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DDS TRANSMITTAL# 22-07

TO: All Developmental Disabilities Administration (DDA) Day Services Providers

FROM: Winslow Woodland, Deputy Director, Developmental Disabilities Administration (DDA) *WW*
Hakima Muhammad, Operation Program Manager *HM*

DATE: March 7, 2022

RE: Day Provider Attestation Letter

The Department on Disability Services (DDS), Developmental Disabilities Administration (DDA), releases this transmittal to reissue guidance on the requirement for DDA Day Program providers to provide attestation letters for temporary retainer payments made available to during the COVID-19 Public Health Emergency. Authorized Day Program providers include a provider of one or more of

- Day Habilitation,
- Employment Readiness,
- Individualized Day Supports, or
- Supported Employment Services.

The Centers for Medicare & Medicaid Services (CMS) approved day program providers for a second round of retainer payments if a person was unable to attend his or her day program services as a result of the COVID-19 Public Health Emergency. Provider attestation letters are due to be submitted to DDS by close of business on **Monday, March 21, 2022**. The District will require an attestation from providers to:

- acknowledge that retainer payments will be subject to recoupment if inappropriate billing or duplicate payments for services occurred (or in periods of disaster, duplicate uses of available funding streams), as identified in a state or federal audit or any other authorized third-party review. Note that "duplicate uses of available funding streams" means using more than one funding stream for the same purpose.
- certify that providers will not lay off staff and will maintain wages at existing levels.

- certify that they had not received funding from any other sources, including but not limited to unemployment benefits and Small Business Administration loans, that would exceed their revenue for the last full quarter prior to the PHE, or that the retainer payments at the level provided by the District would not result in their revenue exceeding that of the quarter prior to the PHE.

Contacts

If you have questions about rates and billing, please email your inquiry to dds.covid19billing@dc.gov.

If you have questions about Appendix K and Transmittals, please contact Pamela Harmon at (202) 738-2625 or pamela.harmon@dc.gov and Bernetrice Parker at (202) 705-9688 or bernetrice.parker@dc.gov.

If you have questions about providing DDA supports and services, please contact Winslow Woodland at (202) 730-1618 or winslow.woodland@dc.gov.

If you have questions about QAPMA provider relations or QRS-specific information, please contact Shasta Brown at (202) 730-1754 or shasta.brown@dc.gov.

Attachment

[Please place on company letterhead]

RETAINER PAYMENT ATTESTATION/DECLARATION FORM

This form is required for HCBS IDD Waiver Day Program Service Providers of Individualized Day Supports, Supported Employment, and Day Habilitation seeking retainer payments as a Medicaid Waiver Program provider under Appendix K (Emergency Preparedness and Response and COVID-19 Addendum) as approved by the Centers for Medicaid and Medicare Services (CMS) on August 27, 2020.

Provider understands that eligibility criteria for retainer payment billing are as follows:

1. Retainer payments are received by billing for units authorized in the individual service plan that were not provided due to the novel coronavirus (COVID-19) Public Health Emergency (PHE).
2. Units billed shall not exceed the amount, scope, and duration otherwise authorized for the Day Program Service provider.
3. Retainer payments may not be billed when the person chooses to receive day program services through a different provider.
4. Retainer payments for day services are limited to 5 days per week.
5. Authorized day program providers may submit claims for retainer payments for up to 30 consecutive days.
6. Reimbursement is available for multiple consecutive day periods (up to 3 episodes or 90 days total).
7. Reimbursement for the provision of other services is separate and includes costs for staff rendering other services.

Provider Name: [Insert Name of HCBS IDD Waiver Day Program Service Provider]

Time Period: [Insert Applicable Time Period]

HCBS IDD Waiver Participants: [Insert Name of Applicable Participant]

By affixing my signature, the undersigned hereby attests, assures, and declares under penalty of perjury Provider's compliance as a Medicaid Waiver Provider seeking reimbursement through retainer payments under Appendix K and further as follows:

1. Provider understands that retainer payments will be subject to recoupment if inappropriate billing or duplicate payments for services occurred.
2. Provider did not lay off staff and maintained wages at existing levels during the period represented by retainer payments.
3. Provider did not receive funding from any other sources that would exceed its revenue for the last full quarter prior to the PHE (*i.e.* October 1, 2019 – December 31, 2019).



4. Provider did not receive unemployment benefits used to reimburse staff wages during the period of retainer payment reimbursement.
5. Provider did not receive funding from any other sources, including but not limited to unemployment benefits and Small Business Administration loans, that exceeded revenue for the last full quarter prior to the PHE (and did not require repayment).
6. Provider did not receive funding from Cares Act Provider Relief Fund.
7. Provider did not receive revenue greater than that of the quarter prior to the PHE or that the retainer payments at the level provided by the state would not result in their revenue exceeding that of the quarter prior to the PHE.

Signature: _____ **Date:** _____

Print Name: _____

Title of Authorized Agent for Day Program Service Provider:
