

## **Table of Contents**

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

**State Plan Amendment (SPA) #:**      **21-0010**

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  
601 E. 12th St., Room 355  
Kansas City, Missouri 64106



Medicaid and CHIP Operations Group

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April 26, 2022

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

Re: State Plan Amendment (SPA) DC-21-0010

Dear Director Byrd:

The Centers for Medicare & Medicaid Services (CMS) reviewed your Medicaid State Plan Amendment (SPA) submitted under transmittal number (TN) DC-21-0010. This amendment proposes to allow the District to transition its Section 1115 Behavioral Health Transformation Demonstration Program services to permanent State Plan authority in order to retain authority to provide Medicaid reimbursement.

This letter is to inform you that the District of Columbia Medicaid SPA 21-0010 was approved on April 26, 2022, with an effective date of January 1, 2022.

If you have any questions, please contact LCDR Frankeena McGuire at (215) 861-4754 or [Frankeena.McGuire@cms.hhs.gov](mailto:Frankeena.McGuire@cms.hhs.gov).

Sincerely,

A solid black rectangular box redacting the signature of the sender.

Sophia A. Hinojosa, Acting Director  
Division of Program Operations

cc:  
Mario Ramsey, DHCF

<b>TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL</b>	1. TRANSMITTAL NUMBER: <b>21-0010</b>	2. STATE: <b>District of Columbia</b>
	3. PROGRAM IDENTIFICATION: <b>Title XIX of the Social Security Act</b>	

TO: Regional Administrator Centers for Medicare & Medicaid Services Department of Health and Human Services	4. PROPOSED EFFECTIVE DATE: <b>January 1, 2022</b>
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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: <b>42 U.S.C. 1396, et seq</b>	7. FEDERAL BUDGET IMPACT: <b>FFY22: \$4,953,116.39</b> <b>FFY23: \$6,888,133.86</b>
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8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:  Supplement 6 to Attachment 3.1-A: Pages 1 - 27; Supplement 1 to Attachment 3.1-A: Page 20; Supplement 3 to Attachment 3.1-B: Pages 1 - 27; Supplement 1 to Attachment 3.1B: Page 19; and Supplement 2 to Attachment 4.19-B: Pages 1-4	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable): <b>Supplement 6 to Attachment 3.1-A: Pages 1 - 32;</b> <b>Supplement 1 to Attachment 3.1-A: Page 20;</b> <b>Supplement 3 to Attachment 3.1-B: Pages 1 - 32;</b> <b>Supplement 1 to Attachment 3.1B: Page 19; and</b> <b>Supplement 2 to Attachment 4.19-B: Page 1 – 6</b>
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10. SUBJECT OF AMENDMENT:  
**Mental Health Rehabilitative Services (MHRS) / Adult Substance Use Rehabilitative Services (ASURS) / Behavioral Health Stabilization / Transition Planning Services**

11. GOVERNOR'S REVIEW (Check One)

GOVERNOR'S OFFICE REPORTED NO COMMENT       OTHER, AS SPECIFIED:  
 COMMENTS OF GOVERNOR'S OFFICE ENCLOSED      **D.C. Act. 22-444**  
 NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

12. SIGNATURE OF STATE AGENCY OFFICIAL 	16. RETURN TO  Melisa Byrd Senior Deputy Director/Medicaid Director Department of Health Care Finance 441 4 <sup>th</sup> Street, NW, 9 <sup>th</sup> Floor, South Washington, DC 20001
13. TYPED NAME <b>Melisa Byrd</b>	
14. TITLE <b>Senior Deputy Director/Medicaid Director</b>	
15. DATE SUBMITTED 6/30/21	

**FOR REGIONAL OFFICE USE ONLY**

17. DATE RECEIVED June 30, 2021	18. DATE APPROVED <b>04/26/2022</b>
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**PLAN APPROVED – ONE COPY ATTACHED**

19. EFFECTIVE DATE OF APPROVED MATERIAL <b>01/01/2022</b>	20. SIGNATURE OF REGIONAL OFFICIAL 
21. TYPED NAME <b>Sophia A. Hinojosa</b>	22. TITLE <b>Acting Director, Division of Program Operations</b>

23. REMARKS

**13. Other Diagnostic, Screening, Preventive, and Rehabilitative Services i.e., Other Than Those Provided Elsewhere in this Plan**

- a. Diagnostic Services are delivered pursuant to Supplement 1 to Attachment 3.1-A.
- b. Screening Services are delivered pursuant to Supplement 1 to Attachment 3.1-A.
- c. Preventive Services are delivered pursuant to Supplement 1 to Attachment 3.1-A.
- d. Rehabilitative Services are covered for Medicaid-eligible individuals who are in need of mental health or substance use services due to mental illness, serious emotional disturbance, or substance use disorder. Covered services include: I) Mental Health Rehabilitative Services; II) Adult Substance Use Rehabilitative Services; III) Behavioral Health Stabilization Services; and IV) Transition Planning Service.

**I. MENTAL HEALTH REHABILITATIVE SERVICES (“MHRS”)** are available to all Medicaid-eligible individuals who have mental illness or a serious emotional disturbance and are in need of mental health services, and elect to receive, or have a legally authorized representative elect on their behalf, Mental Health Rehabilitative Option Services (“mental health rehabilitative services”). Consistent with EPSDT requirements, MHRS are available to all Medicaid-eligible individuals, including those under age twenty-one (21).

A. MHRS offer a continuum of care for people with complex needs through intensive, community-based services to reduce the functional impact of mental illness or serious emotional disturbance and support transitions to less intensive levels of care. Covered MHRS are:

1. Screening, Assessment, and Diagnosis
2. Medication/Somatic Treatment
3. Counseling/Therapy
4. Community Support
5. Crisis/Emergency Services
6. Clinical Care Coordination
7. Rehabilitation Day Services
8. Intensive Day Treatment (“IDT”)
9. Community Based Intervention (“CBI”)
10. Assertive Community Treatment (“ACT”)
11. Child-Parent Psychotherapy (“CPP”)
12. Trauma-Focused Cognitive Behavioral Therapy (“TF-CBT”)
13. Functional Family Therapy (“FFT”)
14. Trauma Recovery and Empowerment Services
15. Trauma Systems Therapy (“TST”)
16. Psychosocial Rehabilitative (“Clubhouse”) Services

**B. MHRS Provider Qualifications**

1. MHRS must be provided through certified MHRS providers and comply with the

requirements set forth in the District of Columbia Municipal Regulations. Each MHRS provider's standards and qualifications shall include, but are not limited to, the following:

- a. Be certified as an MHRS provider by the District of Columbia ("District") Department of Behavioral Health ("DBH");
- b. Demonstrate the administrative and financial management capability to meet District of Columbia and federal requirements;
- c. Demonstrate the clinical capacity and ability to provide services to individuals needing MHRS;
- d. Maintain individual case records in accordance with District of Columbia and federal requirements;
- e. Have policies and procedures that require services to be provided in accordance with DBH-established, service-specific standards. Each MHRS provider during the certification process submit its policies to DBH for review and approval; and
- f. Have a written complaint and grievance policy and shall provide all consumers with notice of the policy upon initiation of services.

### **C. Practitioner Qualifications**

#### **1. Practitioners Eligible to Recommend MHRS**

MHRS must be recommended by one of the following Qualified Practitioners licensed to diagnose mental illness or serious emotional disturbance, to the extent permitted by and in accordance with District law and regulations:

- a. Psychiatrists - Licensed by the District of Columbia to furnish services within their scope of practice in accordance with District law.
- b. Psychologists - Licensed by the District of Columbia to furnish services within their scope of practice in accordance with District law.
- c. Licensed Independent Clinical Social Workers ("LICSWs") - Licensed by the District of Columbia to furnish services within their scope of practice in accordance with District law
- d. Advanced Practice Registered Nurses ("APRNs") - Licensed by the District of Columbia to furnish services within their scope of practice in accordance with District law.
- e. Licensed Professional Counselors ("LPCs") - Licensed by the District of Columbia to furnish services within their scope of practice in accordance with District law.
- f. Licensed Marriage and Family Therapists ("LMFTs") - Licensed by the District of Columbia to furnish services within their scope of practice in accordance with District law.
- g. Physician Assistants ("PAs") - Licensed by the District of Columbia to furnish services within their scope of practice in accordance with District law.
- h. Licensed Graduate Professional Counselors ("LGPCs") - Licensed by the District of Columbia to furnish services within their scope of practice in accordance with District law.; and  
Licensed Graduate Social Workers ("LGSWs") - Licensed by the District of Columbia to furnish services within their scope of practice in accordance with

District law.

## 2. Practitioners Eligible to Provide MHRS

MHRS must be delivered by Eligible Practitioners. There are three (3) categories of Eligible Practitioners:

- a. Qualified Practitioners eligible to recommend and deliver MHRS- Licensed by the District of Columbia to furnish services within their scope of practice in accordance with District law.;
- b. Other Qualified Practitioners who are eligible to deliver MHRS, but not recommend MHRS, to the extent permitted by and in accordance with District law and regulations, including any applicable supervision requirements:
  - i. Registered Nurses (“RNs”) - Licensed by the District of Columbia to furnish services within their scope of practice in accordance with District law.
  - ii. Licensed Independent Social Workers (“LISWs”) - Licensed by the District of Columbia to furnish services within their scope of practice in accordance with District law.  
Psychology Associates - Licensed by the District of Columbia to furnish services within their scope of practice in accordance with District law.
  - iii. Certified Addiction Counselors I & II (“CACs”) – Licensed/certified by the District of Columbia to furnish services within their scope of practice in accordance with District law.
  - iv. Licensed Practical Nurses (“LPNs”) - Licensed by the District of Columbia to furnish services within their scope of practice in accordance with District law.;
- c. Credentialed Staff under the supervision of Qualified Practitioners identified in #1 and #2 above, to the extent permitted by and in accordance with District law and regulations.

The authority for each category and subcategory of Eligible Practitioners to deliver MHRS are described within each service category provided below.

## D. MHRS Services and Definitions

### 1. Screening, Assessment, and Diagnosis

- a. Definition: Screening, Assessment, and Diagnosis services represent an initial evaluation and the ongoing collection of relevant information (using any assessment instruments specified by DBH) about an individual who may require MHRS and any needed referrals to other behavioral health services. Covered Services include:
  - i. Initial Assessment: Determination of an individual’s need for MHRS or other types of behavioral health treatment or support services.
  - ii. Comprehensive Diagnostic Assessment: Comprehensive clinical and functional evaluation of a consumer’s mental health condition(s) that

results in the issuance of a Diagnostic Assessment Report. The report includes a clinical formulation and recommendations for service delivery that provide the basis for the development of an individualized Plan of Care. A Comprehensive Diagnostic Assessment shall determine, based on the consumer's diagnosis, strengths, barriers, and recovery goals, which MHRS are appropriate and/or which other behavioral health, human, or social services are needed. The Comprehensive Diagnostic Assessment shall also evaluate the consumer's level of readiness and motivation to engage in treatment, and screen and assess the need for evidence-based practices, as appropriate and applicable.

- iii. Ongoing Diagnostic Assessment: If there is a valid Diagnostic Assessment Report available, the Ongoing Diagnostic Assessment is used to update, validate, and assess a consumer's current treatment and support needs. The Ongoing Diagnostic Assessment should result in an updated Diagnostic Assessment Report.
- b. Limitations: Authorization is required in accordance with applicable regulations.
- c. Eligible Practitioners: 1) Qualified Practitioners who may provide Screening, Assessment, and Diagnosis services are: Psychiatrists, Psychologists, LICSWs, APRNs, LPCs, LMFTs, PAs, LGPCs, and LGSWs. 2) Qualified Practitioners who may provide Screening and Assessment, but not Diagnosis Services, are: RNs, LISWs, and Psychology Associates. 3) Credentialed Staff under supervision of a Qualified Practitioner licensed to practice independently may provide Screening Services, but not Assessment or Diagnosis Services.

## 2. Medication/Somatic Treatment

- a. Definition: Medication/Somatic Treatment services are medical services and interventions including: physical examinations; prescription, supervision, or administration of medications; monitoring and interpreting results of laboratory diagnostic procedures related to medications; and medical interventions needed for effective mental health treatment, provided as either an individual or group intervention. Medication/Somatic Treatment services include monitoring the side effects and interactions of medications and the adverse reactions a consumer may experience, and providing restorative information and direction for symptom and medication self-management. Group Medication/Somatic Treatment shall be therapeutic, educational, and interactive with a strong emphasis on group member selection and shall facilitate therapeutic peer interaction and support.
- b. Limitations: No annual limits.

- c. Eligible Practitioners: 1) Qualified Practitioners: Psychiatrists, APRNs, PAs, RNs, and LPNs.

### **3. Counseling/Therapy**

- a. Definition: Counseling/Therapy services are comprised of a direct, interactive process conducted in individual, group, or family settings and focused on assisting a consumer who is manifesting a mental illness or emotional disturbance. Counseling/Therapy is the informed and intentional application of clinical methods and interpersonal stances derived from established psychological principles for the purpose of assisting people to modify their behaviors, cognitions, emotions, and/or other personal characteristics in directions that the participants deem desirable. Counseling/Therapy aims to cultivate the awareness, skills, and supports to facilitate long-term recovery from mental illness and emotional disturbance, and addresses the specific issues identified in an individual's treatment plan. Counseling/Therapy shall be conducted in accordance with the requirements established in District regulations as follows:
- i. Individual Counseling/Therapy: direct interaction with a consumer for the purpose of supporting the individual's recovery.
  - ii. Group Counseling/Therapy: engagement with two or more consumers that facilitates disclosure of issues that permit generalization to a larger group; promotes help-seeking and supportive behaviors; encourages productive and positive interpersonal communication; provides psycho-education; and develops motivation through peer collaboration and encouragement, and structured and constructive feedback.
  - iii. Family Counseling/Therapy: planned, goal-oriented therapeutic interaction between a qualified practitioner, the consumer, and his or her family. Family Counseling/Therapy may occur without the consumer present if it is for the benefit of the consumer and related to recovery from mental illness or emotional disturbance. A family member is someone with whom the consumer has a significant relationship and whose participation is important to the consumer's recovery.
  - iv. Family therapy service that involves the participation of a non-Medicaid eligible is for the direct benefit of the beneficiary. The service must actively involve the beneficiary in the sense of being tailored to the beneficiary's individual needs. There may be times when, based on clinical judgment, the beneficiary is not present during the delivery of the service, but remains the focus of the service.
- b. Limitations: Authorization is required in accordance with applicable regulations.
- c. Eligible Practitioners: 1) Qualified Practitioners: Psychiatrists, Psychologists,

LICSWs, APRNs, LISWs, LPCs, LMFTs, LGSWs, LGPCs, and Psychology Associates.

#### 4. Community Support

- a. Definition: Community Support services are rehabilitative, psychoeducational, and supportive services to assist the consumer in achieving rehabilitation and recovery goals that focus on mental health wellness. Community Support services include:
- i. Participation in the team developing and implementing a consumer's individualized Plan of Care;
  - ii. Mental health interventions to increase and improve independent and community living skills, social skills, and support networks, and address social determinants of health, in order to ameliorate life stresses resulting from the consumer's mental illness or emotional disturbance. This service does not include services provided at prisons or institutions for mental disease, as defined for the purposes of Medicaid reimbursement.;
  - iii. Provide restorative information to the consumer, and restorative information and consultation to the consumer's family and support system that is directed exclusively to the well-being and benefit of the consumer; Community support service that involves the participation of a non-Medicaid eligible is for the direct benefit of the beneficiary. The service must actively involve the beneficiary in the sense of being tailored to the beneficiary's individual needs. There may be times when, based on clinical judgment, the beneficiary is not present during the delivery of the service, but remains the focus of the service.
  - iv. Individual mental health interventions (e.g., psychoeducation, problem solving, coaching, reflection, feedback) for the development of interpersonal and community coping skills that allow consumers to function effectively in their key life roles, including adapting to home, school, and work environments;
  - v. Assisting the consumer in symptom self-monitoring and self-management for the identification and minimization of the negative effects of psychiatric symptoms, which interfere with the consumer's daily living, financial management, personal development, or school or work performance;
  - vi. Developing strategies and supportive mental health interventions via identification of community resources and referrals and linkages to other services that address the consumer's social determinants of health, avoid out-of-home placements, and build stronger support networks;
  - vii. Developing mental health relapse prevention strategies and plans and coaching the consumer to implement them and teaching the consumer and the consumer's family and support system to recognize and manage possible triggers that could destabilize recovery efforts, in order to prevent crisis; and
  - viii. Providing non-clinical care coordination for consumer including linkages

and referrals to inpatient hospital stays and SUD residential treatment as covered under ASURS. Transitions of care shall be provided within five (5) calendar days after a consumer enters an eligible institutional setting or within thirty (30) calendar days prior to a consumer's discharge from an eligible institutional setting. This service does not include services provided at prisons or institutions for mental disease, as defined for the purposes of Medicaid reimbursement

- b. Limitations: Authorization is required in accordance with applicable regulations.
- c. Eligible Practitioners: 1) Qualified Practitioners: Psychiatrists, Psychologists, LICSWs, APRNs, LISWs, LPCs, RNs, LMFTs, LGSWs, LGPCs, Psychology Associates, and PAs. 2) Under the supervision of a Qualified Practitioner licensed to practice independently: Credentialed Staff.

## 5. Crisis/Emergency Services

- a. Definition: Crisis/Emergency Services are immediate face-to-face or telephonic responses to a mental health emergency that are available twenty-four (24) hours per day, seven (7) days per week. Crisis/Emergency Services are provided by DBH-certified Core Services Agencies (CSAs) to their consumers involved in an active crisis. Services consist of an immediate response to evaluate and screen the presenting situation, assist in immediate crisis stabilization and resolution, and ensure the consumer's access to any needed follow-up care at the appropriate level, providing the necessary consultation to any such follow-up provider during the transfer in care. The CSA shall adjust its staffing to meet the requirements for an immediate response.
- b. Limitations: Authorization is required in accordance with applicable regulations.
- c. Eligible Practitioners: 1) Qualified Practitioners: Psychiatrists, Psychologists, LICSWs, APRNs, LISWs, LPCs, RNs, LMFTs, LGSWs, LGPCs, Psychology Associates, and PAs. 2) Under the supervision of a Qualified Practitioner licensed to practice independently: Credentialed Staff.

## 6. Clinical Care Coordination

- a. Definition: Clinical Care Coordination ("CCC") is the coordination of care between the behavioral health clinician and the clinical personnel of an external provider (e.g., primary care, another behavioral health provider, or hospital). CCC occurs when the practitioner via direct face-to-face contact, video-conferencing, or telephone, communicates treatment needs, assessments, and treatment information to external health care providers and facilitates appropriate linkages with other health care professionals, including transitions into or from higher levels of care or institutional settings. CCC also includes treatment planning and Plan of Care implementation activities when

the clinician and consumer are directly meeting. CCC services adopts a “whole-person” approach to address the consumer’s needs related to physical health, behavioral health, and social determinants of health.

- b. Limitations: No annual limits.
- c. Eligible Practitioners: 1) Qualified Practitioners: Psychiatrists, Psychologists, LICSWs, APRNs, LISWs, LPCs, RNs, LMFTs, LGSWs, LGPCs, and PAs.

## **7. Rehabilitation Day Services**

- a. Definition: Rehabilitation Day Services is a structured clinical program intended to develop skills and foster social role integration through a range of social, psychoeducational, behavioral, and cognitive mental health interventions. Rehabilitation Day Services are curriculum-driven and assist the consumer in the retention or restoration of community living, socialization, and adaptive skills. Rehabilitation Day Services are offered most often in group settings, but may be provided individually. Rehabilitation day services include:
  - i. Assisting the consumer in developing instrumental activities of daily living (IADL) to strengthen the consumer’s independent living and social skills, including the ability to make decisions regarding self-care;
  - ii. Mental health interventions to improve socialization skills, coping skills, and health and wellness skills including education on self-management of symptoms, medications and side effects, and promote the use of resources to integrate the consumer into the community;
  - iii. Providing coaching and therapy that facilitates consumer choice and active involvement of consumers in their mental health recovery;
  - iv. Developing supportive mental health interventions through goal-setting and strategy development through which consumers can influence and shape service development
- b. Limitations: Authorization is required in accordance with applicable regulations.
- c. Eligible Practitioners: 1) Qualified Practitioners: Psychiatrists, Psychologists, LICSWs, APRNs, LISWs, LMFTs, LPCs, RNs, LGSWs, LGPCs, Psychology Associates, and PAs. 2) Under the supervision of a Qualified Practitioner licensed to practice independently: Credentialed Staff.

## **8. Intensive Day Treatment**

- a. Definition: Intensive Day Treatment (“IDT”) is a structured, intensive, and coordinated acute treatment program that serves as an alternative to acute inpatient treatment or as a step-down service from inpatient care, and is rendered by an inter-disciplinary team to provide stabilization of psychiatric

impairments. IDT shall be time-limited and available for no less than five (5) hours a day, seven (7) days a week. Daily physician and nursing services are essential components of this service.

IDT offers short-term, day programming consisting of therapeutically intensive, acute, and active treatment. The IDT provider shall provide services that closely resemble the intensity and comprehensiveness of inpatient services. Intensive Day Treatment shall include psychiatric, other medical, nursing, social work, medication/somatic treatment, care coordination, and psychology services focusing on timely crisis intervention and psychiatric stabilization so that consumers can return to their normal daily lives. IDT services shall only be provided to consumers who are not a danger to themselves or others, but who have behavioral health issues that are incapacitating and which interfere with their ability to carry out daily activities.

IDT services shall be provided within a structured program of care which offers individualized, strengths-based, active, and timely treatment directed toward the alleviation of the impairment which caused the admission to IDT. IDT shall be an active treatment program that consists of documented mental health interventions that address the individualized needs of the consumer, as identified in the Plan of Care. IDT services and interventions consist of structured individual and group activities and therapies that are planned and goal-oriented and provided under active psychiatric supervision.

- b. Limitations Authorization is required in accordance with applicable regulations.
- c. Eligible Practitioners: 1) Qualified Practitioners: Psychiatrists, Psychologists, LICSWs, APRNs, LISWs, LPCs, RNs, LMFTs, LGSWs, LGPCs, Psychology Associates, and PAs. 2) Under the supervision of a Qualified Practitioner licensed to practice independently: Credentialed Staff

## 9. Community Based Intervention

- a. Definition: Community Based Intervention (“CBI”) services are time-limited intensive mental health intervention services delivered to children, youth, and young adults, intended to prevent the utilization of an out-of-home therapeutic resource by the consumer (i.e., psychiatric hospital or residential treatment facility). Three (3) levels of CBI shall be available: CBI Level 1 shall utilize the Multisystemic Therapy model adopted by DBH; CBI Levels 2 and 3 shall utilize the Intensive Home and Community-Based Services model adopted by DBH. CBI is primarily focused on the development of consumer skills and is delivered in the family setting for the consumer to function in a family environment. These services are available twenty-four (24) hours a day, seven (7) days a week.

CBI services: (1) diffuse the current situation to reduce the likelihood of a recurrence that, if not addressed, could result in the use of more intensive therapeutic interventions; (2) provide referrals to other needed social, mental health, and physical health services, as needed; (3) provide mental health service and support interventions for consumers that develop and improve the ability of parents, legal guardians, or significant others to care for the consumer; and 4) support transitions of care for consumers beginning or ending CBI treatment, including within five (5) calendar days after a consumer enters an eligible institutional setting or within thirty (30) calendar days prior to a consumer's discharge from an eligible institutional setting. CBI services shall be delivered primarily in natural settings and shall include in-home services.

Community based intervention service that involves the participation of a non-Medicaid eligible is for the direct benefit of the beneficiary. The service must actively involve the beneficiary in the sense of being tailored to the beneficiary's individual needs. There may be times when, based on clinical judgment, the beneficiary is not present during the delivery of the service, but remains the focus of the service.

- b. Limitations: Authorization is required in accordance with applicable regulations.
- c. Eligible Practitioners: 1) Qualified Practitioners: Psychiatrists, Psychologists, LICSWs, APRNs, LISWs, LPCs, LMFTs, LGSWs, LGPCs, and Psychology Associates. Practitioners shall meet training requirements for the modality being provided pursuant to applicable District regulations.

## 10. Assertive Community Treatment

- a. Definition: Assertive Community Treatment ("ACT") is an intensive integrated rehabilitative, crisis, treatment, and mental health community support provided by an interdisciplinary team to individuals with serious and persistent mental illness. ACT services are provided to consumers in accordance with their individualized Plan of Care and using the evidence-based practice model adopted by DBH, which establishes service implementation expectations. Service coverage by the ACT Team is required twenty-four (24) hours per day, seven (7) days per week. Consistent with Early and Periodic Screening, Diagnostic and Treatment (EPSDT) requirements, these services are provided to individuals under twenty-one (21) if medically necessary.

ACT shall include a comprehensive and integrated set of medical and psychosocial services for the treatment of the consumer's mental health condition that is provided in non-office settings by the consumer's ACT Team. The ACT Team provides MHRS community support services that are

interwoven with treatment and rehabilitative services and regularly scheduled team meetings.

Rehabilitative services offered by the ACT Team will be prior authorized and covered for Medicaid eligible individuals who are in need of mental health or substance abuse services due to mental illness, serious emotional disturbance, or substance use disorder. Services shall include:

- i. Completion of comprehensive and ongoing assessments and development and updating of a self-care-oriented Plan of Care (if a current and effective one does not already exist);
- ii. Medication prescription, administration, and monitoring (excluding MAT);
- iii. Crisis assessment and intervention;
- iv. Symptom assessment and management;
- v. Individual and group counseling/therapy;
- vi. Substance use disorder treatment for consumers with a co-occurring substance use disorder;
- vii. Psychosocial rehabilitation and skill development;
- viii. Interpersonal social and interpersonal skill training;
- ix. Education, support, and consultation to consumers' families and/or their support system, which is directed exclusively to the well-being and benefit of the consumer;
- x. Referrals and linkages to other services that address the consumer's social determinants of health
- xi. Daily living skills training and acquisition; and
- xii. Coordination of medical and psychosocial services, including supporting transitions of care for consumers within five (5) calendar days after a consumer enters an eligible institutional setting or within thirty (30) calendar days prior to a consumer's discharge from an institutional setting.

Assertive Community Treatment service that involves the participation of a non-Medicaid eligible is for the direct benefit of the beneficiary. The service must actively involve the beneficiary in the sense of being tailored to the beneficiary's individual needs. There may be times when, based on clinical judgment, the beneficiary is not present during the delivery of the service, but remains the focus of the service.

- b. Limitations: Authorization is required in accordance with applicable regulations.
- c. Eligible Practitioners: 1) Qualified Practitioners: Psychiatrists, Psychologists, LICSWs, APRNs, LISWs, LPCs, RNs, LMFTs, LGSWs, LGPCs, Psychology Associates, PAs, and CACs. 2) Under supervision of certain Qualified Practitioners, per applicable District law and regulations: Credentialed Staff.

## 11. Child-Parent Psychotherapy

- a. Definition: Child-Parent Psychotherapy (“CPP”) is a relationship based treatment intervention to address children’s exposure to trauma or maltreatment. CPP sessions are conjoint with the child’s parent(s) or caregiver(s) and focus on improving the child’s development trajectory. CPP helps restore developmental functioning and reduce trauma symptoms in the wake of trauma by focusing on restoring the attachment relationship that was negatively affected by trauma. CPP is geared toward young children, who suffer from traumatic stress and often have difficulty regulating their behaviors and emotions during distress. These children may be easily frightened, difficult to console, aggressive, impulsive, or exhibit fearfulness of new situations. These children may also have difficulty sleeping, fail to maintain recently acquired developmental skills, and show regression in functioning and behavior.

CPP Sessions focus on child and parent or caregiver interactions and clinicians who provide support on healthy coping, affect regulation, and increased appropriate reciprocity between the child and his/her parent or caregiver to treat symptoms emerging from exposure to trauma. The goal of CPP is to strengthen the child and parent or caregiver relationship through an integrated approach of psychotherapy and the provision of attentional support, interpretation, and enactment. The therapeutic interventions restore the developmental trajectory through the following:

- i. Reduce post-traumatic stress reactions and symptoms in children;
- ii. Improve child functioning while also improving the child-parent or child-caregiver attachment relationship negatively affected by trauma;
- iii. Establish a sense of safety and trust within the child-parent or child-caregiver relationship; and
- iv. Return a child to a normal developmental trajectory through the restoration of child sensitivity and responsiveness.

Child-parent psychotherapy service that involves the participation of a non-Medicaid eligible is for the direct benefit of the beneficiary. The service must actively involve the beneficiary in the sense of being tailored to the beneficiary’s individual needs. There may be times when, based on clinical judgment, the beneficiary is not present during the delivery of the service, but remains the focus of the service.

- b. Limitations: No annual limits.
- c. Eligible Practitioners: 1) Qualified Practitioners: Psychiatrists, Psychologists, LICSWs, APRNs, LISWs, LPCs, LMFTs, LGSWs, LGPCs, and Psychology Associates. CPP practitioners shall have completed DBH-approved CPP clinical training.

## 12. Trauma-Focused Cognitive-Behavioral Therapy

- a. Definition: Trauma-Focused Cognitive Behavioral Therapy (“TF-CBT”) is a psychotherapeutic intervention for youth, designed to address significant emotional and behavioral difficulties related to traumatic life events. TF-CBT sessions focus on addressing the child’s posttraumatic stress disorder, depression, anxiety, externalizing behaviors, sexualized behaviors, feelings of shame, and mistrust. TF-CBT also provides parents or caregivers with the tools needed to reinforce the content covered with the child between sessions and after treatment has ended.

The goal of TF-CBT is to assist children in overcoming the negative effects of traumatic life events through the following:

- i. Target symptoms of post-traumatic stress disorder (often co-occurring with depression and other behavioral problems);
- ii. Address and improve issues commonly experienced by traumatized children (including poor self-esteem, difficulty trusting others, mood instability, and self-injurious behavior);
- iii. Increase stress management skills of children; and
- iv. Improve the child’s problem-solving and safety skills.

Trauma focused cognitive behavioral therapy service that involves the participation of a non-Medicaid eligible is for the direct benefit of the beneficiary. The service must actively involve the beneficiary in the sense of being tailored to the beneficiary’s individual needs. There may be times when, based on clinical judgment, the beneficiary is not present during the delivery of the service, but remains the focus of the service.

- b. Limitations: No annual limits.
- c. Eligible Practitioners: 1) Qualified Practitioners: Psychiatrists, Psychologists, LICSWs, APRNs, LISWs, LMFTs, LPCs, LGSWs, LGPCs, and Psychology Associates. TF-CBT practitioners shall have completed DBH-approved TF-CBT clinical training.

## 13. Functional Family Therapy

- a. Definition: Functional Family Therapy (“FFT”) is a short-term, family-based therapeutic intervention for youth who:
- i. Have a documented history of moderate to serious behavioral problems;
  - ii. Exhibit significant externalizing behavior which impairs functioning in at least one (1) area (e.g., school or home); or
  - iii. Are at risk of a disruption in placement.

Both youths and their caregivers must be willing to participate in FFT for the duration of the intervention. FFT is geared toward youth who suffer from feelings of aggression and exhibit argumentative or defiant behavior, such as Oppositional Defiance Disorder (ODD). FFT is designed to improve youth

compliance, or positive engagement within-family attributions, enhanced communication, and supportiveness, while decreasing intense negativity and dysfunctional patterns of behavior. The complete range of cognitive, emotional, and behavioral domains are targeted for change based on the specific risk and protective factors profile of each family. FFT consists of five major components: engagement, motivation, relational assessment, behavior change, and generalization. The phase-based goals of FFT are to:

- i. engage and motivate youth and their families by decreasing family hostility, conflict, and blame; increasing hope; and building balanced alliances with family members;
- ii. reduce and eliminate the problem behaviors and accompanying family relational patterns through individualized behavior change interventions; and
- iii. generalize changes across problem situations by increasing the family's capacity to utilize various community resources adequately and to engage in relapse prevention.

Functional family therapy service that involves the participation of a non-Medicaid eligible is for the direct benefit of the beneficiary. The service must actively involve the beneficiary in the sense of being tailored to the beneficiary's individual needs. There may be times when, based on clinical judgment, the beneficiary is not present during the delivery of the service, but remains the focus of the service.

- b. Limitations: No annual limits.
- c. Eligible Practitioners: 1) Qualified Practitioners: Psychiatrists, Psychologists, LICSWs, APRNs, LISWs, LMFTs, LPCs, LGSWs, LGPCs, and Psychology Associates. FFT practitioners shall have completed DBH-approved FFT clinical training.

#### **14. Trauma Recovery and Empowerment Services**

- a. Definition: Trauma Recovery and Empowerment Services is a structured group therapy intervention for individuals who have survived trauma and have either substance use disorders, mental health conditions, or both. Trauma Recovery and Empowerment Services draws on cognitive restructuring, skills training, and psychoeducational and peer support to address recovery and healing from sexual, physical, and emotional abuse. Trauma Recovery and Empowerment Services is trauma-specific and requires at least two facilitators for each group. The components are therapy sessions focused on:
  - i. Empowerment, self-comfort, and accurate self-monitoring, as well as ways to establish safe physical and emotional boundaries;
  - ii. The trauma experience and its consequences; and
  - iii. Skills building, including emphases on communication style, decision-

making, regulating overwhelming feelings, and establishing safer, more reciprocal relationships.

- b. Limitations: No annual limits.
- c. Eligible Practitioners: 1) Qualified Practitioners: Psychiatrists, Psychologists, LICSWs, LPCs, APRNs, LISWs, LMFTs, LGSWs, LGPCs, and Psychology Associates. Trauma Recovery and Empowerment Services practitioners shall have completed DBH-approved Trauma Recovery and Empowerment Services training.

## 15. Trauma Systems Therapy

- a. Definition: Trauma Systems Therapy (“TST”) is a comprehensive, phase-based model for treating traumatic stress in children and adolescents that adds to individually-based approaches by specifically addressing the child’s social environment and/or system of care. TST is designed to provide an integrated highly coordinated system of services guided by the specific understanding of the nature of child traumatic stress. TST focuses on the interaction between the child’s difficulties regulating their emotions and the deficits within the child’s social environment. The three (3) phases of the model are Safety-Focused, Regulation-Focused, and Beyond Trauma. TST is intended for children and youth who have: (1) been exposed to trauma; (2) plausible trauma histories; (3) difficulty regulating emotional and behavioral states; (4) dysregulation that is plausibly related to the trauma history; and (5) stable housing or a plan to achieve stable housing in the community.

Trauma systems therapy service that involves the participation of a non-Medicaid eligible is for the direct benefit of the beneficiary. The service must actively involve the beneficiary in the sense of being tailored to the beneficiary’s individual needs. There may be times when, based on clinical judgment, the beneficiary is not present during the delivery of the service, but remains the focus of the service. TST services include:

- i. Individual therapy – Individual therapy services for symptom and behavior management; development, restoration, or enhancement of adaptive behaviors and skills; and enhancement or maintenance of daily living skills.
- ii. Community support – Rehabilitation and environmental supports essential to assist the consumer in achieving rehabilitation and recovery goals that focus on building and maintaining a therapeutic relationship with the consumer.
- iii. Crisis support – Mental health services that support the consumer through crisis, such as meeting with the consumer in the community or an emergency department to help calm the consumer; implementing the crisis plan developed for the consumer; assisting the consumer to reach an

- emergency department; and providing pertinent mental health information about a consumer to an emergency department to assist in addressing a crisis.
- iv. Care coordination – Coordinates access to covered mental health services and other covered Medicaid services.
  - v. Skills building – Provides support interventions that develop and improve the ability of parents, legal guardians, or significant others to care for the consumer’s behavioral and emotional disturbances such as but not limited to consumer self-help, parenting techniques, problem solving, behavior management, communication techniques, medication management, monitoring, and follow up for family members and other caregivers.
  - vi. TST treatment plan support – Provides ongoing assessments and evaluations to develop and/or revise the individual treatment plan goals and objectives.
- b. Limitations: No annual limits.
- c. Eligible Practitioners: 1) Qualified Practitioners: Psychiatrists, Psychologists, LICSWs, APRNs, LISWs, LMFTs, LPCs, LGSWs, LGPCs, and Psychology Associates. TST practitioners shall have completed DBH-approved TST training.

## 16. Psychosocial Rehabilitative (“Clubhouse”) Services

- a. Definition: Psychosocial Rehabilitation (“Clubhouse”) Service is an evidence-based practice that utilizes behavioral, cognitive, and supportive interventions to assist individuals with mental health diagnoses via a work-ordered day provided primarily in a group rehabilitative setting and in a collaborative environment where Clubhouse staff and members work side-by-side to operate the program. Component services for Clubhouse Service include:
- i. Identifying and managing situations and prodromal symptoms to reduce the frequency, duration, and severity of psychological relapses;
  - ii. Improving functional competence to respond to a psychiatric crisis;
  - iii. Improving functional competence to understand the role psychotropic medications play in the stabilization of the individual’s well-being;
  - iv. Increasing independent living competencies;
  - v. Strengthening of social and interpersonal abilities;
  - vi. Increasing personal adjustment abilities to reduce dependency on professional caregivers and to enhance independence;
  - vii. Increasing cognitive and adult role competency;
  - viii. Identifying and developing of organizational support; and
  - ix. Identifying and developing existing natural supports for addressing personal needs.

- b. Limitations: No annual limits.
  
- c. Eligible Practitioners: 1) Qualified Practitioners: Psychiatrists, Psychologists, LICSWs, LPCs, LMFTs, PAs, LGSWs, LGPCs. 2) Under the supervision of a Qualified Practitioner licensed to practice independently: Credentialed Staff. Practitioners shall meet additional training and professional experience requirements as specified in applicable District regulations.

**II. ADULT SUBSTANCE USE REHABILITATIVE SERVICES (“ASURS”)** are available to all Medicaid-eligible individuals who elect to receive medically necessary treatment for substance use disorder (“SUD”), who have a legally authorized representative elect on their behalf for them to receive medically necessary treatment for SUD, or who are otherwise legally obligated to seek medically necessary treatment for SUD.

ASURS are intended to reduce or ameliorate SUD through therapeutic interventions that assist an individual in restoring maximum functionality. Consistent with EPSDT requirements, these services are provided to individuals under twenty-one (21), if medically necessary.

**A. Covered ASURS services are:**

1. Screening, Assessment, and Diagnosis
2. Clinical Care Coordination (“CCC”)
3. Crisis Intervention
4. Counseling/Therapy
5. Trauma Recovery and Empowerment Services
6. Medication/Somatic Treatment
7. Recovery Support Services (“RSS”)
8. Methadone Services in Opioid Treatment Programs
9. Medically Monitored Inpatient Withdrawal Management (“MMIWM”)

**B. ASURS Program Assurances**

As the single state agency for the administration of the medical assistance program (“Medicaid”), the Department of Health Care Finance (“DHCF”) assures state-wideness and comparability for ASURS treatment. Additionally, Medicaid beneficiaries shall maintain free choice of providers for ASURS treatment programs, and practitioners in accordance with 42 C.F.R. § 431.51.

The Medicaid eligibility determination process shall facilitate assurance that there will be no duplication of services or claiming between fee-for-service ASURS treatment and any SUD treatment services delivered through Medicaid managed care contractors.

DHCF assures that federal financial participation (FFP) shall not be available for services provided to individuals who are incarcerated.

### **C. ASURS Program Exclusions**

Medicaid reimbursement for ASURS treatment is not available for the following:

1. Treatment for inmates in public institutions, as defined in 42 C.F.R. § 435.1010;
2. Room and board;
3. Transportation services;
4. Educational, vocational, and job training services;
5. Services delivered as a component of human subjects research or clinical trials;
6. Educational, vocational, and job training services;
7. Screening and prevention services (other than those provided under EPSDT requirements)
8. Services rendered by parents or other family members including biological, step, and adopted relatives;
9. Legal services;
10. Services that are not provided and documented in accordance with DBH-established, service--specific standards;
11. Social or recreational services;
12. Services which are not medically appropriate as determined by the District Medicaid program; and
13. Services furnished to persons other than the consumer, when those services are not directed exclusively to the well-being and benefit of the consumer.

### **D. ASURS Provider Qualifications**

#### **1. Practitioners Eligible to Recommend ASURS**

ASURS must be recommended by one of the following Qualified Practitioners licensed to diagnose SUD, to the extent permitted by and in accordance with District law and regulations:

- a. Physicians- Licensed by the District of Columbia to furnish services within their scope of practice in accordance with District law.
- b. Psychologists- Licensed by the District of Columbia to furnish services within their scope of practice in accordance with District law.
- c. Licensed Independent Clinical Social Workers (“LICSWs”) - Licensed by the District of Columbia to furnish services within their scope of practice in accordance with District law.
- d. Licensed Professional Counselors (“LPCs”) - Licensed by the District of Columbia to furnish services within their scope of practice in accordance with District law.
- e. Licensed Marriage and Family Therapists (“LMFTs”) - Licensed by the District of Columbia to furnish services within their scope of practice in accordance with District law.
- f. Advanced Practice Registered Nurses (“APRNs”) - Licensed by the District of

Columbia to furnish services within their scope of practice in accordance with District law.

g. Licensed Independent Social Workers (“LISWs”) - Licensed by the District of Columbia to furnish services within their scope of practice in accordance with District law.

h. Licensed Graduate Professional Counselors (“LGPCs”) - Licensed by the District of Columbia to furnish services within their scope of practice in accordance with District law; and

i. Physician Assistants (“PAs”) - Licensed by the District of Columbia to furnish services within their scope of practice in accordance with District law.

## **2. Practitioners Eligible to Provide ASURS**

ASURS must be delivered by Eligible Practitioners. There are three (3) categories of Eligible Practitioners:

a. Qualified Practitioners eligible to deliver and recommend ASURS - Licensed by the District of Columbia to furnish services within their scope of practice in accordance with District law.;

b. Other Qualified Practitioners who are eligible to deliver ASURS, but not recommend ASURS, to the extent permitted by and in accordance with District law and regulations, including any applicable supervision requirements:

i. Psychology Associates; - Licensed by the District of Columbia to furnish services within their scope of practice in accordance with District law.

ii. Licensed Graduate Social Workers (“LGSWs”) - Licensed by the District of Columbia to furnish services within their scope of practice in accordance with District law.

Registered Nurses (“RNs”) - Licensed by the District of Columbia to furnish services within their scope of practice in accordance with District law.

iii. Certified Addiction Counselors I and II (“CACs”) – Licensed/certified by the District of Columbia to furnish services within their scope of practice in accordance with District law.

c. Credentialed Staff to the extent permitted by and in accordance with District law and regulations, including any applicable supervision requirements.

## **F. ASURS Services and Definitions**

### **1. Crisis Intervention**

a. Definition: Crisis Intervention Services are immediate face-to-face or telephonic responses to a substance use emergency that are available twenty-four (24) hours per day, seven (7) days per week. Crisis/Emergency Services are provided to clients involved in an active crisis. Services consist of an immediate response to evaluate and screen the presenting situation, assist in

immediate crisis stabilization and resolution, and ensure the individual's access to any needed follow-up care at the appropriate level, providing the necessary consultation to any such follow-up provider during the transfer in care. The Crisis/Emergency Services provider shall adjust its staffing to meet the requirements for an immediate response.

- b. Limitations: Crisis Intervention shall not be billed on the same day as MMIWM.
- c. Eligible Practitioners: 1) Qualified Practitioners: Physicians, Psychologists, LICSWs, LPCs, LMFTs, LGSWs, APRNs, RNs, LISWs, PAs, LGPCs, CACs, and Psychology Associates.

## 2. Recovery Support Services (“RSS”)

- a. Definition: RSS are non-clinical services that assist the individual in achieving or sustaining recovery from an SUD. RSS are available to individuals with an SUD who are currently in treatment or have moved into recovery from substance use, and individuals who have self-identified with SUD, but are assessed as not needing treatment. Services include but are not limited to goal setting and monitoring; making referrals; assisting with linkages (including supporting transitions of care for clients within five (5) calendar days after a client enters an eligible institutional setting or within thirty (30) calendar days prior to a client's discharge from an eligible institutional setting); assisting with the completion of benefits, housing or financial forms; assisting with strategy development and coping skills; providing education around social skill development and life skills.
- b. Limitations: No limitations.
- c. Eligible Practitioners: 1) Qualified Practitioners are: Physicians, Psychologists, LICSWs, LPCs, LMFTs, LGSWs, APRNs, LISWs, LGPCs, CACs, and Psychology Associates. 2) Credentialed Staff to the extent permitted by and in accordance with District law and regulations, including any applicable supervision requirements.

## 3. Methadone Services in Opioid Treatment Programs

- a. Methadone is a medication used in Medication Assisted Treatment (MAT) of opioid use disorder (OUD). MAT is the use of pharmacotherapy in conjunction with Counseling/Therapy for treatment of substance use disorders. Methadone for treatment of OUD is provided in opioid treatment programs (OTPs). A beneficiary who receives methadone must also receive Counseling/Therapy, as clinically necessary. Use of this service should be in accordance with ASAM service guidelines and practice guidelines issued by

the Department of Behavioral Health. Methadone Services in OTPs are described in Supplement 1 to Attachment 3.1-A. page 20.

#### 4. **Medically Monitored Inpatient Withdrawal Management ("MMIWM")**

- a. Definition: A 24-hour, medically directed evaluation and withdrawal management program that provides a mixture of professional SUD treatment services in accordance with ASAM criteria. MMIWM is the appropriate level of care for individuals who are assessed as meeting the ASAM criteria for Level 3.7 withdrawal management. The service is for individuals with sufficiently severe signs and symptoms of withdrawal from psychoactive substances or alcohol such that medical and nursing care monitoring and services are necessary, but hospitalization is not needed.
- b. Limitations: A MMIWM stay shall not exceed five (5) days without authorization from DBH, in accordance with applicable regulations and billing procedures. A MMIWM provider shall not bill CCC for a client on the same day as rendering MMWIM to such client. MMIWM shall not be billed on the same day as Crisis Intervention, Medication/Somatic Treatment, and Methadone Services in OTPs.
- c. Eligible Practitioners: 1) Qualified Practitioners: Physicians, Psychologists, PAs, RNs, LICSWs, LISWs, LGSWs, APRNs, LPCs, LMFTs, LGPCs, CACs, and Psychology Associates.

**BEHAVIORAL HEALTH STABILIZATION SERVICES ("STABILIZATION")** address a behavioral health crisis event which requires a non-hospitalization response. Behavioral Health Stabilization services are twenty-four (24) hours per day, seven (7) days per week, year-round services that address an unplanned event requiring a response when an individual struggles to manage their psychiatric or substance use related symptoms without de-escalation or other intervention. This also includes situations in which daily life challenges result in or put an individual at risk of an escalation in symptoms. These services are community-based and intended for individuals who are experiencing a behavioral health crisis. Stabilization services are:

- A. Comprehensive Psychiatric Emergency Program ("CPEP")
- B. Adult Mobile Crisis and Outreach
- C. Youth Mobile Crisis
- D. Psychiatric Crisis Stabilization.

#### **A. Provider Qualifications**

Stabilization services must be recommended by one of the following:

- 1) Qualified Practitioners, to the extent permitted by and in accordance with District law and regulations:
  1. Psychiatrists- Licensed by the District of Columbia to furnish services within their

- scope of practice in accordance with District law.
2. Physicians- Licensed by the District of Columbia to furnish services within their scope of practice in accordance with District law.
  3. Psychologists - Licensed by the District of Columbia to furnish services within their scope of practice in accordance with District law.
  4. Licensed Independent Clinical Social Workers (“LICSWs”) - Licensed by the District of Columbia to furnish services within their scope of practice in accordance with District law.
  5. Advanced Practice Registered Nurses (“APRNs”) - Licensed by the District of Columbia to furnish services within their scope of practice in accordance with District law.
  6. Registered Nurses (“RNs”) - Licensed by the District of Columbia to furnish services within their scope of practice in accordance with District law.
  7. Physician Assistants (“PAs”) - Licensed by the District of Columbia to furnish services within their scope of practice in accordance with District law.
  8. Licensed Independent Social Workers (“LISWs”) - Licensed by the District of Columbia to furnish services within their scope of practice in accordance with District law.
  9. Licensed Professional Counselors (“LPCs”) - Licensed by the District of Columbia to furnish services within their scope of practice in accordance with District law.
  10. Licensed Graduate Social Workers (“LGSWs”) - Licensed by the District of Columbia to furnish services within their scope of practice in accordance with District law.
  11. Licensed Graduate Professional Counselors (“LGPCs”) - Licensed by the District of Columbia to furnish services within their scope of practice in accordance with District law.
  12. Psychology Associates - Licensed by the District of Columbia to furnish services within their scope of practice in accordance with District law.
  13. Certified Addiction Counselors I and II (“CACs”) - Licensed by the District of Columbia to furnish services within their scope of practice in accordance with District law.
- 2) Credentialed Staff to the extent permitted by and in accordance with District law and regulations, including any applicable supervision requirements.

## **B. Behavioral Health Stabilization Services and Definitions**

### **1. Comprehensive Psychiatric Emergency Program (“CPEP”)**

- a. Definition: Comprehensive Psychiatric Emergency Program (CPEP) services are services provided on an emergent basis to individuals experiencing a behavioral health crisis. Consistent with EPSDT requirements, these services are provided to individuals under twenty-one (21), if medically necessary. These services provide or ensure the provision of psychiatric emergency services, which includes the following services:
  - i. Brief Psychiatric Crisis: Mental health diagnostic examination, and, as

- appropriate, treatment interventions on the individual's behalf and a discharge plan. Other activities include medication monitoring, observation, and care coordination with other providers.
- ii. **Extended Psychiatric Crisis:** Assessment and monitoring of an individual in crisis which results in a comprehensive psychiatric emergency treatment plan and a discharge plan. Other activities include any clinically indicated examinations and assessments as appropriate for the individual's presenting problems, medication monitoring, observation, and care coordination with other providers  
**Extended Observation:** Evaluation and monitoring of a patient by a psychiatrist and other clinical staff when a crisis has not sufficiently resolved for safe discharge to the community. This interaction includes a mental health diagnostic assessment, and, if necessary, treatment activities including prescribing or administering medication, and evaluation and monitoring for treatment effectiveness.
- b. **Limitations:** Not applicable.
  - c. **Eligible Practitioners:** 1) Qualified Practitioners: Psychiatrists, Physicians, Psychologists, LICSWs, APRNs, RNs, PAs, LISWs, LPCs, LGSWs, LGPCs, and Psychology Associates. 2) Credentialed Staff to the extent permitted by and in accordance with District law and regulations, including any applicable supervision requirements. Qualified Practitioners and Credentialed Staff are licensed by the District of Columbia to furnish services within their scope of practice in accordance with state law.

## 2. Adult Mobile Crisis and Outreach

- a. **Definition:** Adult Mobile Crisis and Outreach services are acute behavioral health crisis interventions and behavioral health outreach services provided to individuals in the community to minimize the individual's involvement as appropriate with law enforcement, emergency room use, or hospitalizations. These services include rapid response, assessment, and treatment of behavioral health crisis situations that involve adults and occur in the community or via the telephone. Services are provided with the immediate goals of preventing exacerbation of the underlying condition, limiting the risk of injury to the individual or others, and connecting the individual to clinically appropriate, ongoing care. Consistent with EPSDT requirements, these services are provided to individuals under twenty-one (21), if medically necessary. Covered services are:
  - i. **Mobile Crisis Intervention:** Rapid response, assessment, and resolution of behavioral health crisis situations. Services must optimize clinical interventions by meeting individuals in home or community settings.
  - ii. **Behavioral Health Outreach Services:** Initial evaluation and assessment for individuals in the community who are unable or unwilling to use clinic- or hospital-based services, or for individuals for whom hospitalization is not

clinically appropriate. Other activities include linkages to other services or providers; providing emotional support; life skills education; and therapeutic interventions as appropriate.

- b. Limitations: Not applicable.
- c. Eligible Practitioners: 1) Qualified Practitioners: Physicians; Psychologists; LICSWs; APRNs; PAs; RNs; LISWs; LPCs; LMFTs; LGPCs; LGSWs; Psychology Associates; and CACs. 2) Credentialed Staff to the extent permitted by and in accordance with District law and regulations, including any applicable supervision requirements.

### 3. Youth Mobile Crisis Intervention

- a. Definition: Youth Mobile Crisis Intervention services are services that engage children and youth, who may be experiencing a behavioral health crisis, in treatment. Covered services include screening for mental health and SUD service needs; administration of acute behavioral health crisis stabilization and psychiatric assessments to children, youth, and their families; developing rapport; providing support; and providing referrals to appropriate resources, including longer-term mental health or SUD rehabilitative services. Providers assist with connections to treatment, care coordination, and other social services as required.

Youth mobile crisis intervention service that involves the participation of a non-Medicaid eligible is for the direct benefit of the beneficiary. The service must actively involve the beneficiary in the sense of being tailored to the beneficiary's individual needs. There may be times when, based on clinical judgment, the beneficiary is not present during the delivery of the service, but remains the focus of the service.

- b. Limitations: Not applicable.
- c. Eligible Practitioners: 1) Qualified Practitioners: Physician; Psychologists; LICSWs; APRNs; PAs; RNs; LISWs; LPCs; LMFTs; LGPCs; LGSWs; Psychology Associates; and CACs; 2) Credentialed Staff to the extent permitted by and in accordance with District of Columbia law and regulations, including any applicable supervision requirements.

### 4. Psychiatric Crisis Stabilization

- a. Definition: Psychiatric Crisis Stabilization services are residential services that offer therapeutic, community-based, home-like treatment for individuals living in the community who are in need of support to ameliorate psychiatric symptoms and, based upon a psychiatric assessment conducted on-site, are deemed appropriate for services within a structured, closely monitored

temporary setting. Individuals shall have ongoing access to comprehensive nursing assessment and plan of care development; psychiatric consultation and assessment; crisis counseling; medication monitoring; and discharge planning. Consistent with EPSDT requirements, these services are provided to individuals under twenty-one (21), if medically necessary.

- b. Limitations: Authorization is required in accordance with applicable regulations.
- c. Eligible Practitioners: 1) Qualified Practitioners: Psychiatrists, Psychologists, LICSWs, APRNs, RNs, PAs, LISWs, LPCs, Psychology Associates, LGSWs, and LGPCs. 2) Credentialed Staff under the supervision of certain Qualified Practitioners, to the extent permitted by and in accordance with District of Columbia law and regulations.

### **III. TRANSITION PLANNING SERVICE (“TRANSITION PLANNING”)**

The Transition Planning Service is for beneficiaries stepping down from an institutional stay in an inpatient hospital or residential SUD treatment setting related to a primary mental health or SUD diagnosis certain institutional treatment settings to identify and connect them to needed treatment and support services in order to promote recovery and reduce the chances of avoidable hospital or residential treatment readmissions. Eligible beneficiaries are those with an institutional admission related to a primary mental health or substance use disorder (“SUD”) diagnosis. The Transition Planning Service components must be rendered to the individual within the period beginning thirty (30) calendar days prior to discharge and concluding thirty (30) calendar days after discharge. The Transition Planning Service must be recommended by a practitioner licensed to diagnose mental illness, serious emotional disturbance, or SUD to the extent permitted by and in accordance with District law and regulations.

#### **A. Transition Planning Provider Qualifications**

Transition Planning Services must be provided through Department of Behavioral Health-certified (“DBH-certified”) Transition Planning Service providers and comply with the requirements set forth in the District of Columbia Municipal Regulations.

#### **B. Transition Planning Service Exclusions**

The Transition Planning Service is not available for beneficiaries enrolled in Medicaid managed care, a District of Columbia 1915(c) Home and Community-Based Services Waiver program, or a District Health Homes program as authorized under Section 1945 of the Social Security Act.

#### **C. Transition Planning Service Definition**

1. Definition:
  - a. Transition Planning services are services provided to Medicaid-eligible beneficiaries stepping down from Medicaid-covered institutional treatment settings/stays to identify and connect them to needed treatment and support

services in order to promote recovery and reduce the chances of avoidable hospital or residential treatment readmissions. These services include development of a discharge plan and care coordination related to implementation of the identified needs within the period beginning thirty (30) calendar days prior to discharge and concluding thirty (30) calendar days after discharge. Transition Planning provider activities, as appropriate and applicable to the individual, include, but are not limited to the following:

- i. Discharge plan development activities, which include:
    - A. Participating in and conducting, when appropriate, assessments of the individual's needs (both for behavioral health and physical health treatment, as well as other supports);
    - B. Participating in the discharging facility's discharge planning process and treatment team meetings; and
    - C. Meeting with the individual and their family and natural supports to collect information relevant to discharge plan development and ensuring participation by the individual in discharge planning.
  - ii. Discharge plan implementation activities, which include:
    - A. Meeting with the individual and their family and/or other supports to promote understanding of the discharge plan;
    - B. Helping select post-discharge treatment providers and re-establishing, as appropriate, any pre-existing linkages;
    - C. Collaborating with the discharging facility on:
      - I. Making follow-up treatment appointments, care coordination, and securing needed prior authorizations and other arrangements,
      - II. Acquisition of other needed services and supports, and
      - III. Medication reconciliation and ensuring a sufficient supply of medication at discharge; and
      - IV. Conducting outreach to and follow-up with the individual and their post-discharge treatment providers to facilitate and ensure appointments are completed, other needed connections are made, and tracking the status of discharge plan implementation.
- b. Limitations: Authorization is required in accordance with applicable regulations and billing procedures.
- c. Eligible Practitioners: 1) To the extent permitted by and in accordance with District law and regulations: Physicians, Psychologists, Licensed Independent Clinical Social Workers, Advanced Practice Registered Nurses, Licensed Professional Counselors, and Licensed Marriage and Family Therapists. 2) Under the supervision of individuals described in E.1), to the extent permitted by and in accordance with District law and regulations: Recovery Coaches, Certified Peer Specialists, or an individual who holds at least a bachelor's

degree in social work, counseling, psychology, or closely related field from an accredited college or university. Practitioners shall meet additional training and professional experience requirements as specified in applicable District regulations.

**I. Methadone Services in Opioid Treatment Programs (OTPs) under Adult Substance Use Rehabilitative Services (referenced in Supplement 1 to Attachment 3-1A, page 20).**

- a. Definition: Methadone is a medication used in Medication Assisted Treatment (MAT) of opioid use disorder (OUD). MAT is the use of pharmacotherapy in conjunction with SUD Counseling/Therapy for treatment of substance use disorders. Methadone for treatment of OUD is provided in OTPs. A beneficiary who receives methadone must also receive SUD Counseling/Therapy as clinically indicated. Use of this service should be in accordance with the American Society of Addiction Medicine service guidelines and practice guidelines issued by the Department of Behavioral Health.
- b. Unit of Service:
  - i. The reimbursable units of a Methadone Service in an OTP shall be:
    1. One (1) dose for the medication, and
    2. One (1) session for the administration of the medication
- c. Administration consists of dispensing of the medication and therapeutic guidance.
- d. Limitations:
  - i. For in-office administration, a maximum of one (1) dose per day, unless split-dosing is medically indicated. When split-dosing, a maximum of two (2) doses per day are permitted.
  - ii. For take-home dispensation, the number of doses dispensed up to the limits allowable per federal regulations.
- e. Billing
  - i. One (1) administration session may be billed for each unit of medication dispensed on an in-office basis.
  - ii. One (1) administration session may be billed when medication is dispensed on a take-home basis, regardless of the number of doses dispensed.
- f. Location/Setting:
  - i. The pharmacotherapy component of OTP services shall be rendered in facilities which meet the requirements set forth in 42 CFR Part 8, Certification of Opioid Treatment Programs and which are certified by the Department of Behavioral Health as a Level: Opioid Treatment Program.
- g. Qualified Practitioners, to the extent permitted by and in accordance with District law and regulations, including any applicable supervision requirements:
  - i. Physicians; Advanced Practice Registered Nurses; Physicians Assistants; Registered Nurses; or Licensed Practical Nurses.

**13. Other Diagnostic, Screening, Preventive, and Rehabilitative Services i.e., Other Than Those Provided Elsewhere in this Plan**

- a. Diagnostic Services are delivered pursuant to Supplement 1 to Attachment 3.1-B.
- b. Screening Services are delivered pursuant to Supplement 1 to Attachment 3.1-B.
- c. Preventive Services are delivered pursuant to Supplement 1 to Attachment 3.1-B.
- d. Rehabilitative Services are covered for Medicaid-eligible individuals who are in need of mental health or substance use services due to mental illness, serious emotional disturbance, or substance use disorder. Covered services include: I) Mental Health Rehabilitative Services; II) Adult Substance Use Rehabilitative Services; III) Behavioral Health Stabilization Services; and IV) Transition Planning Service.

**I. MENTAL HEALTH REHABILITATIVE SERVICES (“MHRS”)** are available to all Medicaid-eligible individuals who have mental illness or a serious emotional disturbance and are in need of mental health services, and elect to receive, or have a legally authorized representative elect on their behalf, Mental Health Rehabilitative Option Services (“mental health rehabilitative services”). Consistent with EPSDT requirements, MHRS are available to all Medicaid-eligible individuals, including those under age twenty-one (21).

A. MHRS offer a continuum of care for people with complex needs through intensive, community-based services to reduce the functional impact of mental illness or serious emotional disturbance and support transitions to less intensive levels of care. Covered MHRS are:

1. Screening, Assessment, and Diagnosis
2. Medication/Somatic Treatment
3. Counseling/Therapy
4. Community Support
5. Crisis/Emergency Services
6. Clinical Care Coordination
7. Rehabilitation Day Services
8. Intensive Day Treatment (“IDT”)
9. Community Based Intervention (“CBI”)
10. Assertive Community Treatment (“ACT”)
11. Child-Parent Psychotherapy (“CPP”)
12. Trauma-Focused Cognitive Behavioral Therapy (“TF-CBT”)
13. Functional Family Therapy (“FFT”)
14. Trauma Recovery and Empowerment Services
15. Trauma Systems Therapy (“TST”)
16. Psychosocial Rehabilitative (“Clubhouse”) Services

**B. MHRS Provider Qualifications**

1. MHRS must be provided through certified MHRS providers and comply with the

requirements set forth in the District of Columbia Municipal Regulations. Each MHRS provider's standards and qualifications shall include, but are not limited to, the following:

- a. Be certified as an MHRS provider by the District of Columbia ("District") Department of Behavioral Health ("DBH");
- b. Demonstrate the administrative and financial management capability to meet District of Columbia and federal requirements;
- c. Demonstrate the clinical capacity and ability to provide services to individuals needing MHRS;
- d. Maintain individual case records in accordance with District of Columbia and federal requirements;
- e. Have policies and procedures that require services to be provided in accordance with DBH-established, service-specific standards. Each MHRS provider during the certification process submit its policies to DBH for review and approval; and
- f. Have a written complaint and grievance policy and shall provide all consumers with notice of the policy upon initiation of services.

### **C. Practitioner Qualifications**

#### **1. Practitioners Eligible to Recommend MHRS**

MHRS must be recommended by one of the following Qualified Practitioners licensed to diagnose mental illness or serious emotional disturbance, to the extent permitted by and in accordance with District law and regulations:

- a. Psychiatrists - Licensed by the District of Columbia to furnish services within their scope of practice in accordance with District law.
- b. Psychologists - Licensed by the District of Columbia to furnish services within their scope of practice in accordance with District law.
- c. Licensed Independent Clinical Social Workers ("LICSWs") - Licensed by the District of Columbia to furnish services within their scope of practice in accordance with District law
- d. Advanced Practice Registered Nurses ("APRNs") - Licensed by the District of Columbia to furnish services within their scope of practice in accordance with District law.
- e. Licensed Professional Counselors ("LPCs") - Licensed by the District of Columbia to furnish services within their scope of practice in accordance with District law.
- f. Licensed Marriage and Family Therapists ("LMFTs") - Licensed by the District of Columbia to furnish services within their scope of practice in accordance with District law.
- g. Physician Assistants ("PAs") - Licensed by the District of Columbia to furnish services within their scope of practice in accordance with District law.
- h. Licensed Graduate Professional Counselors ("LGPCs") - Licensed by the District of Columbia to furnish services within their scope of practice in accordance with District law.; and  
Licensed Graduate Social Workers ("LGSWs") - Licensed by the District of Columbia to furnish services within their scope of practice in accordance with

District law.

## 2. Practitioners Eligible to Provide MHRS

MHRS must be delivered by Eligible Practitioners. There are three (3) categories of Eligible Practitioners:

- a. Qualified Practitioners eligible to recommend and deliver MHRS - Licensed by the District of Columbia to furnish services within their scope of practice in accordance with District law;
- b. Other Qualified Practitioners who are eligible to deliver MHRS, but not recommend MHRS, to the extent permitted by and in accordance with District law and regulations, including any applicable supervision requirements:
  - i. Registered Nurses (“RNs”) - Licensed by the District of Columbia to furnish services within their scope of practice in accordance with District law.
  - ii. Licensed Independent Social Workers (“LISWs”) - Licensed by the District of Columbia to furnish services within their scope of practice in accordance with District law.  
Psychology Associates - Licensed by the District of Columbia to furnish services within their scope of practice in accordance with District law.
  - iii. Certified Addiction Counselors I & II (“CACs”) – Licensed/certified by the District of Columbia to furnish services within their scope of practice in accordance with District law.
  - iv. Licensed Practical Nurses (“LPNs”); and - Licensed by the District of Columbia to furnish services within their scope of practice in accordance with District law.
- c. Credentialed Staff under the supervision of Qualified Practitioners identified in #1 and #2 above, to the extent permitted by and in accordance with District law and regulations.

The authority for each category and subcategory of Eligible Practitioners to deliver MHRS are described within each service category provided below.

## D. MHRS Services and Definitions

### 1. Screening, Assessment, and Diagnosis

- a. Definition: Screening, Assessment, and Diagnosis services represent an initial evaluation and the ongoing collection of relevant information (using any assessment instruments specified by DBH) about an individual who may require MHRS and any needed referrals to other behavioral health services. Covered Services include:
  - i. Initial Assessment: Determination of an individual’s need for MHRS or other types of behavioral health treatment or support services.
  - ii. Comprehensive Diagnostic Assessment: Comprehensive clinical and functional evaluation of a consumer’s mental health condition(s) that

results in the issuance of a Diagnostic Assessment Report. The report includes a clinical formulation and recommendations for service delivery that provide the basis for the development of an individualized Plan of Care. A Comprehensive Diagnostic Assessment shall determine, based on the consumer's diagnosis, strengths, barriers, and recovery goals, which MHRS are appropriate and/or which other behavioral health, human, or social services are needed. The Comprehensive Diagnostic Assessment shall also evaluate the consumer's level of readiness and motivation to engage in treatment, and screen and assess the need for evidence-based practices, as appropriate and applicable.

- iii. Ongoing Diagnostic Assessment: If there is a valid Diagnostic Assessment Report available, the Ongoing Diagnostic Assessment is used to update, validate, and assess a consumer's current treatment and support needs. The Ongoing Diagnostic Assessment should result in an updated Diagnostic Assessment Report.
- b. Limitations: Authorization is required in accordance with applicable regulations.
- c. Eligible Practitioners: 1) Qualified Practitioners who may provide Screening, Assessment, and Diagnosis services are: Psychiatrists, Psychologists, LICSWs, APRNs, LPCs, LMFTs, PAs, LGPCs, and LGSWs. 2) Qualified Practitioners who may provide Screening and Assessment, but not Diagnosis Services, are: RNs, LISWs, and Psychology Associates. 3) Credentialed Staff under supervision of a Qualified Practitioner licensed to practice independently may provide Screening Services, but not Assessment or Diagnosis Services.

## 2. Medication/Somatic Treatment

- a. Definition: Medication/Somatic Treatment services are medical services and interventions including: physical examinations; prescription, supervision, or administration of medications; monitoring and interpreting results of laboratory diagnostic procedures related to medications; and medical interventions needed for effective mental health treatment, provided as either an individual or group intervention. Medication/Somatic Treatment services include monitoring the side effects and interactions of medications and the adverse reactions a consumer may experience, and providing restorative information and direction for symptom and medication self-management. Group Medication/Somatic Treatment shall be therapeutic, educational, and interactive with a strong emphasis on group member selection and shall facilitate therapeutic peer interaction and support.
- b. Limitations: No annual limits.

- c. Eligible Practitioners: 1) Qualified Practitioners: Psychiatrists, APRNs, PAs, RNs, and LPNs.

### **3. Counseling/Therapy**

- a. Definition: Counseling/Therapy services are comprised of a direct, interactive process conducted in individual, group, or family settings and focused on assisting a consumer who is manifesting a mental illness or emotional disturbance. Counseling/Therapy is the informed and intentional application of clinical methods and interpersonal stances derived from established psychological principles for the purpose of assisting people to modify their behaviors, cognitions, emotions, and/or other personal characteristics in directions that the participants deem desirable. Counseling/Therapy aims to cultivate the awareness, skills, and supports to facilitate long-term recovery from mental illness and emotional disturbance, and addresses the specific issues identified in an individual's treatment plan. Counseling/Therapy shall be conducted in accordance with the requirements established in District regulations as follows:
- i. Individual Counseling/Therapy: direct interaction with a consumer for the purpose of supporting the individual's recovery.
  - ii. Group Counseling/Therapy: engagement with two or more consumers that facilitates disclosure of issues that permit generalization to a larger group; promotes help-seeking and supportive behaviors; encourages productive and positive interpersonal communication; provides psycho-education; and develops motivation through peer collaboration and encouragement, and structured and constructive feedback.
  - iii. Family Counseling/Therapy: planned, goal-oriented therapeutic interaction between a qualified practitioner, the consumer, and his or her family. Family Counseling/Therapy may occur without the consumer present if it is for the benefit of the consumer and related to recovery from mental illness or emotional disturbance. A family member is someone with whom the consumer has a significant relationship and whose participation is important to the consumer's recovery.
  - iv. Family therapy service that involves the participation of a non-Medicaid eligible is for the direct benefit of the beneficiary. The service must actively involve the beneficiary in the sense of being tailored to the beneficiary's individual needs. There may be times when, based on clinical judgment, the beneficiary is not present during the delivery of the service, but remains the focus of the service.
- b. Limitations: Authorization is required in accordance with applicable regulations.
- c. Eligible Practitioners: 1) Qualified Practitioners: Psychiatrists, Psychologists, LICSWs, APRNs, LISWs, LPCs, LMFTs, LGSWs, LGPCs, and Psychology

Associates.

#### 4. Community Support

- a. Definition: Community Support services are rehabilitative, psychoeducational, and supportive services to assist the consumer in achieving rehabilitation and recovery goals that focus on mental health wellness. Community Support services include:
- i. Participation in the team developing and implementing a consumer's individualized Plan of Care;
  - ii. Mental health interventions to increase and improve independent and community living skills, social skills, and support networks, and address social determinants of health, in order to ameliorate life stresses resulting from the consumer's mental illness or emotional disturbance. This service does not include services provided at prisons or institutions for mental disease, as defined for the purposes of Medicaid reimbursement.;
  - iii. Provide restorative information to the consumer, and restorative information and consultation to the consumer's family and support system that is directed exclusively to the well-being and benefit of the consumer; Community support service that involves the participation of a non-Medicaid eligible is for the direct benefit of the beneficiary. The service must actively involve the beneficiary in the sense of being tailored to the beneficiary's individual needs. There may be times when, based on clinical judgment, the beneficiary is not present during the delivery of the service, but remains the focus of the service.
  - iv. Individual mental health interventions (e.g., psychoeducation, problem solving, coaching, reflection, feedback) for the development of interpersonal and community coping skills that allow consumers to function effectively in their key life roles, including adapting to home, school, and work environments;
  - v. Assisting the consumer in symptom self-monitoring and self-management for the identification and minimization of the negative effects of psychiatric symptoms, which interfere with the consumer's daily living, financial management, personal development, or school or work performance;
  - vi. Developing strategies and supportive mental health interventions via identification of community resources and referrals and linkages to other services that address the consumer's social determinants of health, avoid out-of-home placements, and build stronger support networks;
  - vii. Developing mental health relapse prevention strategies and plans and coaching the consumer to implement them and teaching the consumer and the consumer's family and support system to recognize and manage possible triggers that could destabilize recovery efforts, in order to prevent crisis; and
  - viii. Providing non-clinical care coordination for consumer including linkages and referrals to inpatient hospital stays and SUD residential treatment as

covered under ASURS. Transitions of care shall be provided within five (5) calendar days after a consumer enters an eligible institutional setting or within thirty (30) calendar days prior to a consumer's discharge from an eligible institutional setting. This service does not include services provided at prisons or institutions for mental disease, as defined for the purposes of Medicaid reimbursement.

- b. Limitations: Authorization is required in accordance with applicable regulations.
- c. Eligible Practitioners: 1) Qualified Practitioners: Psychiatrists, Psychologists, LICSWs, APRNs, LISWs, LPCs, RNs, LMFTs, LGSWs, LGPCs, Psychology Associates, and PAs. 2) Under the supervision of a Qualified Practitioner licensed to practice independently: Credentialed Staff.

## **5. Crisis/Emergency Services**

- a. Definition: Crisis/Emergency Services are immediate face-to-face or telephonic responses to a mental health emergency that are available twenty-four (24) hours per day, seven (7) days per week. Crisis/Emergency Services are provided by DBH-certified Core Services Agencies (CSAs) to their consumers involved in an active crisis. Services consist of an immediate response to evaluate and screen the presenting situation, assist in immediate crisis stabilization and resolution, and ensure the consumer's access to any needed follow-up care at the appropriate level, providing the necessary consultation to any such follow-up provider during the transfer in care. The CSA shall adjust its staffing to meet the requirements for an immediate response.
- b. Limitations: Authorization is required in accordance with applicable regulations .
- c. Eligible Practitioners: 1) Qualified Practitioners: Psychiatrists, Psychologists, LICSWs, APRNs, LISWs, LPCs, RNs, LMFTs, LGSWs, LGPCs, Psychology Associates, and PAs. 2) Under the supervision of a Qualified Practitioner licensed to practice independently: Credentialed Staff.

## **6. Clinical Care Coordination**

- a. Definition: Clinical Care Coordination ("CCC") is the coordination of care between the behavioral health clinician and the clinical personnel of an external provider (e.g., primary care, another behavioral health provider, or hospital). CCC occurs when the practitioner via direct face-to-face contact, video-conferencing, or telephone, communicates treatment needs, assessments, and treatment information to external health care providers and facilitates appropriate linkages with other health care professionals, including transitions into or from higher levels of care or institutional settings. CCC also includes treatment planning and Plan of Care implementation activities when the clinician and consumer are directly meeting. CCC services adopts a

“whole-person” approach to address the consumer’s needs related to physical health, behavioral health, and social determinants of health.

- b. Limitations: No annual limits.
- c. Eligible Practitioners: 1) Qualified Practitioners: Psychiatrists, Psychologists, LICSWs, APRNs, LISWs, LPCs, RNs, LMFTs, LGSWs, LGPCs, and PAs.

## 7. Rehabilitation Day Services

- a. Definition: Rehabilitation Day Services is a structured clinical program intended to develop skills and foster social role integration through a range of social, psychoeducational, behavioral, and cognitive mental health interventions. Rehabilitation Day Services are curriculum-driven and assist the consumer in the retention or restoration of community living, socialization, and adaptive skills. Rehabilitation Day Services are offered most often in group settings, but may be provided individually. Rehabilitation day services include:
  - 1. Assisting the consumer in developing instrumental activities of daily living (IADL) to strengthen the consumer’s independent living and social skills, including the ability to make decisions regarding self-care;
  - 2. Mental health interventions to improve socialization skills, coping skills, and health and wellness skills including education on self-management of symptoms, medications and side effects, and promote the use of resources to integrate the consumer into the community;
  - 3. Providing coaching and therapy that facilitates consumer choice and active involvement of consumers in their mental health recovery;
  - 4. Developing supportive mental health interventions through goal-setting and strategy development through which consumers can influence and shape service development
- b. Limitations: Authorization is required in accordance with applicable regulations.
- c. Eligible Practitioners: 1) Qualified Practitioners: Psychiatrists, Psychologists, LICSWs, APRNs, LISWs, LMFTs, LPCs, RNs, LGSWs, LGPCs, Psychology Associates, and PAs. 2) Under the supervision of a Qualified Practitioner licensed to practice independently: Credentialed Staff.

## 8. Intensive Day Treatment

- a. Definition: Intensive Day Treatment (“IDT”) is a structured, intensive, and coordinated acute treatment program that serves as an alternative to acute inpatient treatment or as a step-down service from inpatient care, and is rendered by an inter-disciplinary team to provide stabilization of psychiatric impairments. IDT shall be time-limited and available for no less than five (5)

hours a day, seven (7) days a week. Daily physician and nursing services are essential components of this service.

IDT offers short-term, day programming consisting of therapeutically intensive, acute, and active treatment. The IDT provider shall provide services that closely resemble the intensity and comprehensiveness of inpatient services. Intensive Day Treatment shall include psychiatric, other medical, nursing, social work, medication/somatic treatment, care coordination, and psychology services focusing on timely crisis intervention and psychiatric stabilization so that consumers can return to their normal daily lives. IDT services shall only be provided to consumers who are not a danger to themselves or others, but who have behavioral health issues that are incapacitating and which interfere with their ability to carry out daily activities.

IDT services shall be provided within a structured program of care which offers individualized, strengths-based, active, and timely treatment directed toward the alleviation of the impairment which caused the admission to IDT. IDT shall be an active treatment program that consists of documented mental health interventions that address the individualized needs of the consumer, as identified in the Plan of Care. IDT services and interventions consist of structured individual and group activities and therapies that are planned and goal-oriented and provided under active psychiatric supervision.

- b. Limitations Authorization is required in accordance with applicable regulations.
- c. Eligible Practitioners: 1) Qualified Practitioners: Psychiatrists, Psychologists, LICSWs, APRNs, LISWs, LPCs, RNs, LMFTs, LGSWs, LGPCs, Psychology Associates, and PAs. 2) Under the supervision of a Qualified Practitioner licensed to practice independently: Credentialed Staff

## 9. Community Based Intervention

- a. Definition: Community Based Intervention (“CBI”) services are time-limited intensive mental health intervention services delivered to children, youth, and young adults, intended to prevent the utilization of an out-of-home therapeutic resource by the consumer (i.e., psychiatric hospital or residential treatment facility). Three (3) levels of CBI shall be available: CBI Level 1 shall utilize the Multisystemic Therapy model adopted by DBH; CBI Levels 2 and 3 shall utilize the Intensive Home and Community-Based Services model adopted by DBH. CBI is primarily focused on the development of consumer skills and is delivered in the family setting for the consumer to function in a family environment. These services are available twenty-four (24) hours a day, seven (7) days a week.

CBI services: (1) diffuse the current situation to reduce the likelihood of a

recurrence that, if not addressed, could result in the use of more intensive therapeutic interventions; (2) provide referrals to other needed social, mental health, and physical health services, as needed; (3) provide mental health service and support interventions for consumers that develop and improve the ability of parents, legal guardians, or significant others to care for the consumer; and 4) support transitions of care for consumers beginning or ending CBI treatment, including within five (5) calendar days after a consumer enters an eligible institutional setting or within thirty (30) calendar days prior to a consumer's discharge from an eligible institutional setting. CBI services shall be delivered primarily in natural settings and shall include in-home services.

Community based intervention service that involves the participation of a non-Medicaid eligible is for the direct benefit of the beneficiary. The service must actively involve the beneficiary in the sense of being tailored to the beneficiary's individual needs. There may be times when, based on clinical judgment, the beneficiary is not present during the delivery of the service, but remains the focus of the service.

- b. Limitations: Authorization is required in accordance with applicable regulations.
- c. Eligible Practitioners: 1) Qualified Practitioners: Psychiatrists, Psychologists, LICSWs, APRNs, LISWs, LPCs, LMFTs, LGSWs, LGPCs, and Psychology Associates. Practitioners shall meet training requirements for the modality being provided pursuant to applicable District regulations.

## 10. Assertive Community Treatment

- a. Definition: Assertive Community Treatment ("ACT") is an intensive integrated rehabilitative, crisis, treatment, and mental health community support provided by an interdisciplinary team to individuals with serious and persistent mental illness. ACT services are provided to consumers in accordance with their individualized Plan of Care and using the evidence-based practice model adopted by DBH, which establishes service implementation expectations. Service coverage by the ACT Team is required twenty-four (24) hours per day, seven (7) days per week. Consistent with Early and Periodic Screening, Diagnostic and Treatment (EPSDT) requirements, these services are provided to individuals under twenty-one (21), if medically necessary.

ACT shall include a comprehensive and integrated set of medical and psychosocial services for the treatment of the consumer's mental health condition that is provided in non-office settings by the consumer's ACT Team. The ACT Team provides MHRS community support services that are interwoven with treatment and rehabilitative services and regularly scheduled

team meetings.

Rehabilitative services offered by the ACT Team will be prior authorized and covered for Medicaid eligible individuals who are in need of mental health or substance abuse services due to mental illness, serious emotional disturbance, or substance use disorder. Services shall include:

- i. Completion of comprehensive and ongoing assessments and development and updating of a self-care-oriented Plan of Care (if a current and effective one does not already exist);
- ii. Medication prescription, administration, and monitoring (excluding MAT);
- iii. Crisis assessment and intervention;
- iv. Symptom assessment and management;
- v. Individual and group counseling/therapy;
- vi. Substance use disorder treatment for consumers with a co-occurring substance use disorder;
- vii. Psychosocial rehabilitation and skill development;
- viii. Interpersonal social and interpersonal skill training;
- ix. Education, support, and consultation to consumers' families and/or their support system, which is directed exclusively to the well-being and benefit of the consumer;
- x. Referrals and linkages to other services that address the consumer's social determinants of health
- xi. Daily living skills training and acquisition; and
- xii. Coordination of medical and psychosocial services, including supporting transitions of care for consumers within five (5) calendar days after a consumer enters an eligible institutional setting or within thirty (30) calendar days prior to a consumer's discharge from an institutional setting.

Assertive Community Treatment service that involves the participation of a non-Medicaid eligible is for the direct benefit of the beneficiary. The service must actively involve the beneficiary in the sense of being tailored to the beneficiary's individual needs. There may be times when, based on clinical judgment, the beneficiary is not present during the delivery of the service, but remains the focus of the service.

- b. Limitations: Authorization is required in accordance with applicable regulations.
- c. Eligible Practitioners: 1) Qualified Practitioners: Psychiatrists, Psychologists, LICSWs, APRNs, LISWs, LPCs, RNs, LMFTs, LGSWs, LGPCs, Psychology Associates, PAs, and CACs. 2) Under supervision of certain Qualified Practitioners, per applicable District law and regulations: Credentialed Staff.

## 11. Child-Parent Psychotherapy

- a. Definition: Child-Parent Psychotherapy (“CPP”) is a relationship-based treatment intervention to address children’s exposure to trauma or maltreatment. CPP sessions are conjoint with the child’s parent(s) or caregiver(s) and focus on improving the child’s development trajectory. CPP helps restore developmental functioning and reduce trauma symptoms in the wake of trauma by focusing on restoring the attachment relationship that was negatively affected by trauma. CPP is geared toward young children, who suffer from traumatic stress and often have difficulty regulating their behaviors and emotions during distress. These children may be easily frightened, difficult to console, aggressive, impulsive, or exhibit fearfulness of new situations. These children may also have difficulty sleeping, fail to maintain recently acquired developmental skills, and show regression in functioning and behavior.

CPP Sessions focus on child and parent or caregiver interactions and clinicians who provide support on healthy coping, affect regulation, and increased appropriate reciprocity between the child and his/her parent or caregiver to treat symptoms emerging from exposure to trauma. The goal of CPP is to strengthen the child and parent or caregiver relationship through an integrated approach of psychotherapy and the provision of attentional support, interpretation, and enactment. The therapeutic interventions restore the developmental trajectory through the following:

- i. Reduce post-traumatic stress reactions and symptoms in children;
- ii. Improve child functioning while also improving the child-parent or child-caregiver attachment relationship negatively affected by trauma;
- iii. Establish a sense of safety and trust within the child-parent or child-caregiver relationship; and
- iv. Return a child to a normal developmental trajectory through the restoration of child sensitivity and responsiveness.

Child-parent psychotherapy service that involves the participation of a non-Medicaid eligible is for the direct benefit of the beneficiary. The service must actively involve the beneficiary in the sense of being tailored to the beneficiary’s individual needs. There may be times when, based on clinical judgment, the beneficiary is not present during the delivery of the service, but remains the focus of the service.

- b. Limitations: No annual limits.
- c. Eligible Practitioners: 1) Qualified Practitioners: Psychiatrists, Psychologists, LICSWs, APRNs, LISWs, LPCs, LMFTs, LGSWs, LGPCs, and Psychology Associates. CPP practitioners shall have completed DBH-approved CPP clinical training.

## 12. Trauma-Focused Cognitive-Behavioral Therapy

- a. Definition: Trauma-Focused Cognitive Behavioral Therapy (“TF-CBT”) is a psychotherapeutic intervention for youth, designed to address significant emotional and behavioral difficulties related to traumatic life events. TF-CBT sessions focus on addressing the child’s posttraumatic stress disorder, depression, anxiety, externalizing behaviors, sexualized behaviors, feelings of shame, and mistrust. TF-CBT also provides parents or caregivers with the tools needed to reinforce the content covered with the child between sessions and after treatment has ended.

The goal of TF-CBT is to assist children in overcoming the negative effects of traumatic life events through the following:

- i. Target symptoms of post-traumatic stress disorder (often co-occurring with depression and other behavioral problems);
- ii. Address and improve issues commonly experienced by traumatized children (including poor self-esteem, difficulty trusting others, mood instability, and self-injurious behavior);
- iii. Increase stress management skills of children; and
- iv. Improve the child’s problem-solving and safety skills.

Trauma focused cognitive behavioral therapy service that involves the participation of a non-Medicaid eligible is for the direct benefit of the beneficiary. The service must actively involve the beneficiary in the sense of being tailored to the beneficiary’s individual needs. There may be times when, based on clinical judgment, the beneficiary is not present during the delivery of the service, but remains the focus of the service.

- b. Limitations: No annual limits.
- c. Eligible Practitioners: 1) Qualified Practitioners: Psychiatrists, Psychologists, LICSWs, APRNs, LISWs, LMFTs, LPCs, LGSWs, LGPCs, and Psychology Associates. TF-CBT practitioners shall have completed DBH-approved TF-CBT clinical training.

### 13. Functional Family Therapy

- a. Definition: Functional Family Therapy (“FFT”) is a short-term, family-based therapeutic intervention for youth who:
- i. Have a documented history of moderate to serious behavioral problems;
  - ii. Exhibit significant externalizing behavior which impairs functioning in at least one (1) area (e.g., school or home); or
  - iii. Are at risk of a disruption in placement.

Both youths and their caregivers must be willing to participate in FFT for the duration of the intervention. FFT is geared toward youth who suffer from feelings of aggression and exhibit argumentative or defiant behavior, such as Oppositional Defiance Disorder (ODD). FFT is designed to improve youth compliance, or positive engagement within-family attributions, enhanced communication, and supportiveness, while decreasing intense negativity and

dysfunctional patterns of behavior. The complete range of cognitive, emotional, and behavioral domains are targeted for change based on the specific risk and protective factors profile of each family. FFT consists of five major components: engagement, motivation, relational assessment, behavior change, and generalization. The phase-based goals of FFT are to:

- i. engage and motivate youth and their families by decreasing family hostility, conflict, and blame; increasing hope; and building balanced alliances with family members;
- ii. reduce and eliminate the problem behaviors and accompanying family relational patterns through individualized behavior change interventions; and
- iii. generalize changes across problem situations by increasing the family's capacity to utilize various community resources adequately and to engage in relapse prevention.

Functional family therapy service that involves the participation of a non-Medicaid eligible is for the direct benefit of the beneficiary. The service must actively involve the beneficiary in the sense of being tailored to the beneficiary's individual needs. There may be times when, based on clinical judgment, the beneficiary is not present during the delivery of the service, but remains the focus of the service.

- b. Limitations: No annual limits.
- c. Eligible Practitioners: 1) Qualified Practitioners: Psychiatrists, Psychologists, LICSWs, APRNs, LISWs, LMFTs, LPCs, LGSWs, LGPCs, and Psychology Associates. FFT practitioners shall have completed DBH-approved FFT clinical training.

#### **14. Trauma Recovery and Empowerment Services**

- a. Definition: Trauma Recovery and Empowerment Services is a structured group therapy intervention for individuals who have survived trauma and have either substance use disorders, mental health conditions, or both. Trauma Recovery and Empowerment Services draws on cognitive restructuring, skills training, and psychoeducational and peer support to address recovery and healing from sexual, physical, and emotional abuse. Trauma Recovery and Empowerment Services is trauma-specific and requires at least two facilitators for each group. The components are therapy sessions focused on:
  - i. Empowerment, self-comfort, and accurate self-monitoring, as well as ways to establish safe physical and emotional boundaries;
  - ii. The trauma experience and its consequences; and
  - iii. Skills building, including emphases on communication style, decision-making, regulating overwhelming feelings, and establishing safer, more

reciprocal relationships.

- b. Limitations: No annual limits.
  
- c. Eligible Practitioners: 1) Qualified Practitioners: Psychiatrists, Psychologists, LICSWs, LPCs, APRNs, LISWs, LMFTs, LGSWs, LGPCs, and Psychology Associates. Trauma Recovery and Empowerment Services practitioners shall have completed DBH-approved Trauma Recovery and Empowerment Services training.

### 15. Trauma Systems Therapy

- a. Definition: Trauma Systems Therapy (“TST”) is a comprehensive, phase-based model for treating traumatic stress in children and adolescents that adds to individually-based approaches by specifically addressing the child’s social environment and/or system of care. TST is designed to provide an integrated highly coordinated system of services guided by the specific understanding of the nature of child traumatic stress. TST focuses on the interaction between the child’s difficulties regulating their emotions and the deficits within the child’s social environment. The three (3) phases of the model are Safety-Focused, Regulation-Focused, and Beyond Trauma. TST is intended for children and youth who have: (1) been exposed to trauma; (2) plausible trauma histories; (3) difficulty regulating emotional and behavioral states; (4) dysregulation that is plausibly related to the trauma history; and (5) stable housing or a plan to achieve stable housing in the community.

Trauma systems therapy service that involves the participation of a non-Medicaid eligible is for the direct benefit of the beneficiary. The service must actively involve the beneficiary in the sense of being tailored to the beneficiary’s individual needs. There may be times when, based on clinical judgment, the beneficiary is not present during the delivery of the service, but remains the focus of the service. TST services include:

- i. Individual therapy - Individual therapy services for symptom and behavior management; development, restoration, or enhancement of adaptive behaviors and skills; and enhancement or maintenance of daily living skills.
- ii. Community support - Rehabilitation and environmental supports essential to assist the consumer in achieving rehabilitation and recovery goals that focus on building and maintaining a therapeutic relationship with the consumer.
- iii. Crisis support - Mental health services that support the consumer through crisis, such as meeting with the consumer in the community or an

emergency department to help calm the consumer; implementing the crisis plan developed for the consumer; assisting the consumer to reach an emergency department; and providing pertinent mental health information about a consumer to an emergency department to assist in addressing a crisis.

- iv. Care coordination - Coordinates access to covered mental health services and other covered Medicaid services.
  - v. Skills building - Provides support interventions that develop and improve the ability of parents, legal guardians, or significant others to care for the consumer's behavioral and emotional disturbances such as but not limited to consumer self-help, parenting techniques, problem solving, behavior management, communication techniques, medication management, monitoring, and follow up for family members and other caregivers.
  - vi. TST treatment plan support - Provides ongoing assessments and evaluations to develop and/or revise the individual treatment plan goals and objectives.
- b. Limitations: No annual limits.
- c. Eligible Practitioners: 1) Qualified Practitioners: Psychiatrists, Psychologists, LICSWs, APRNs, LISWs, LMFTs, LPCs, LGSWs, LGPCs, and Psychology Associates. TST practitioners shall have completed DBH-approved TST training.

## 16. Psychosocial Rehabilitative (“Clubhouse”) Services

- a. Definition: Psychosocial Rehabilitation (“Clubhouse”) Service is an evidence-based practice that utilizes behavioral, cognitive, and supportive interventions to assist individuals with mental health diagnoses via a work-ordered day provided primarily in a group rehabilitative setting and in a collaborative environment where Clubhouse staff and members work side-by-side to operate the program. Component services include: peer counseling, skills building through provider coordinated, therapeutic activities, and provision of information to facilitate further development of behavioral, cognitive maintenance strategies. Areas of focus for Clubhouse Services include:
- i. Identifying and managing situations and prodromal symptoms to reduce the frequency, duration, and severity of psychological relapses;
  - ii. Improving functional competence to respond to a psychiatric crisis;
  - iii. Improving functional competence to understand the role psychotropic medications play in the stabilization of the individual's well-being;
  - iv. Increasing independent living competencies;
  - v. Strengthening of social and interpersonal abilities;
  - vi. Increasing personal adjustment abilities to reduce dependency on professional caregivers and to enhance independence;
  - vii. Increasing cognitive and adult role competency;

- viii. Identifying and developing of organizational support; and
- ix. Identifying and developing existing natural supports for addressing personal needs.

b. Limitations: No annual limits.

c. Eligible Practitioners: 1) Qualified Practitioners: Psychiatrists, Psychologists, LICSWs, LPCs, LMFTs, PAs, LGSWs, LGPCs. 2) Under the supervision of a Qualified Practitioner licensed to practice independently: Credentialed Staff. Practitioners shall meet additional training and professional experience requirements as specified in applicable District regulations.

**II. ADULT SUBSTANCE USE REHABILITATIVE SERVICES (“ASURS”)** are available to all Medicaid-eligible individuals who elect to receive medically necessary treatment for substance use disorder (“SUD”), who have a legally authorized representative elect on their behalf for them to receive medically necessary treatment for SUD, or who are otherwise legally obligated to seek medically necessary treatment for SUD.

ASURS are intended to reduce or ameliorate SUD through therapeutic interventions that assist an individual in restoring maximum functionality. Consistent with EPSDT requirements, these services are provided to individuals under twenty-one (21), if medically necessary.

**A.** Covered ASURS services are:

1. Screening, Assessment, and Diagnosis
2. Clinical Care Coordination (“CCC”)
3. Crisis Intervention
4. Counseling/Therapy
5. Trauma Recovery and Empowerment Services
6. Medication/Somatic Treatment
7. Recovery Support Services (“RSS”)
8. Methadone Services in Opioid Treatment Programs
9. Medically Monitored Inpatient Withdrawal Management (“MMIWM”)

**B. ASURS Program Assurances**

As the single state agency for the administration of the medical assistance program (“Medicaid”), the Department of Health Care Finance (“DHCF”) assures state-wideness and comparability for ASURS treatment. Additionally, Medicaid beneficiaries shall maintain free choice of providers for ASURS treatment programs, and practitioners in accordance with 42 C.F.R. § 431.51.

The Medicaid eligibility determination process shall facilitate assurance that there will be no duplication of services or claiming between fee-for-service ASURS

treatment and any SUD treatment services delivered through Medicaid managed care contractors.

DHCF assures that federal financial participation (FFP) shall not be available for services provided to individuals who are incarcerated.

### **C. ASURS Program Exclusions**

Medicaid reimbursement for ASURS treatment is not available for the following:

1. Treatment for inmates in public institutions, as defined in 42 C.F.R. § 435.1010;
2. Room and board;
3. Transportation services;
4. Educational, vocational, and job training services;
5. Services delivered as a component of human subjects research or clinical trials;
6. Educational, vocational, and job training services;
7. Screening and prevention services (other than those provided under EPSDT requirements)
8. Services rendered by parents or other family members including biological, step, and adopted relatives;
9. Legal services;
10. Services that are not provided and documented in accordance with DBH-established, service--specific standards;
11. Social or recreational services;
12. Services which are not medically appropriate as determined by the District Medicaid program; and
13. Services furnished to persons other than the consumer, when those services are not directed exclusively to the well-being and benefit of the consumer.

### **D. ASURS Provider Qualifications**

#### **1. Practitioners Eligible to Recommend ASURS**

ASURS must be recommended by one of the following Qualified Practitioners licensed to diagnose SUD, to the extent permitted by and in accordance with District law and regulations:

- a. Physicians- Licensed by the District of Columbia to furnish services within their scope of practice in accordance with District law.
- b. Psychologists- Licensed by the District of Columbia to furnish services within their scope of practice in accordance with District law.
- c. Licensed Independent Clinical Social Workers (“LICSWs”) - Licensed by the District of Columbia to furnish services within their scope of practice in accordance with District law.
- d. Licensed Professional Counselors (“LPCs”) - Licensed by the District of Columbia to furnish services within their scope of practice in accordance with District law.
- e. Licensed Marriage and Family Therapists (“LMFTs”) - Licensed by the District of Columbia to furnish services within their scope of practice in

accordance with District law.

f. Advanced Practice Registered Nurses (“APRNs”) - Licensed by the District of Columbia to furnish services within their scope of practice in accordance with District law.

g. Licensed Independent Social Workers (“LISWs”) - Licensed by the District of Columbia to furnish services within their scope of practice in accordance with District law.

h. Licensed Graduate Professional Counselors (“LGPCs”) - Licensed by the District of Columbia to furnish services within their scope of practice in accordance with District law; and

i. Physician Assistants (“PAs”) - Licensed by the District of Columbia to furnish services within their scope of practice in accordance with District law.

## **2. Practitioners Eligible to Provide ASURS**

ASURS must be delivered by Eligible Practitioners. There are three (3) categories of Eligible Practitioners:

a. Qualified Practitioners eligible to deliver and recommend ASURS - Licensed by the District of Columbia to furnish services within their scope of practice in accordance with District law;

b. Other Qualified Practitioners who are eligible to deliver ASURS, but not recommend ASURS, to the extent permitted by and in accordance with District law and regulations, including any applicable supervision requirements:

i. Psychology Associates - Licensed by the District of Columbia to furnish services within their scope of practice in accordance with District law

ii. Licensed Graduate Social Workers (“LGSWs”) - Licensed by the District of Columbia to furnish services within their scope of practice in accordance with District law.

Registered Nurses (“RNs”) - Licensed by the District of Columbia to furnish services within their scope of practice in accordance with District law.

iii. Certified Addiction Counselors I and II (“CACs”) – Licensed/certified by the District of Columbia to furnish services within their scope of practice in accordance with District law.

c. Credentialed Staff to the extent permitted by and in accordance with District law and regulations, including any applicable supervision requirements.

## **F. ASURS Services and Definitions**

### **1. Crisis Intervention**

a. Definition: Crisis Intervention Services are immediate face-to-face or telephonic responses to a substance use emergency that are available twenty-four (24) hours per day, seven (7) days per week. Crisis/Emergency Services

are provided to clients involved in an active crisis. Services consist of an immediate response to evaluate and screen the presenting situation, assist in immediate crisis stabilization and resolution, and ensure the individual's access to any needed follow-up care at the appropriate level, providing the necessary consultation to any such follow-up provider during the transfer in care. The Crisis/Emergency Services provider shall adjust its staffing to meet the requirements for an immediate response.

- b. Limitations: Crisis Intervention shall not be billed on the same day as MMIWM.
- c. Eligible Practitioners: 1) Qualified Practitioners: Physicians, Psychologists, LICSWs, LPCs, LMFTs, LGSWs, APRNs, RNs, LISWs, PAs, LGPCs, CACs, and Psychology Associates.

## 2. Recovery Support Services (“RSS”)

- a. Definition: RSS are non-clinical services that assist the individual in achieving or sustaining recovery from an SUD. RSS are available to individuals with an SUD who are currently in treatment or have moved into recovery from substance use, and individuals who have self-identified with SUD, but are assessed as not needing treatment. Services include but are not limited to goal setting and monitoring; making referrals; assisting with linkages (including supporting transitions of care for clients within five (5) calendar days after a client enters an eligible institutional setting or within thirty (30) calendar days prior to a client's discharge from an eligible institutional setting); assisting with the completion of benefits, housing or financial forms; assisting with strategy development and coping skills; providing education around social skill development and life skills.
- b. Limitations: No limitations.
- c. Eligible Practitioners: 1) Qualified Practitioners are: Physicians, Psychologists, LICSWs, LPCs, LMFTs, LGSWs, APRNs, LISWs, LGPCs, CACs, and Psychology Associates. 2) Credentialed Staff to the extent permitted by and in accordance with District law and regulations, including any applicable supervision requirements.

## 3. Methadone Services in Opioid Treatment Programs

- a. Methadone is a medication used in Medication Assisted Treatment (MAT) of opioid use disorder (OUD). MAT is the use of pharmacotherapy in conjunction with Counseling/Therapy for treatment of substance use disorders. Methadone for treatment of OUD is provided in opioid treatment programs (OTPs). A beneficiary who receives methadone must also receive

Counseling/Therapy, as clinically necessary. Use of this service should be in accordance with ASAM service guidelines and practice guidelines issued by the Department of Behavioral Health. Methadone Services in OTPs are described in Supplement 1 to Attachment 3.1-B, page 19.

#### 4. **Medically Monitored Inpatient Withdrawal Management ("MMIWM")**

- a. Definition: A 24-hour, medically directed evaluation and withdrawal management program that provides a mixture of professional SUD treatment services in accordance with ASAM criteria. MMIWM is the appropriate level of care for individuals who are assessed as meeting the ASAM criteria for Level 3.7 withdrawal management. The service is for individuals with sufficiently severe signs and symptoms of withdrawal from psychoactive substances or alcohol such that medical and nursing care monitoring and services are necessary, but hospitalization is not needed.
- b. Limitations: A MMIWM stay shall not exceed five (5) days without authorization from DBH, in accordance with applicable regulations and billing procedures. A MMIWM provider shall not bill CCC for a client on the same day as rendering MMWIM to such client. MMIWM shall not be billed on the same day as Crisis Intervention, Medication/Somatic Treatment, and Methadone Services in OTPs.
- c. Eligible Practitioners: 1) Qualified Practitioners: Physicians, Psychologists, PAs, RNs, LICSWs, LISWs, LGSWs, APRNs, LPCs, LMFTs, LGPCs, CACs, and Psychology Associates.

**BEHAVIORAL HEALTH STABILIZATION SERVICES ("STABILIZATION")** address a behavioral health crisis event which requires a non-hospitalization response. Behavioral Health Stabilization services are twenty-four (24) hours per day, seven (7) days per week, year round services that address an unplanned event requiring a response when an individual struggles to manage their psychiatric or substance use related symptoms without de-escalation or other intervention. This also includes situations in which daily life challenges result in or put an individual at risk of an escalation in symptoms. These services are community-based and intended for individuals who are experiencing a behavioral health crisis. Stabilization services are:

- A. Comprehensive Psychiatric Emergency Program ("CPEP")
- B. Adult Mobile Crisis and Outreach
- C. Youth Mobile Crisis
- D. Psychiatric Crisis Stabilization.

#### **A. Provider Qualifications**

Stabilization services must be recommended by one of the following:

- 1) Qualified Practitioners, to the extent permitted by and in accordance with District law

- and regulations:
1. Psychiatrists- Licensed by the District of Columbia to furnish services within their scope of practice in accordance with District law.
  2. Physicians- Licensed by the District of Columbia to furnish services within their scope of practice in accordance with District law.
  3. Psychologists - Licensed by the District of Columbia to furnish services within their scope of practice in accordance with District law.
  4. Licensed Independent Clinical Social Workers (“LICSWs”) - Licensed by the District of Columbia to furnish services within their scope of practice in accordance with District law.
  5. Advanced Practice Registered Nurses (“APRNs”) - Licensed by the District of Columbia to furnish services within their scope of practice in accordance with District law.
  6. Registered Nurses (“RNs”) - Licensed by the District of Columbia to furnish services within their scope of practice in accordance with District law.
  7. Physician Assistants (“PAs”) - Licensed by the District of Columbia to furnish services within their scope of practice in accordance with District law.
  8. Licensed Independent Social Workers (“LISWs”) - Licensed by the District of Columbia to furnish services within their scope of practice in accordance with District law.
  9. Licensed Professional Counselors (“LPCs”) - Licensed by the District of Columbia to furnish services within their scope of practice in accordance with District law.
  10. Licensed Graduate Social Workers (“LGSWs”) - Licensed by the District of Columbia to furnish services within their scope of practice in accordance with District law.
  11. Licensed Graduate Professional Counselors (“LGPCs”) - Licensed by the District of Columbia to furnish services within their scope of practice in accordance with District law.
  12. Psychology Associates - Licensed by the District of Columbia to furnish services within their scope of practice in accordance with District law.
  13. Certified Addiction Counselors I and II (“CACs”) - Licensed by the District of Columbia to furnish services within their scope of practice in accordance with District law.
- 2) Credentialed Staff to the extent permitted by and in accordance with District law and regulations, including any applicable supervision requirements.

## **B. Behavioral Health Stabilization Services and Definitions**

### **1. Comprehensive Psychiatric Emergency Program (“CPEP”)**

- a. **Definition:** Comprehensive Psychiatric Emergency Program (CPEP) services are services provided on an emergent basis to individuals experiencing a behavioral health crisis. Consistent with EPSDT requirements, these services are provided to individuals under twenty-one (21), if medically necessary. These services provide or ensure the provision of psychiatric emergency services, which includes the following services:

- i. **Brief Psychiatric Crisis:** Mental health diagnostic examination, and, as appropriate, treatment interventions on the individual's behalf and a discharge plan. Other activities include medication monitoring, observation, and care coordination with other providers.
  - ii. **Extended Psychiatric Crisis:** Assessment and monitoring of an individual in crisis which results in a comprehensive psychiatric emergency treatment plan and a discharge plan. Other activities include any clinically indicated examinations and assessments as appropriate for the individual's presenting problems, medication monitoring, observation, and care coordination with other providers
- Extended Observation:** Evaluation and monitoring of a patient by a psychiatrist and other clinical staff when a crisis has not sufficiently resolved for safe discharge to the community. This interaction includes a mental health diagnostic assessment, and, if necessary, treatment activities including prescribing or administering medication, and evaluation and monitoring for treatment effectiveness.
- b. **Limitations:** Not applicable.
  - c. **Eligible Practitioners:** 1) Qualified Practitioners: Psychiatrists, Physicians, Psychologists, LICSWs, APRNs, RNs, PAs, LISWs, LPCs, LGSWs, LGPCs, and Psychology Associates. 2) Credentialed Staff to the extent permitted by and in accordance with District law and regulations, including any applicable supervision requirements. Qualified Practitioners and Credentialed Staff are licensed by the District of Columbia to furnish services within their scope of practice in accordance with state law.

## **2. Adult Mobile Crisis and Outreach**

- a. **Definition:** Adult Mobile Crisis and Outreach services are acute behavioral health crisis interventions and behavioral health outreach services provided to individuals in the community in order to minimize the individual's involvement as appropriate with law enforcement, emergency room use, or hospitalizations. These services include rapid response, assessment, and treatment of behavioral health crisis situations that involve adults and occur in the community or via the telephone. Services are provided with the immediate goals of preventing exacerbation of the underlying condition, limiting the risk of injury to the individual or others, and connecting the individual to clinically appropriate, ongoing care. Consistent with EPSDT requirements, these services are provided to individuals under twenty-one (21), if medically necessary. Covered services are:
  - i. **Mobile Crisis Intervention:** Rapid response, assessment, and resolution of behavioral health crisis situations. Services must optimize clinical interventions by meeting individuals in home or community settings.
  - ii. **Behavioral Health Outreach Services:** Initial evaluation and assessment for individuals in the community who are unable or unwilling to use clinic- or hospital-based services, or for individuals for whom hospitalization is not clinically appropriate. Other activities include linkages to other services or

providers; providing emotional support; life skills education; and therapeutic interventions as appropriate.

- b. Limitations: Not applicable.
- c. Eligible Practitioners: 1) Qualified Practitioners: Physicians; Psychologists; LICSWs; APRNs; PAs; RNs; LISWs; LPCs; LMFTs; LGPCs; LGSWs; Psychology Associates; and CACs. 2) Credentialed Staff to the extent permitted by and in accordance with District law and regulations, including any applicable supervision requirements.

### 3. Youth Mobile Crisis Intervention

- a. Definition: Youth Mobile Crisis Intervention services are services that engage children and youth, who may be experiencing a behavioral health crisis, in treatment. Covered services include screening for mental health and SUD service needs; administration of acute behavioral health crisis stabilization and psychiatric assessments to children, youth, and their families; developing rapport; providing support; and providing referrals to appropriate resources, including longer-term mental health or SUD rehabilitative services. Providers assist with connections to treatment, care coordination, and other social services as required.

Youth mobile crisis intervention service that involves the participation of a non-Medicaid eligible is for the direct benefit of the beneficiary. The service must actively involve the beneficiary in the sense of being tailored to the beneficiary's individual needs. There may be times when, based on clinical judgment, the beneficiary is not present during the delivery of the service, but remains the focus of the service.

- b. Limitations: Not applicable.
- c. Eligible Practitioners: 1) Qualified Practitioners: Physician; Psychologists; LICSWs; APRNs; PAs; RNs; LISWs; LPCs; LMFTs; LGPCs; LGSWs; Psychology Associates; and CACs; 2) Credentialed Staff to the extent permitted by and in accordance with District of Columbia law and regulations, including any applicable supervision requirements.

### 4. Psychiatric Crisis Stabilization

- a. Definition: Psychiatric Crisis Stabilization services are residential services that offer therapeutic, community-based, home-like treatment for individuals living in the community who need support to ameliorate psychiatric symptoms and, based upon a psychiatric assessment conducted on-site, are deemed appropriate for services within a structured, closely monitored temporary setting. Individuals shall have ongoing access to comprehensive nursing assessment and plan of care development; psychiatric consultation and assessment; crisis counseling; medication monitoring; and discharge planning. Consistent with EPSDT requirements, these services are provided to

individuals under twenty-one (21), if medically necessary.

- b. Limitations: Authorization is required in accordance with applicable regulations.
- c. Eligible Practitioners: 1) Qualified Practitioners: Psychiatrists, Psychologists, LICSWs, APRNs, RNs, PAs, LISWs, LPCs, Psychology Associates, LGSWs, and LGPCs. 2) Credentialed Staff under the supervision of certain Qualified Practitioners, to the extent permitted by and in accordance with District of Columbia law and regulations.

### **III. TRANSITION PLANNING SERVICE (“TRANSITION PLANNING”)**

The Transition Planning Service is for beneficiaries stepping down from an institutional stay in an inpatient hospital or residential SUD treatment setting related to a primary mental health or SUD diagnosis to certain institutional treatment settings to identify and connect them to needed treatment and support services in order to promote recovery and reduce the chances of avoidable hospital or residential treatment readmissions. Eligible beneficiaries are those with an institutional admission related to a primary mental health or substance use disorder (“SUD”) diagnosis. The Transition Planning Service components must be rendered to the individual within the period beginning thirty (30) calendar days prior to discharge and concluding thirty (30) calendar days after discharge. The Transition Planning Service must be recommended by a practitioner licensed to diagnose mental illness, serious emotional disturbance, or SUD to the extent permitted by and in accordance with District law and regulations.

#### **A. Transition Planning Provider Qualifications**

Transition Planning Services must be provided through Department of Behavioral Health-certified (“DBH-certified”) Transition Planning Service providers and comply with the requirements set forth in the District of Columbia Municipal Regulations.

#### **B. Transition Planning Service Exclusions**

The Transition Planning Service is not available for beneficiaries enrolled in Medicaid managed care, a District of Columbia 1915(c) Home and Community-Based Services Waiver program, or a District Health Homes program as authorized under Section 1945 of the Social Security Act.

#### **C. Transition Planning Service Definition**

1. Definition:
  - a. Transition Planning services are services provided to Medicaid-eligible beneficiaries stepping down from Medicaid-covered institutional treatment settings/stays to identify and connect them to needed treatment and support services in order to promote recovery and reduce the chances of avoidable hospital or residential treatment readmissions. These services include

development of a discharge plan and care coordination related to implementation of the identified needs within the period beginning thirty (30) calendar days prior to discharge and concluding thirty (30) calendar days after discharge. Transition Planning provider activities, as appropriate and applicable to the individual, include, but are not limited to the following:

- i. Discharge plan development activities, which include:
  - A. Participating in and conducting, when appropriate, assessments of the individual's needs (both for behavioral health and physical health treatment, as well as other supports);
  - B. Participating in the discharging facility's discharge planning process and treatment team meetings; and
  - C. Meeting with the individual and their family and natural supports to collect information relevant to discharge plan development and ensuring participation by the individual in discharge planning.
- ii. Discharge plan implementation activities, which include:
  - A. Meeting with the individual and their family and/or other supports to promote understanding of the discharge plan;
  - B. Helping select post-discharge treatment providers and re-establishing, as appropriate, any pre-existing linkages;
  - C. Collaborating with the discharging facility on:
    - I. Making follow-up treatment appointments, care coordination, and securing needed prior authorizations and other arrangements,
    - II. Acquisition of other needed services and supports, and
    - III. Medication reconciliation and ensuring a sufficient supply of medication at discharge; and
    - IV. Conducting outreach to and follow-up with the individual and their post-discharge treatment providers to facilitate and ensure appointments are completed, other needed connections are made, and tracking the status of discharge plan implementation.
- b. Limitations: Authorization is required in accordance with applicable regulations and billing procedures.
- c. Eligible Practitioners: 1) To the extent permitted by and in accordance with District law and regulations: Physicians, Psychologists, Licensed Independent Clinical Social Workers, Advanced Practice Registered Nurses, Licensed Professional Counselors, and Licensed Marriage and Family Therapists. 2) Under the supervision of individuals described in E.1), to the extent permitted by and in accordance with District law and regulations: Recovery Coaches, Certified Peer Specialists, or an individual who holds at least a bachelor's degree in social work, counseling, psychology, or closely related field from an accredited college or university. Practitioners shall meet additional training and professional experience requirements as specified in applicable District

regulations.

**I. Methadone Services in Opioid Treatment Programs (OTPs) under Adult Substance Use Rehabilitative Services (referenced in Supplement 1 to Attachment 3-1B, page 19).**

- a. Definition: Methadone is a medication used in Medication Assisted Treatment (MAT) of opioid use disorder (OUD). MAT is the use of pharmacotherapy in conjunction with SUD Counseling/Therapy for treatment of substance use disorders. Methadone for treatment of OUD is provided in OTPs. A beneficiary who receives methadone must also receive SUD Counseling/Therapy as clinically indicated. Use of this service should be in accordance with the American Society of Addiction Medicine service guidelines and practice guidelines issued by the Department of Behavioral Health.
- b. Unit of Service:
  - i. The reimbursable units of a Methadone Service in an OTP shall be:
    1. One (1) dose for the medication, and
    2. One (1) session for the administration of the medication
- c. Administration consists of dispensing of the medication and therapeutic guidance.
- d. Limitations:
  - i. For in-office administration, a maximum of one (1) dose per day, unless split-dosing is medically indicated. When split-dosing, a maximum of two (2) doses per day are permitted.
  - ii. For take-home dispensation, the number of doses dispensed up to the limits allowable per federal regulations.
- e. Billing
  - i. One (1) administration session may be billed for each unit of medication dispensed on an in-office basis.
  - ii. One (1) administration session may be billed when medication is dispensed on a take-home basis, regardless of the number of doses dispensed.
- f. Location/Setting:
  - i. The pharmacotherapy component of OTP services shall be rendered in facilities which meet the requirements set forth in 42 CFR Part 8, Certification of Opioid Treatment Programs and which are certified by the Department of Behavioral Health as a Level: Opioid Treatment Program.
- g. Qualified Practitioners, to the extent permitted by and in accordance with District law and regulations, including any applicable supervision requirements:
  - i. Physicians; Advanced Practice Registered Nurses; Physicians Assistants; Registered Nurses; or Licensed Practical Nurses.

Reimbursement Methodology: Other Diagnostic, Screening, Preventive, and Rehabilitative Services, i.e., Other Than Those Provided Elsewhere in the Plan

I. Mental Health Rehabilitation Services (MHRS)

A. The following Mental Health Rehabilitation Services (MHRS), when rendered by providers certified by the Department of Behavioral Health, are available for all Medicaid eligible individuals who elect to receive, or have a legally authorized representative elect on their behalf, Rehabilitation Option services and who have mental illness or a serious emotional disturbance:

1. Screening, Assessment, and Diagnosis
2. Medication/Somatic Treatment
3. Counseling/Therapy
4. Community Support
5. Crisis/Emergency Services
6. Clinical Care Coordination
7. Rehabilitation Day Services
8. Intensive Day Treatment
9. Community Based Intervention
10. Assertive Community Treatment
11. Child-Parent Psychotherapy
12. Trauma-Focused Cognitive Behavioral Therapy
13. Functional Family Therapy
14. Trauma Recovery and Empowerment Services
15. Trauma Systems Therapy
16. Psychosocial Rehabilitative Services (“Clubhouse”)

B. MHRS shall be reimbursed according to a fee schedule rate for each MHRS identified in an individualized Plan of Care and rendered to eligible consumers.

C. A fee schedule rate for each MHRS shall be established based on analysis of comparable services rendered by similar professionals in the District of Columbia and other states. Rates shall be reviewed annually.

D. The reimbursable unit of service for Screening, Assessment, and Diagnosis services shall be per occurrence.

1. The reimbursable unit of service of Medication/Somatic Treatment, Counseling/Therapy, Community Support, Crisis/Emergency Services, Clinical Care Coordination, Assertive Community Treatment, Community Based Intervention, Child-Parent Psychotherapy, Trauma-Focused Cognitive Behavioral Therapy, Functional Family Therapy, Trauma Recovery and Empowerment Services, and Trauma Systems Therapy shall be fifteen (15) minutes. Separate reimbursement rates shall be established for services eligible to be rendered either off-site or in group settings.

2. The reimbursable unit of service for Rehabilitation Day Services, Intensive Day Treatment, and Clubhouse shall be one (1) day.

E. Rates shall be consistent with efficiency, economy, and quality of care.

## II. Adult Substance Use Rehabilitative Services (ASURS)

A. The following Adult Substance Use Rehabilitative Services (ASURS), when provided by programs certified by the Department of Behavioral Health, are available to all Medicaid eligible individuals eighteen (18) years of age and older who elect to receive, have a legally authorized representative elect on their behalf, or are otherwise legally obligated to seek rehabilitative services for substance use disorder. Medicaid-reimbursable ASURS include the following categories of services:

1. Screening, Assessment, and Diagnosis
2. Clinical Care Coordination
3. Crisis Intervention
4. Counseling/Therapy
5. Trauma Recovery Empowerment Services
6. Medication/Somatic Treatment
7. Medication Management
8. Recovery Support Services
9. Methadone Services in Opioid Treatment Programs
10. Medically Monitored Inpatient Withdrawal Management

B. ASURS shall be reimbursed according to a fee schedule rate for each ASURS identified in an approved treatment plan. Reimbursement shall not be allowed for any costs associated with room and board.

C. Rates shall be consistent with efficiency, economy, and quality of care.

D. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of adult substance abuse rehabilitative services. The DHCF fee schedule is effective for service provided on or after January 1, 2022. All rates are published on the state agency's website at [www.dc-medicaid.com/dcwebportal/home](http://www.dc-medicaid.com/dcwebportal/home).

## III. Behavioral Health Stabilization Services

A. Behavioral health stabilization services are twenty-four (24) hours per day, seven (7) days per week, year round services that address an unplanned event requiring a response when an individual struggles to manage their psychiatric or substance use related symptoms without de-escalation or other intervention. This also includes situations in

which daily life challenges result in or put an individual at risk of an escalation in symptoms. These services are community-based and intended for individuals who are experiencing a behavioral health crisis but who do not require hospitalization.

Stabilization services include:

1. Comprehensive Psychiatric Emergency Program;
2. Adult Mobile Crisis and Outreach;
3. Youth Mobile Crisis; and
4. Psychiatric Crisis Stabilization.

B. Rates shall be consistent with efficiency, economy, and quality of care.

C. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of crisis stabilization services. The DHCF fee schedule is effective for service provided on or after January 1, 2022. All rates are published on the state agency's website at [www.dc-medicaid.com/dcwebportal/home](http://www.dc-medicaid.com/dcwebportal/home).

#### IV. Transition Planning Service

A. Reimbursement for the Transition Planning Service, when rendered by providers certified by the Department of Behavioral Health, is available for beneficiaries who are stepping down from certain institutional treatment settings after an admission related to a primary mental health or substance use disorder diagnosis.

B. The rate shall be consistent with efficiency, economy, and quality of care.

C. The fee development methodology will primarily be composed of provider cost modeling, through DC provider compensation studies, and cost data, and fees from similar State Medicaid programs may also be considered. The following list outlines the major components of the cost model to be used in developing the fee methodology:

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 personnel costs, management personnel costs, occupancy costs, security costs, and maintenance, insurance 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

- D. Except as otherwise noted in the plan, state-developed fee schedule rate is the same for both governmental and private providers of the Transition Planning Service. The DHCF fee schedule is effective for services provided on or after January 1, 2022. All rates are published on the state agency's website at [www.dc-medicaid.com/dcwebportal/home](http://www.dc-medicaid.com/dcwebportal/home).
  
- E. The reimbursable unit of service for the Transition Planning Service shall be one (1) unit per eligible discharge.