

## **Table of Contents**

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

**State Plan Amendment (SPA) #:** **23-0007**

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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September 8, 2023

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

Re: District of Columbia State Plan Amendment (SPA) 23-0007

Dear Melisa Byrd:

The Centers for Medicare & Medicaid Services (CMS) reviewed your Medicaid State Plan Amendment (SPA) submitted under transmittal number (TN) 23-0007. This District of Columbia proposes to amend its state plan to add coverage of Intensive Care Coordination (ICC) services for children and youth with significant behavioral concerns, update the reimbursement methodology for Assertive Community Treatment (ACT) from a fifteen (15) minute unit to a thirty (30) day period unit, and affirm coverage specifications and service standards as required to qualify for the enhanced Federal Medical Assistance Percentage (FMAP) on community-based mobile crisis services as authorized under §1947 of the Social Security Act.

We conducted our review of your submittal according to statutory requirements in Title XIX of the Social Security Act and implementing regulations at 42 CFR §440.169, §440.225, and §441.18. This letter is to inform you that the District of Columbia's Medicaid SPA 23-0007 was approved on September 8, 2023, with an effective date of August 1, 2023.

If you have any questions, please contact Terri Fraser at 410-786-5573 or via email at [Terri.Fraser@cms.hhs.gov](mailto:Terri.Fraser@cms.hhs.gov).

Sincerely,

A solid black rectangular box redacting the signature of James G. Scott.

James G. Scott, Director  
Division of Program Operations

<b>TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: CENTERS FOR MEDICARE &amp; MEDICAID SERVICES</b>		1. TRANSMITTAL NUMBER: <b>DC 23-0007</b>	2. STATE: <b>District of Columbia</b>
		3. PROGRAM IDENTIFICATION: TITLE <u>XIX</u> OF THE SOCIAL SECURITY ACT	
TO: CENTER DIRECTOR CENTERS FOR MEDICARE & MEDICAID SERVICES DEPARTMENT OF HEALTH AND HUMAN SERVICES		4. PROPOSED EFFECTIVE DATE: August 1, 2023	
5. FEDERAL STATUTE/REGULATION CITATION: 42 CFR §440.169, 42 CFR §441.18, 42 CFR §440.225		6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars): a. FFY 2023 <u>\$5,913,628</u> b. FFY 2024 <u>\$23,717,150</u>	
7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 3.1-A, p. 8 Supplement 2 to Attachment 3.1-A, p. 1-4 Supplement 6 to Attachment 3.1-A, p. 1, 17-17a, 23- <del>24</del> 27 Attachment 3.1-B, p.7 Supplement 2 to Attachment 3.1-B, p. 1-4 Supplement 3 to Attachment 3.1-B, p 1, 17-17a, 23- <del>24</del> 27 Supplement 2 to Attachment 4.19-B, p. 1-2		8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable): TN# 13-18, Attachment 3.1-A, p. 8 TN# 13-03, Supplement 2 to Attachment 3.1-A, p. 1-6 4 TN# 21-0010, Supplement 6 to Attachment 3.1-A, p.1, 17, 23-27 TN# 13-18, Attachment 3.1-B, p.7 TN# 13-03, Supplement 2 to Attachment 3.1-B, p. 1-6 4 TN# 21-0010, Supplement 3 to Attachment 3.1-B, p. 1, 17, 23-27 TN# <del>21-0010</del> , 22-0005 Supplement 2 to Attachment 4.19-B, p. 1-2	
9. SUBJECT OF AMENDMENT: To update reimbursement methodology for Assertive Community Treatment. To include coverage for Intensive Care Coordination (ICC) services for children and youth with significant behavioral concerns. To confirm coverage specifications and service standards as required to qualify for enhanced the Federal Medical Assistance Percentage (FMAP) on community-based mobile crisis services under §1947 of the Social Security Act.			
10. GOVERNOR'S REVIEW (Check One)			
<input type="checkbox"/> GOVERNOR'S OFFICE REPORTED NO COMMENT <input type="checkbox"/> COMMENTS OF GOVERNOR'S OFFICE ENCLOSED <input type="checkbox"/> NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL		<input checked="" type="checkbox"/> OTHER, AS SPECIFIED: D.C. Act: 22-434	
11. SIGNATURE OF STATE AGENCY OFFICIAL		15. RETURN TO  Melisa Byrd Senior Deputy Director/Medicaid Director Department of Health Care Finance 441 4 <sup>th</sup> Street, NW, 9 <sup>th</sup> Floor, South Washington, DC 20001	
12. TYPED NAME Melisa Byrd			
13. TITLE Senior Deputy Director/Medicaid Director			
14. DATE SUBMITTED July 10, 2023			
<b>FOR CMS USE ONLY</b>			
16. DATE RECEIVED      07/10/2023		17. DATE APPROVED <b>09/08/2023</b>	
<b>PLAN APPROVED – ONE COPY ATTACHED</b>			
18. EFFECTIVE DATE OF APPROVED MATERIAL 08/01/2023		19. SIGNA	
20. TYPED NAME OF APPROVING OFFICIAL James G. Scott		21. TITLE OF APPROVING OFFICIAL Director, Division of Program Operations	
22. REMARKS			

Boxes 7, 8, and 14: State authorized pen and ink change on 08/25/2023

Box 8: State authorized pen and ink change on 8/29/2023.

State Plan under Title XIX of the Social Security Act
State/Territory: District of Columbia

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND
REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

19. Case management services and Tuberculosis related services

a. Case management services as defined in, and to the groups specified in, Supplements 2
and 4 to Attachment 3.1-A (in accordance with section 1905(a)(19) or section 1915(g) of
the Act).

X Provided: X With limitations\*
Not Provided.

b. Special tuberculosis (TB) related services under section 1902(z)(2)(F) of the Act.

X Provided: X With limitations\*
Not Provided.

20. Extended services for pregnant women

a. Pregnancy-related and postpartum services for a 60-day period after the pregnancy ends
and any remaining days in the month in which the 60th day falls.

X Provided:
Additional coverage ++

b. Services for any other medical conditions that may complicate pregnancy.

X Provided:
Additional coverage ++

c. Face-to-face Tobacco Cessation Counseling Services and Pharmacotherapy for Pregnant
Women

X Provided: With limitations\*
Not provided.

\*Description provided on attachment.

++ Attached is a description of increases in covered services beyond limitations for all groups described
in this attachment and/or any additional services provided to pregnant women only.

**State Plan under Title XIX of the Social Security Act  
State/Territory: District of Columbia**

**TARGETED CASE MANAGEMENT SERVICES  
Intensive Care Coordination Services for  
Children and Youth with Significant Behavioral Concerns**

Target Group (42 Code of Federal Regulations 441.18(a)(8)(i) and 441.18(a)(9)):

Children and youth who: (1) are under age twenty-two (22); and (2) exhibit significant functional impairment at home, school, or in the community due to behavioral health conditions as reflected in a standardized functional assessment tool.

Individuals must also be: (1) at risk of being placed outside their home as assessed by an independently licensed behavioral health practitioner; (2) returning from an out-of-home placement; (3) involved with two (2) or more District government agencies; or (4) have had three (3) or more behavioral health related hospitalizations within a six (6) month period.

\_\_\_ Target group includes individuals transitioning to a community setting. Case-management services will be made available for up to \_\_\_ consecutive days of a covered stay in a medical institution. The target group does not include individuals between ages 22 and 64 who are served in Institutions for Mental Disease or individuals who are inmates of public institutions). (State Medicaid Directors Letter (SMDL), July 25, 2000)

Areas of State in which services will be provided (§1915(g)(1) of the Act):

- Entire State  
\_\_\_ Only in the following geographic areas:

Comparability of services (§§1902(a)(10)(B) and 1915(g)(1))

- \_\_\_ Services are provided in accordance with §1902(a)(10)(B) of the Act.  
 Services are not comparable in amount duration and scope (§1915(g)(1)).

Definition of services (42 CFR 440.169): Targeted case management services are defined as services furnished to assist individuals, eligible under the State Plan, in gaining access to needed medical, social, educational, and other services. Targeted Case Management includes the following assistance:

- ❖ Comprehensive assessment and periodic reassessment of individual needs, to determine the need for any medical, educational, social, or other services. These assessment activities include:
  - taking client history;
  - identifying the individual's needs and completing related documentation; and
  - gathering information from other sources such as family members, medical providers, social workers, and educators (if necessary), to form a complete assessment of the eligible individual;
  - the comprehensive assessment is completed upon admission to services and at least annually thereafter.
  
- ❖ Development (and periodic revision) of a specific care plan that is based on the information collected through the assessment that:
  - specifies the goals and actions to address the medical, social, educational, and other services needed by the individual;

- includes activities such as ensuring the active participation of the eligible individual, and working with the individual (or the individual's authorized health care decision maker) and others to develop those goals; and
  - identifies a course of action to respond to the assessed needs of the eligible individual;
- ❖ Referral and related activities (such as scheduling appointments for the individual) to help the eligible individual obtain needed services including:
- activities that help link the individual with medical, social, educational providers, or other programs and services that are capable of providing needed services to address identified needs and achieve goals specified in the care plan; and
- ❖ Monitoring and follow-up activities:
- activities and contacts that are necessary to ensure the care plan is implemented and adequately addresses the eligible individual's needs, and which may be with the individual, family members, service providers, or other entities or individuals and conducted as frequently as necessary, and including at least one annual monitoring, to determine whether the following conditions are met:
    - services are being furnished in accordance with the individual's care plan;
    - services in the care plan are adequate; and
    - changes in the needs or status of the individual are reflected in the care plan. Monitoring and follow-up activities include making necessary adjustments in the care plan and service arrangements with providers;
    - the plan of care is reviewed at least monthly following the National Wraparound Initiative ("NWI") High Fidelity Wraparound model.

\_\_\_\_\_ Case management includes contacts with non-eligible individuals that are directly related to identifying the eligible individual's needs and care, for the purposes of helping the eligible individual access services; identifying needs and supports to assist the eligible individual in obtaining services; providing case managers with useful feedback, and alerting case managers to changes in the eligible individual's needs.  
(42 CFR 440.169(e))

Qualifications of providers (42 CFR 441.18(a)(8)(v) and 42 CFR 441.18(b)):

For purposes of this SPA, case managers are referred to as care coordinators. Care coordinators are certified by Department of Behavioral Health as a Mental Health Rehabilitative Services (MHRS) provider in accordance with 22-A DCMR Chapter 34.

TCM services must be delivered by care coordinators with specialized training and skills necessary to assure fidelity to the NWI model and the District of Columbia Children's System of Care Guiding Principles.

Care coordinators must possess a minimum of a B.A. or B.S. degree in social work, psychology, or related field and have a minimum of three (3) years of experience in a human services profession. A minimum of four (4) years employment in the human services field may be substituted for a bachelor's degree.

Care Coordinator Supervisors shall: (1) have at least two (2) years of supervisory experience; (2) have at least five (5) years of experience in case management; (3) possess a master's degree in social work, psychology, or other related professions; and

(4) be an independently licensed behavioral health practitioner. Supervisors shall have supervisory certification from the National Wraparound Implementation Center. Supervisors are responsible for ensuring that case management is implemented to the NWI fidelity standards, the ten (10) NWI Principles of Wraparound, and the District of Columbia Children's System of Care Guiding Principles.

Freedom of choice (42 CFR 441.18(a)(1)):

The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.

1. Eligible individuals will have free choice of any qualified Medicaid provider within the specified geographic area identified in this plan.
2. Eligible individuals will have free choice of any qualified Medicaid providers of other medical care under the plan.

Freedom of Choice Exception (§1915(g)(1) and 42 CFR 441.18(b)):

\_\_\_\_\_ Target group consists of eligible individuals with developmental disabilities or with chronic mental illness. Providers are limited to qualified Medicaid providers of case management services capable of ensuring that individuals with developmental disabilities or with chronic mental illness receive needed services:

Access to Services (42 CFR 441.18(a)(2), 42 CFR 441.18(a)(3), 42 CFR 441.18(a)(6)):

The State assures the following:

- Case management (including targeted case management) services will not be used to restrict an individual's access to other services under the plan.
- Individuals will not be compelled to receive case management services, condition receipt of case management (or targeted case management) services on the receipt of other Medicaid services, or condition receipt of other Medicaid services on receipt of case management (or targeted case management) services; and
- Providers of case management services do not exercise the agency's authority to authorize or deny the provision of other services under the plan.

Payment (42 CFR 441.18(a)(4)):

Payment for case management or targeted case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

Case Records (42 CFR 441.18(a)(7)):

Providers maintain case records that document for all individuals receiving case management as follows: (i) The name of the individual; (ii) The dates of the case management services; (iii) The name of the provider agency (if relevant) and the person providing the case management service; (iv) The nature, content, units of the case management services received and whether goals specified in the care plan have been achieved; (v) Whether the individual has declined services in the care plan; (vi) The need for, and occurrences of, coordination with other case managers; (vii) A timeline for obtaining needed services; (viii) A timeline for reevaluation of the plan.

Limitations:

Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §440.169 when the case management

activities are an integral and inseparable component of another covered Medicaid service (State Medicaid Manual (SMM) 4302.2(F)).

Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §440.169 when the case management activities constitute the direct delivery of underlying medical, educational, social, or other services to which an eligible individual has been referred, including for foster care programs, services such as, but not limited to, the following: research gathering and completion of documentation required by the foster care program; assessing adoption placements; recruiting or interviewing potential foster care parents; serving legal papers; home investigations; providing transportation; administering foster care subsidies; making placement arrangements. (42 CFR 441.18(c))

FFP only is available for case management services or targeted case management services if there are no other third parties liable to pay for such services, including as reimbursement under a medical, social, educational, or other program except for case management that is included in an individualized education program or individualized family service plan consistent with §1903(c) of the Act. (§§1902(a)(25) and 1905(c))



**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. 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 – Attachment 3.1A, Supp. 6
  - 2. Medication/Somatic Treatment– Attachment 3.1A, Supp. 6
  - 3. Counseling/Therapy – Attachment 3.1A, Supp. 6
  - 4. Community Support– Attachment 3.1A, Supp. 6
  - 5. Crisis/Emergency Services– Attachment 3.1A, Supp. 6
  - 6. Clinical Care Coordination– Attachment 3.1A, Supp. 6
  - 7. Rehabilitation Day Services – Attachment 3.1A, Supp. 6
  - 8. Intensive Day Treatment – Attachment 3.1A, Supp. 6
  - 9. Community Based Intervention – Attachment 3.1A, Supp. 6
  - 10. Assertive Community Treatment – Attachment 3.1A, Supp.6
  - 11. Child-Parent Psychotherapy – Attachment 3.1A, Supp. 6
  - 12. Trauma-Focused Cognitive Behavioral Therapy – Attachment 3.1A, Supp. 6
  - 13. Functional Family Therapy – Attachment 3.1A, Supp. 6
  - 14. Trauma Recovery and Empowerment Services – Attachment 3.1A, Supp. 6
  - 15. Trauma Systems Therapy – Attachment 3.1A, Supp. 6
  - 16. Psychosocial Rehabilitative (“Clubhouse”) Services – Attachment 3.1A, Supp. 6
- b. Limitations: No annual limits.

- c. Eligible Practitioners: 1) Qualified Practitioners: Psychiatrists, Psychologists, LICSWs, LPCs, LMFTs, PAs, LGSWs, LGPCs. 2) Credentialed staff under

the supervision of a Qualified Practitioner licensed to practice independently.  
The requirements for credentialed staff are as follows:

- i. High school diploma or high school equivalency and
- ii. Personal experience with the mental health services system through the receipt of services or one cumulative year of the provision of supports to adults with mental illness or children and youth with mental illness or serious emotional disturbance.

Practitioners shall meet additional training and professional experience requirements as specified in applicable District regulations.

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- 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”).

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 – Attachment 3.1A, Supp. 6
2. Clinical Care Coordination – Attachment 3.1A, Supp. 6
3. Crisis Intervention– Attachment 3.1A, Supp. 6
4. Counseling/Therapy– Attachment 3.1A, Supp. 6
5. Trauma Recovery and Empowerment Services– Attachment 3.1A, Supp. 6
6. Medication/Somatic Treatment – Attachment 3.1A, Supp. 6
7. Recovery Support Services – Attachment 3.1A, Supp. 6
8. Methadone Services in Opioid Treatment Programs – Attachment 3.1A, Supp. 6
9. Medically Monitored Inpatient Withdrawal Management – Attachment 3.1A, Supp. 6

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.

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- 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.
  - iii. **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.
- a. **Limitations:** Not applicable.
  - b. **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. Requirements for credentialed staff are as follows:
    - i. High school diploma or high school equivalency and
    - ii. Personal experience with the mental health services system through the receipt of services or one cumulative year of the provision of supports to adults with mental illness or children and youth with mental illness or serious emotional disturbance.

## 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 intended to minimize the individual's involvement with law enforcement, emergency room use, or hospitalizations. These services are available 24 hours per day, seven days per week and include rapid response, assessment, and treatment of behavioral health crisis situations. Services are delivered by a multidisciplinary team which consists of, at minimum, two people and must include at least one professional or paraprofessional with expertise in mental health services and the appropriate qualifications to conduct a mobile crisis screening and assessment. At least one member of the multidisciplinary team must be face-to-face with the individual. The immediate goals of the services include 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, including those 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; and therapeutic interventions as appropriate.

a. Limitations: Not applicable.

b. 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. The requirements for credentialed staff are as follows:

- i. High school diploma or high school equivalency and
- ii. Personal experience with the mental health services system through the receipt of services or one cumulative year of the provision of supports to adults with mental illness or children and youth with mental illness or serious emotional disturbance.

### **3. Youth Mobile Crisis Intervention**

c. Definition: Youth Mobile Crisis Intervention services are services that engage children and youth, who may be experiencing a behavioral health crisis, in treatment. Services are available 24 hours per day, seven days per week and 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. Services are delivered by a multidisciplinary team which consists of, at minimum, two people and must include at least one professional or paraprofessional with expertise in mental health services and the appropriate qualifications to conduct a mobile crisis screening and assessment. At least one member of the multidisciplinary team must be face-to-face with the individual. 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.

d. Limitations: Not applicable.

e. 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. The requirements for credentialed staff are as follows:

- i. High school diploma or high school equivalency and
- ii. Personal experience with the mental health services system through the receipt of services or one cumulative year of the provision of supports to adults with mental illness or children and youth with mental illness or serious emotional disturbance.

#### **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. Medicaid services are not provided to individuals at institutions for mental disease.
- 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. The requirements for credentialed staff are as follows:
  - i. High school diploma or high school equivalency and
  - ii. Personal experience with the mental health services system through the receipt of services or one cumulative year of the provision of supports to adults with mental illness or children and youth with mental illness or serious emotional disturbance.

### **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.



State Plan under Title XIX of the Social Security Act  
State/Territory: District of Columbia

**TARGETED CASE MANAGEMENT SERVICES**  
**Intensive Care Coordination Services for**  
**Children and Youth with Significant Behavioral Concerns**

Target Group (42 Code of Federal Regulations 441.18(a)(8)(i) and 441.18(a)(9)):

Children and youth who: (1) are under age twenty-two (22); and (2) exhibit significant functional impairment at home, school, or in the community due to behavioral health conditions as reflected in a standardized functional assessment tool.

Individuals must also be: (1) at risk of being placed outside their home as assessed by an independently licensed behavioral health practitioner; (2) returning from an out-of-home placement; (3) involved with two (2) or more District government agencies; or (4) have had three (3) or more behavioral health related hospitalizations within a six (6) month period.

\_\_\_ Target group includes individuals transitioning to a community setting. Case-management services will be made available for up to \_\_\_ consecutive days of a covered stay in a medical institution. The target group does not include individuals between ages 22 and 64 who are served in Institutions for Mental Disease or individuals who are inmates of public institutions). (State Medicaid Directors Letter (SMDL), July 25, 2000)

Areas of State in which services will be provided (§1915(g)(1) of the Act):

- Entire State  
 Only in the following geographic areas:

Comparability of services (§§1902(a)(10)(B) and 1915(g)(1))

- \_\_\_ Services are provided in accordance with §1902(a)(10)(B) of the Act.  
 Services are not comparable in amount duration and scope (§1915(g)(1)).

Definition of services (42 CFR 440.169): Targeted case management services are defined as services furnished to assist individuals, eligible under the State Plan, in gaining access to needed medical, social, educational, and other services. Targeted Case Management includes the following assistance:

- ❖ Comprehensive assessment and periodic reassessment of individual needs, to determine the need for any medical, educational, social, or other services. These assessment activities include:
  - taking client history;
  - identifying the individual's needs and completing related documentation; and
  - gathering information from other sources such as family members, medical providers, social workers, and educators (if necessary), to form a complete assessment of the eligible individual;
  - the comprehensive assessment is completed upon admission to services and at least annually thereafter.
  
- ❖ Development (and periodic revision) of a specific care plan that is based on the information collected through the assessment that
  - specifies the goals and actions to address the medical, social, educational, and other services needed by the individual;

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- includes activities such as ensuring the active participation of the eligible individual, and working with the individual (or the individual's authorized health care decision maker) and others to develop those goals; and
  - identifies a course of action to respond to the assessed needs of the eligible individual;
- ❖ Referral and related activities (such as scheduling appointments for the individual) to help the eligible individual obtain needed services including
- activities that help link the individual with medical, social, educational providers, or other programs and services that are capable of providing needed services to address identified needs and achieve goals specified in the care plan; and
- ❖ Monitoring and follow-up activities:
- activities and contacts that are necessary to ensure the care plan is implemented and adequately addresses the eligible individual's needs, and which may be with the individual, family members, service providers, or other entities or individuals and conducted as frequently as necessary, and including at least one annual monitoring, to determine whether the following conditions are met:
    - services are being furnished in accordance with the individual's care plan;
    - services in the care plan are adequate; and
    - changes in the needs or status of the individual are reflected in the care plan. Monitoring and follow-up activities include making necessary adjustments in the care plan and service arrangements with providers;
    - the plan of care is reviewed at least monthly following the National Wraparound Initiative ("NWI") High Fidelity Wraparound model.

\_\_\_\_\_ Case management includes contacts with non-eligible individuals that are directly related to identifying the eligible individual's needs and care, for the purposes of helping the eligible individual access services; identifying needs and supports to assist the eligible individual in obtaining services; providing case managers with useful feedback, and alerting case managers to changes in the eligible individual's needs.  
(42 CFR 440.169(e))

Qualifications of providers (42 CFR 441.18(a)(8)(v) and 42 CFR 441.18(b)):

For the purposes of this SPA, case managers are referred to as care coordinators. Care coordinators are certified by Department of Behavioral Health as a Mental Health Rehabilitative Services (MHRS) provider in accordance with 22-A DCMR Chapter 34.

TCM services must be delivered by care coordinators with specialized training and skills necessary to assure fidelity to the NWI model and the District of Columbia Children's System of Care Guiding Principles.

Care coordinators must possess a minimum of a B.A. or B.S. degree in social work, psychology, or related field and have a minimum of three (3) years of experience in a human services profession. A minimum of four (4) years employment in the human services field may be substituted for a bachelor's degree.

Care Coordinator Supervisors shall: (1) have at least two (2) years of supervisory experience; (2) have at least five (5) years of experience in case management; (3) possess a master's degree in social work, psychology, or other related professions; and

(4) be an independently licensed behavioral health practitioner. Supervisors shall have supervisory certification from the National Wraparound Implementation Center. Supervisors are responsible for ensuring that case management is implemented to the NWI fidelity standards, the ten (10) NWI Principles of Wraparound, and the District of Columbia Children's System of Care Guiding Principles.

Freedom of choice (42 CFR 441.18(a)(1)):

The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.

1. Eligible individuals will have free choice of any qualified Medicaid provider within the specified geographic area identified in this plan.
2. Eligible individuals will have free choice of any qualified Medicaid providers of other medical care under the plan.

Freedom of Choice Exception (§1915(g)(1) and 42 CFR 441.18(b)):

\_\_\_\_\_ Target group consists of eligible individuals with developmental disabilities or with chronic mental illness. Providers are limited to qualified Medicaid providers of case management services capable of ensuring that individuals with developmental disabilities or with chronic mental illness receive needed services:

Access to Services (42 CFR 441.18(a)(2), 42 CFR 441.18(a)(3), 42 CFR 441.18(a)(6)):

The State assures the following:

- Case management (including targeted case management) services will not be used to restrict an individual's access to other services under the plan.
- Individuals will not be compelled to receive case management services, condition receipt of case management (or targeted case management) services on the receipt of other Medicaid services, or condition receipt of other Medicaid services on receipt of case management (or targeted case management) services; and
- Providers of case management services do not exercise the agency's authority to authorize or deny the provision of other services under the plan.

Payment (42 CFR 441.18(a)(4)):

Payment for case management or targeted case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

Case Records (42 CFR 441.18(a)(7)):

Providers maintain case records that document for all individuals receiving case management as follows: (i) The name of the individual; (ii) The dates of the case management services; (iii) The name of the provider agency (if relevant) and the person providing the case management service; (iv) The nature, content, units of the case management services received and whether goals specified in the care plan have been achieved; (v) Whether the individual has declined services in the care plan; (vi) The need for, and occurrences of, coordination with other case managers; (vii) A timeline for obtaining needed services; (viii) A timeline for reevaluation of the plan.

Limitations:

Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §440.169 when the case management

activities are an integral and inseparable component of another covered Medicaid service (State Medicaid Manual (SMM) 4302.2(F)).

Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §440.169 when the case management activities constitute the direct delivery of underlying medical, educational, social, or other services to which an eligible individual has been referred, including for foster care programs, services such as, but not limited to, the following: research gathering and completion of documentation required by the foster care program; assessing adoption placements; recruiting or interviewing potential foster care parents; serving legal papers; home investigations; providing transportation; administering foster care subsidies; making placement arrangements. (42 CFR 441.18(c))

FFP only is available for case management services or targeted case management services if there are no other third parties liable to pay for such services, including as reimbursement under a medical, social, educational, or other program except for case management that is included in an individualized education program or individualized family service plan consistent with §1903(c) of the Act. (§§1902(a)(25) and 1905(c))

**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. 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 –Attachment 3.1B, Supp. 3
2. Medication/Somatic Treatment –Attachment 3.1B, Supp. 3
3. Counseling/Therapy –Attachment 3.1B, Supp. 3
4. Community Support –Attachment 3.1B, Supp. 3
5. Crisis/Emergency Services –Attachment 3.1B, Supp. 3
6. Clinical Care Coordination –Attachment 3.1B, Supp. 3
7. Rehabilitation Day Services –Attachment 3.1B, Supp. 3
8. Intensive Day Treatment –Attachment 3.1B, Supp. 3
9. Community Based Intervention –Attachment 3.1B, Supp. 3
10. Assertive Community Treatment –Attachment 3.1B, Supp. 3
11. Child-Parent Psychotherapy –Attachment 3.1B, Supp. 3
12. Trauma-Focused Cognitive Behavioral Therapy –Attachment 3.1B, Supp. 3
13. Functional Family Therapy –Attachment 3.1B, Supp. 3
14. Trauma Recovery and Empowerment Services –Attachment 3.1B, Supp. 3
15. Trauma Systems Therapy –Attachment, 3.1B Supp. 3
16. Psychosocial Rehabilitative (“Clubhouse”) Services –Attachment 3.1B, Supp. 3

**B. MHRS Provider Qualifications**

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

- i. Identifying and developing of organizational support; and
  - ii. Identifying and developing existing natural supports for addressing personal needs.
- a. Limitations: No annual limits.
- b. Eligible Practitioners: 1) Qualified Practitioners: Psychiatrists, Psychologists, LICSWs, LPCs, LMFTs, PAs, LGSWs, LGPCs. 2) Credentialed staff under the supervision of a Qualified Practitioner licensed to practice independently: Credentialed Staff.
- i. High school diploma or high school equivalency and
  - ii. Personal experience with the mental health services system through the receipt of services or one cumulative year of the provision of supports to adults with mental illness or children and youth with mental illness or serious emotional disturbance.

Practitioners shall meet additional training and professional experience requirements as specified in applicable District regulations.

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**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).

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 –Attachment 3.1B, Supp. 3
2. Clinical Care Coordination (“CCC”) –Attachment 3.1B, Supp. 3
3. Crisis Intervention –Attachment 3.1B, Supp. 3
4. Counseling/Therapy –Attachment 3.1B, Supp. 3
5. Trauma Recovery and Empowerment Services –Attachment 3.1B, Supp. 3
6. Medication/Somatic Treatment –Attachment 3.1B, Supp. 3
7. Recovery Support Services (“RSS”) –Attachment 3.1B, Supp. 3
8. Methadone Services in Opioid Treatment Programs –Attachment 3.1B, Supp. 3
9. Medically Monitored Inpatient Withdrawal Management (“MMIWM”) – Attachment 3.1B, Supp. 3

**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

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- 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.
  - iii. 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.
- a. Limitations: Not applicable.
  - b. 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. Requirements for credentialed staff are as follows:
    - i. High school diploma or high school equivalency and
    - ii. Personal experience with the mental health services system through the receipt of services or one cumulative year of the provision of supports to adults with mental illness or children and youth with mental illness or serious emotional disturbance.

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 intended to minimize the individual's involvement with law enforcement, emergency room use, or hospitalizations. These services are available 24 hours per day, seven days per week and include rapid response, assessment, and treatment of behavioral health crisis situations. Services are delivered by a multidisciplinary team which consists of, at minimum, two people and must include at least one professional or paraprofessional with expertise in mental health services and the appropriate qualifications to conduct a mobile crisis screening and assessment. At least one member of the multidisciplinary team must be face-to-face with the individual. The immediate goals of the services include 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, including those 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; 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. Requirements for credentialed staff are as follows:
- i. High school diploma or high school equivalency and
  - ii. Personal experience with the mental health services system through the receipt of services or one cumulative year of the provision of supports to adults with mental illness or children and youth with mental illness or serious emotional disturbance.
- c.

### **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. Services are available 24 hours per day, seven days per week and 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. Services are delivered by a multidisciplinary team which consists of, at minimum, two people and must include at least one professional or paraprofessional with expertise in mental health services and the appropriate qualifications to conduct a mobile crisis screening and assessment. At least one member of the multidisciplinary team must be face-to-face with the individual. 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. The requirements for credentialed staff are as follows:

- i. High school diploma or high school equivalency and
- ii. Personal experience with the mental health services system through the receipt of services or one cumulative year of the provision of supports to adults with mental illness or children and youth with mental illness or serious emotional disturbance.

#### 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. Medicaid services are not provided to individuals at institutions for mental disease.
- 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. The requirements for credentialed staff are as follows:
  - i. High school diploma or high school equivalency and
  - ii. Personal experience with the mental health services system through the receipt of services or one cumulative year of the provision of supports to adults with mental illness or children and youth with mental illness or serious emotional disturbance.

## II. **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.

State Plan under Title XIX of the Social Security Act
State/Territory: District of Columbia

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND
REMEDIAL CARE AND SERVICES PROVIDED TO THE MEDICALLY NEEDY

19. Case management services and Tuberculosis related services

a. Case management services as defined in, and to the group specified in, Supplement 2 to
Attachment 3.1-B (in accordance with section 1905(a)(19) or section 1915(g) of the Act).

X Provided: X With limitations\*

Not Provided.

b. Special tuberculosis (TB) related services under section 1902(z)(2)(F) of the Act.

X Provided: X With limitations\*

Not Provided.

20. Extended services for pregnant women

a. Pregnancy-related and postpartum services for a 60-day period after the pregnancy ends
and any remaining days in the month in which the 60th day falls.

X Provided:

Additional coverage ++

b. Services for any other medical conditions that may complicate pregnancy.

X Provided:

Additional coverage ++

c. Face-to-face Tobacco Cessation Counseling Services and Pharmacotherapy for Pregnant
Women

X Provided: With limitations\*

Not provided.

\*Description provided on attachment.

++ Attached is a description of increases in covered services beyond limitations for all groups described
in this attachment and/or any additional services provided to pregnant women only.

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”)
17. Targeted Case Management

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. The DHCF fee schedule is effective for services provided on or after April 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). Effective October 1, 2022 rates shall be increased by the Market Basket Medicare Economic Index established by the Centers for Medicare and Medicaid Services.

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, 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.
  3. The reimbursable unit of service for Targeted Case Management and Assertive Community Treatment shall be one (1) month.
- 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. Recovery Support Services
  8. Methadone Services in Opioid Treatment Programs
  9. 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](http://www.dc-medicaid.com).

## III. Behavioral Health Stabilization Services