.

If you have any additional questions or need further assistance, please contact Lindsay Michael at 410-786-7197 or Lindsay.michael@cms.hhs.gov.

Sincerely,

A solid black rectangular box used to redact the signature of Todd McMillion.


Todd McMillion, Director
Division of Reimbursement Review

Enclosures

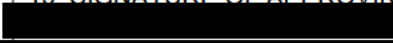
TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES	1. TRANSMITTAL NUMBER: DC-24-0005	2. STATE: District of Columbia
	3. PROGRAM IDENTIFICATION: TITLE <u>XIX</u> OF THE SOCIAL SECURITY ACT	
TO: CENTER DIRECTOR CENTERS FOR MEDICARE & MEDICAID SERVICES DEPARTMENT OF HEALTH AND HUMAN SERVICES	4. PROPOSED EFFECTIVE DATE: May 12, 2024	
5. FEDERAL STATUTE/REGULATION CITATION: Section 9817 of the American Rescue Plan Act of 2021 (42 U.S.C. §§1396d(b))	6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars): a. FFY 2024 _\$28,302,031_____ b. FFY 2025 _\$30,096,822_____	
7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: 4.19-B Part 1 P. 4c-4e 4.19-B Part 1 P. 15-15a 4.19-B Part 1 P. 29-33 4.19-B Part 1 P. 37-38	8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable): 4.19-B Part 1 P. 4c-4e 4.19-B Part 1 P. 15-15a 4.19-B Part 1 P. 29-33 4.19-B Part 1 P. 37-38	

9. SUBJECT OF AMENDMENT:
ARPA Section 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

11. SIGNATURE OF STATE AGENCY OFFICIAL 	15. 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
12. TYPED NAME Angelique Martin on behalf of Melisa Byrd	
13. TITLE Senior Deputy Director/Medicaid Director	
14. DATE SUBMITTED 04/12/24	

FOR CMS USE ONLY

16. DATE RECEIVED April 12, 2024	17. DATE APPROVED May 24, 2024
PLAN APPROVED – ONE COPY ATTACHED	
18. EFFECTIVE DATE OF APPROVED MATERIAL May 12, 2024	19. SIGNATURE OF APPROVING OFFICIAL 
20. TYPED NAME OF APPROVING OFFICIAL Todd McMillion	21. TITLE OF APPROVING OFFICIAL Director, Division of Reimbursement Review
22. REMARKS	

7b. Home Health Services

Home Health services and provider qualifications are outlined per Attachment 3.1A, Supplement 1, page 8.1-9r and Attachment 3.1B, Supplement 1, page 7.1-8r. Reimbursement for Home Health Services shall be based on a prospective payment basis established by the State Medicaid Agency in accordance with the reimbursement methodologies outlined in this section and Section 21. For all services provided, the reimbursement will be the lesser of the amount described in Section 21 or derived from the methodology outlined in this section, or the amount charged by the provider.

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of Home Health Services. The agency's fee schedule rates for Home Health Services were set as of July 1, 2021 and are effective for services provided on or after that date. All rates are published on the agency's website at: <http://www.dc-medicaid.com>.

Living Wage Adjustment

Effective October 1, 2017 and annually thereafter, the reimbursement rates for Home Health Aides shall be adjusted annually with the Living Wage rate published by the District of Columbia, Department of Employment Services. This adjustment entails updating the reimbursement rates to reflect the published living wage amount, to ensure the rates are consistently aligned with current District of Columbia Living wage rates in effect during that fiscal year.

Inflation Adjustment

Effective October 1, 2017 and annually thereafter, the reimbursement rates for Skilled Nursing services shall be adjusted annually by the Medicare Economic Index factor for skilled nursing published by the Centers for Medicare and Medicaid Services.

Administrative Add-ons

All rate methodologies under this section shall include the following administrative expense add-ons in computing the rate amounts:

- 11% Employee Taxes - This is comprised of the Social Security (6.2%), Medicare (1.45%), Workers Compensation (2%) and Unemployment Benefits (1.18%)
- 8% Employee Benefits - Medical Insurance and Sick Leave Provision
- 18% - Provider Administrative overhead, based on the reviewed Fiscal Year (FY) 2013 cost reports filed by Home Health Agencies for Home Health services

Supplemental Payments

(a) Effective on or after May 12, 2024, through March 31, 2025, 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

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) 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 17.6% above the effective DC Living Wage rate. To determine this payment, DHCF will project the Medicaid related expenditures for salary, wages, fringe benefits, and administration associated with paying their direct care workforce at 17.6% above the target wage rate. This projection will be based on the current rate methodology applicable to the eligible Medicaid service provider and will be for the year in which the supplemental payment is made.

(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.

Reimbursement Methodology

Home Health services delivered are defined in Supplement 1 to Attachment 3.1-A beginning at page 9, and include the following Medicaid services:

- Physical Therapy/Speech Therapy/Occupational Therapy;
- Home Health Aide;
- Medical Supplies, Equipment and Appliances; and
- Skilled Nursing Services.

A. Reimbursement for physical therapy, speech therapy, occupational therapy, and home health aide services, and medical supplies, equipment, and appliances is described in Section 21 of Attachment 4.19B, Part 1.

B. Skilled Nursing Services

The reimbursement methodology is designed to ensure that the rates adequately support the unique program requirements for services under the skilled nursing rubric and ensure access to skilled nursing services. There are three (3) distinct skilled nursing rates: (1) assessments and supervisory nurse visits; (2) skilled nursing services provided by a Registered Nurse (R.N.); and (3) skilled nursing services provided by a Licensed Practical Nurse (L.P.N.).

1) Assessments and Supervisory Nurse Visits

The reimbursement rate for initial assessments, reassessments, and supervisory nurse visits is a flat per visit rate and it is delivered by dividing the total annual R.N. cost by the average annual work hours multiplied by a factor of two. The annual cost of an R.N. includes: the average annual wages/salary paid to R.N. plus administrative add-ons stated above.

Based on available salary data obtained from the Bureau of Labor Statistics, Occupational Employment and Wages, for May 2016, the average annual salary for an R.N. in the District of Columbia is \$80,500.

The average annual work hours equals the typical 2080 full time work hours less the 88 federal holiday hours, sick leave, vacation time, and the District's mandatory continuing professional education hours. Further based on information provided by DHCF program staff and inquiries with providers, the duration of the initial assessment and supervisory visit is reasonably estimated to be two hours per visit.

Formula

$$\frac{\text{Annual R.N. Salary} + \text{Administrative Add-ons}}{\text{Average Annual Work Hours}} \times 2 \text{ hours}$$

2) Skilled Nursing Visits by a R.N. or L.P.N.

The reimbursement rate is an hourly rate computed by dividing the total annual cost of either an R.N. or L.P.N. by the average annual work hours. The annual cost of an R.N. or L.P.N. includes: the average annual wages/salary paid to an R.N. or L.P.N. plus administrative add-ons stated above.

Based on available salary data obtained from the Bureau of Labor Statistics, Occupational Employment and Wages for May 2016, the average annual salary for a R.N. and L.P.N. in the District of Columbia are \$80,500 and \$55,200 respectively.

Formula

$$\frac{\text{Annual R.N. or L.P.N. Salary} + \text{Administrative Add-ons}}{\text{Average Annual Work Hours}}$$

24. Personal Care Services

- a. Payment for Personal Care Aide Services shall be provided at an hourly rate established by the State Medicaid Agency to be billed in fifteen (15) minute increments.
- b. Each Provider shall maintain adequate documentation substantiating the delivery of allowable services provided in accordance with PCA service authorization and the person's plan of care for each unit of service submitted on every claim.
- c. Reimbursement will be the lesser of the amount established by the Medicaid agency or the amount charged by the provider.
- d. Claims for PCA services submitted by a Provider in any period during which the person has been admitted to another health care facility shall be denied except on the day when the person is admitted or discharged.
- e. The agency's fee schedule rate was set as of November 14th, 2015 and is effective for services provided on or after that date. The agency's fee schedule rate will be updated annually to reflect changes in the Medicare Home Health Agency Market Basket and changes in the District of Columbia Living Wage All rates are published on the agency's website at www.dhcf.dc.gov. Except as otherwise noted in the Plan, State developed fee schedule rates are the same for both governmental and private individual practitioners and the fee schedule and any annual/periodic adjustments to the fee schedule are published in: <https://www.dc-medicaid.com/dwebportal/nonsecure/feeScheduleDownload>.

f. Supplemental Payments:

(a) Effective on or after May 12, 2024, through March 31, 2025, 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:

- 1915(i) Adult Day Health Providers – Personal Care Aides employed as Direct Care Support staff

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) 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 17.6% above the effective DC Living Wage rate. To determine this payment, DHCF will project the Medicaid related expenditures for salary, wages, fringe benefits, and administration associated with paying their direct care workforce at 17.6% above the target wage rate. This projection will be based on the current rate methodology applicable to the eligible Medicaid service provider and will be for the year in which the supplemental payment is made.

(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.

25. Rehabilitative Services

Mobile Community Outreach Service Teams (MCOTT)

1. MCOTT providers shall be reimbursed at a flat rate for each day on which at least one face-to-face services for the client is provided. This rate will be established by the Medicaid agency. An example follows:

Daily service yearly cost = \$1,753,700.00

Fringe Benefits & Administration (overhead which is 33% of direct service total costs) = \$578,721.00

Total Costs = \$2,332,421.00

Hypothetical number of clients = 100

Rate Calculation: $(\$2332421.00/100) / 365$ days = \$63.90
(this is a per person, per day rate)

2. Services must be medically necessary and prior authorized.
3. Reimbursement will not be made for services provided during a client’s inpatient hospitalization.

Methods and Standards for Establishing Payment Rates

1. **Services Provided Under Section 1915(i) of the Social Security Act.** For each optional service, describe the methods and standards used to set the associated payment rate. *(Check each that applies, and describe methods and standards to set rates):*

<input type="checkbox"/>	HCBS Case Management
<input type="checkbox"/>	HCBS Homemaker
<input type="checkbox"/>	HCBS Home Health Aide
<input type="checkbox"/>	HCBS Personal Care
<input checked="" type="checkbox"/>	<p>HCBS Adult Day Health</p> <p>For ADHP users enrolled in a contracted health plan, the health plan will reimburse covered services consistent with their contracts with DHCF and with the providers. DHCF's reimbursement of services through the health plan is actuarially sound and based on historic utilization of ADHP services.</p> <p>Reimbursement for fee-for-service adult day health services associated with the 1915(i) HCBS State Plan Option shall be paid based upon uniform per-diem rates at two acuity levels.</p> <p>Acuity level 1 and Acuity level 2 services shall be reimbursed in accordance with the District of Columbia Medicaid Fee Schedule.</p> <p>The agency's fee schedule rate will be set as of 4/1/2020 and will be effective for services provided on or after that date. All rates are published on the agency's website at https://www.dc-medicaid.com/dcwebportal/nonsecure/feeScheduleDownload. Except as otherwise noted in the Plan, State developed fee schedule rates are the same for both governmental and private individual practitioners, and the fee schedule and any annual/periodic adjustments to the fee schedule are published in the DHCF Provider Web Portal available at www.dc-medicaid.com/dcwebportal/home.</p> <p>ADHPs will be reimbursed at two different acuity levels. To be eligible for reimbursement at acuity level 1 ADHP services, an individual shall obtain a total score of four (4) or five (5). To be eligible for reimbursement at acuity level 2 ADHP services, an individual shall obtain a total score of six (6) or higher. The specific acuity level does not affect the benefit package received by an individual. ADHP consists of one set of services that are available to all participants, regardless of acuity level. Each participant will receive services based upon their strengths, preferences, and health care needs as reflected by their level of need and person-centered service plan.</p> <p>Recognizing that some participants may have more complex needs (such as a greater need for supervision or support), DHCF has developed two reimbursement rates - one for those who meet the threshold eligibility criteria based upon their assessed needs and the other, for those whose assessed needs are higher. The enhanced rates recognize that staffing levels must increase when participants have higher acuity levels.</p> <p>Adult Day Health providers are defined in this Attachment. Reimbursement for adult day health</p>

services is paid using two bundled per-diem rates that are reasonable and adequate to meet the costs incurred by an efficient and economically prudent provider. The bundled per-diem rate consists of staffing costs in addition to program materials, indirect costs, and administrative costs. Room and board are excluded in the per-diem rates.

The per diem rates are binding rates; the District will pay each provider a fixed per-diem rate. The District will pay the lesser of the per-diem rate or the amount billed by a provider in accordance with standard Medicaid payment methodology. The staffing structure used to develop the rates were tied to the program requirements and is sufficient to allow providers to meet all program requirements, but they are not bound to adhere to the wages or benefit rates included in the rate model beyond compliance with existing federal and District laws (such as our living wage laws) and the program requirements outlined in the SPA. The agency's per diem rates will be effective on the date of approval for any services provided on or after that date. Except as otherwise noted in the Plan, State developed per-diem rates are the same for both governmental and private individual practitioners and will be published via transmittal available at <https://www.dc-medicaid.com>.

Staffing, wages, and benefits

The model incorporates five principal types of employees to ensure adequate staffing to meet beneficiary needs and program requirements. These include direct support personnel (DSP) providing hands-on support and care; social services professionals delivering services and programming; a program director; a registered nurse (RN); and a medical director. The cost of each of these staff types was estimated as a function of five data points: (1) the base wage or salary required to recruit and retain qualified staff and to meet District living wage law; (2) the hours paid staff would be on-duty at the program, as well as hours for paid leave; (3) the ratio of each staff member to beneficiaries attending the program; (4) the number of days in a fiscal year a program would reasonably be operating; and (5) the additional cost of providing employee benefits such as health insurance or other fringe benefits as appropriate.

Information about these five data points and how they were determined for each of the five staffing types are shown in the table below.

	Base wage or salary	Hours on duty per fiscal year	Ratio of staff member to beneficiaries	Number of operating days	Marginal addition for fringe benefits
Direct support personnel	Based on competitive wages in DC	2080 (FTE) plus 80 hours paid leave	1:10 in Acuity 1; 1:4 in Acuity 2	260 (fiscal year, excluding weekends)	20%
Social services personnel	Based on competitive wages in DC	2080 (FTE) plus 80 hours paid leave	1:20	260 (fiscal year, excluding weekends)	20%
Program director	Based on competitive wages in DC	2080 (FTE) plus 80 hours paid leave	1:40	260 (fiscal year, excluding weekends)	20%
Registered nurse	Based on competitive wages in DC	2080 (FTE) plus 80 hours paid leave	1:40	260 (fiscal year, excluding weekends)	20%

				weekends)	
Medical director	Based on competitive wages in DC	520 (0.25 FTE)	1:40	260 (fiscal year, excluding weekends)	No benefits

These data were used to calculate annual total and per-beneficiary costs for each staffing type, which was further refined into a per-diem, per-beneficiary staffing cost.

These costs are used to develop a fee for service rate and are not a part of a CMS approved methodology to identify costs eligible for certification.

Program materials, indirect costs, and administrative costs

In addition to the staffing component, the rate includes additional funding for program materials, supplies, and indirect costs, including: (1) programming supplies; (2) food and snack costs; (3) indirect costs such as rental and building maintenance costs, utilities, telecommunications, and transportation; and (4) staff training and quality management. The estimate of these costs were based in part on qualitative data collection conducted in meetings, site visits, and phone calls with existing District health care providers, and in part on similar cost categories as reported by existing District providers via cost reporting. Annualized costs were translated into per-diem, per-beneficiary rates using an expected operating year of 260 days and expected program size of 40 beneficiaries.

After summing the staffing component and the program and indirect costs, an additional 13% was added to the rate to reflect administrative costs. The District uses this rate for other provider types, and it was used here for consistency.

Lastly, the rate was adjusted to reflect attendance rates; effectively, the rate was increased slightly to accommodate continued operating costs each day a provider is open for business, despite its complete census not attending every day.

Service Limitations

ADHP services shall not be provided to persons who reside in institutions. Providers cannot bill for services that are provided for more than five (5) days per week and for more than eight (8) hours per day. Additionally, providers will not be reimbursed for ADHP services if the participant is receiving the following services concurrently (ie., during the same hours on the date of service):

- a) Day Habilitation and Individualized Day Supports under the 1915(c) Waiver for Individuals with Intellectual and Developmental Disabilities (ID/DD);
- b) Intensive day treatment or day treatment mental health rehabilitative services (MHRS);
- c) Personal Care Aide services; (State Plan and 1915(c) waivers), or
- d) Services funded by the Older Americans Act of 1965, Title IV, Public Law 89-73, 79 Stat. 218, as amended; Public Law 97-115, 95 Stat. 1595; Public Law 98-459, 98 Stat. 1767; Public Law 100-175; Public Law 100-628, 42 U.S.C. 3031-3037b; Public Law 102-375; Public Law 106-501.

A provider will also not be reimbursed for ADHP services if the participant is receiving intensive day treatment mental health rehabilitation services during a twenty-four (24) period that immediately

precedes or follows the receipt of ADHP services, to ensure that the participant is receiving services in the setting most appropriate to his/her clinical needs.

Supplemental Payments

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<input type="checkbox"/>	HCBS Habilitation
<input type="checkbox"/>	HCBS Respite Care
For Individuals with Chronic Mental Illness, the following services:	
<input type="checkbox"/>	HCBS Day Treatment or Other Partial Hospitalization Services
<input type="checkbox"/>	HCBS Psychosocial Rehabilitation
<input type="checkbox"/>	HCBS Clinic Services (whether or not furnished in a facility for CMI)
<input type="checkbox"/>	Other Services (specify below)

State: District of
Columbia TN: 24-0005
Effective: May 12, 2024

§1915(i) State Plan HCBS
Approved: May 24, 2024

Attachment 4.19-B, Part I
Page 33
Supersedes: DC-21-0014

Methods and Standards for Establishing Payment Rates

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<input type="checkbox"/>	HCBS Case Management
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<input type="checkbox"/>	HCBS Home Health Aide
<input type="checkbox"/>	HCBS Personal Care
<input checked="" type="checkbox"/>	<p>HCBS Supported Employment</p> <p>Supported Employment services are reimbursed according to a DHCF fee schedule rate and on a fifteen (15)-minute unit basis. DHCF's fee schedule rate is set as of January 1, 2022 and is effective for services provided on or after that date. All rates are published on the agency's website at www.dc-medicaid.com/dcwebportal/home. Rates are consistent with efficiency, economy, and quality of care. The fee development methodology is primarily composed of provider cost modeling, through DC provider compensation studies and cost data. Fees from similar State Medicaid programs may also be considered.</p> <p>The following list outlines the major components of the cost model used in developing the fee schedule:</p> <ol style="list-style-type: none"> 1. Staffing Direct Wages, including but not limited to: salaries, fringe benefits (e.g., health and dental insurance, Medicare tax, employment tax), and contract costs for eligible direct care service providers; 2. Direct Program Costs, including but not limited to: materials; supplies; staff travel and training costs; program, clinical and support salary and benefit costs; and additional allocable direct service costs unique to a provider; 3. Indirect Costs, including but not limited to: administrative and management personnel costs, occupancy costs, security costs, and maintenance and repair costs; 4. Service utilization statistics, including but not limited to: the total units of service provided and data related to service volume; 5. Productivity Factors, including but not limited to hours of service; and 6. Unique Program Costs. <p>Supplemental Payments</p> <p>(a) Effective on or after May 12, 2024, through March 31, 2025, 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:</p> <ul style="list-style-type: none"> • 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.

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<input type="checkbox"/>	
<input type="checkbox"/>	
<input type="checkbox"/>	
<input type="checkbox"/>	