# Table of Contents

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

**State Plan Amendment (SPA) #:** **24-0004**

This file contains the following documents in the order listed:

**DEPARTMENT OF HEALTH & HUMAN SERVICES**
Centers for Medicare & Medicaid Services
601 E. 12th St., Room 355
Kansas City, Missouri 64106

CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

Medicaid and CHIP Operations Group

June 13, 2024

Melisa Byrd
Senior Deputy Director/Medicaid Director
Department of Health Care Finance
441 4th Street, NW, 9th Floor, South
Washington, DC 20001

Re: DC State Plan Amendment (SPA) #24-0004

Dear Director Byrd:

The Centers for Medicare & Medicaid Services (CMS) reviewed your Medicaid State Plan Amendment (SPA) submitted under transmittal number (TN) #24-0004. This amendment proposes to 1) update the reimbursement methodology for Rehabilitation Day Services and Psychosocial Rehabilitation Services, 2) to add new preventive and screening services, 3) to rename Community Based Intervention Level 1 to multisystemic therapy, and 4) to update the structure of Methadone Services in Opioid Treatment Programs.

We conducted our review of your submittal according to statutory requirements in Title XIX of the Social Security Act and implementing regulations at 42 C.F.R. §440.130 and §440.225. This letter informs you that the District of Columbia's Medicaid SPA TN #24-0004 was approved on June 13, 2024, with an effective date of February 1, 2024.

Enclosed are copies of Form CMS-179 and approved SPA pages to be incorporated into the District of Columbia's State Plan.

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

Sincerely,

[redacted]

James G. Scott, Director
Division of Program Operations

Enclosures

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0193

# TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

**FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES**

1. TRANSMITTAL NUMBER: **DC 24-0004**

2. STATE: **District of Columbia**

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

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

4. PROPOSED EFFECTIVE DATE:
February 1, 2024

5. FEDERAL STATUTE/REGULATION CITATION:
42 CFR §440.130, 42 CFR §440.225,

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars):
a. FFY 2024 $ 5,460,630
b. FFY 2025 $8,642,822

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Supplement 1 to Attachment 3.1-A, p. 20, 21a-b
Supplement 6 to Attachment 3.1-A, p. 4-5, 10
Supplement 1 to Attachment 3.1-B p. 19, 20a-b
Supplement 3 to Attachment 3.1-B, p 4-5, 10
Attachment 4.19-B, p. 13a, 39
Supplement 2 to Attachment 4.19-B, p. 1-2, 4

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: #24-0002 Attachment 4.19-B Page 13a #22-0006 Attachment 4.19-B Page 39
TN # 22-0006; TN # 21-0010 Supplement 1 to Attachment 3.1-A
TN # 23-0015 Supplement 6 to Attachment 3.1-A
TN # 22-0006; TN # 21-0010 Supplement 1 to Attachment 3.1-B
TN # 23-0015 Supplement 3 to Attachment 3.1-B
TN #22-0005; TN # 23-0015 Supplement 2 to Attachment 4.19-B

9. SUBJECT OF AMENDMENT: To update reimbursement methodology for Rehabilitation Day Services and Psychosocial Rehabilitation (Clubhouse) Services. To add screening, as a new service under the Mental Health Rehabilitative Services benefit. To rename Community Based Intervention Level 1, Multisystemic Therapy. To add a new service, Attachment and Biobehavioral Catchup, as a preventive service. To update the structure of Methadone Services in Opioid Treatment Programs.

10. GOVERNOR'S REVIEW *(Check One)*
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:
D.C. Act: 22-434

11. SIGNATURE OF STATE AGENCY OFFICIAL
[redacted]

12. TYPED NAME
Melisa Byrd

13. TITLE
Senior Deputy Director/Medicaid Director

14. DATE SUBMITTED
3/28/24

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

**FOR CMS USE ONLY**

16. DATE RECEIVED 03/28/2024

17. DATE APPROVED **06/13/2024**

**PLAN APPROVED – ONE COPY ATTACHED**

18. EFFECTIVE DATE OF APPROVED MATERIAL
02/01/2024

19. SIG [redacted]

20. TYPED NAME OF APPROVING OFFICIAL
James G. Scott

21. TITLE OF APPROVING OFFICIAL
Director, Division of Program Operations

22. REMARKS

5/28/24 - The District requested a P&I change to Box 8 to include references that were omitted from the form. (TF)
6/5/24 - The District requested P&I change to Boxes 7 and 8 to reference an additional page that was omitted from the form. (TF)

**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: For take-home doses, the number of doses shall be determined based on clinical indications for the beneficiary and be consistent with requirements set forth in 42 CFR Part 8.

c. Limitations: The number of take-home doses dispensed to a beneficiary may not exceed the limits established in 42 CFR Part 8.

d. 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 of Care: Opioid Treatment Program.

e. 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.

c. **Preventive services**: Preventive Services must be prior approved.

I. **Doula services** are provided throughout the perinatal period and the postpartum period. Doulas provide support to the birthing parent throughout the pregnancy and postpartum periods to improve maternal health outcomes. Pursuant to 42 C.F.R. Section 440.130(c), doula services are provided as preventive services and must be recommended by a physician or other licensed practitioner of the healing arts within his or her scope of practice under state law to prevent perinatal complications and/or promote the physical and mental health of the beneficiary.

Doula services provided to the birthing parent during the perinatal and postpartum period include:

1. Perinatal counseling and education, including infant care, to prevent adverse outcomes;
2. Labor support and attendance at delivery, including the development of a birth plan;
3. Coordination with community-based services, to improve beneficiary outcomes;
4. Visits to provide basic infant care;
5. Accompanying the beneficiary to a clinician visit;
6. Lactation support; and
7. Emotional and physical support.

Limits: Doula services are limited to a total of twelve (12) visits across the perinatal and the postpartum period. Limitations may be exceeded with prior authorization if medically necessary.

**Qualified Provider Specifications:**
Qualified doula providers must be at least 18 years of age, possess a high school diploma or equivalent, and possess a current certification by a doula training program or organization, approved by the District of Columbia Department of Health Care Finance.

II. **Attachment and Biobehavioral Catchup (ABC)** is an evidence-based service that targets key issues among young children who have experienced early maltreatment and/or disruptions in care. Pursuant to 42 C.F.R. Section 440.130(c), ABC is provided as a preventive service and must be recommended by a physician or other licensed practitioner of the healing arts within their scope of practice under state law.

ABC is a home visiting program for infants, toddlers, and parents provided by Parent Coaches. Consistent with EPSDT requirements, comparable services will be made available to Medicaid-eligible individuals under

age twenty-one (21), as necessary. Services are provided for the medical benefit of the child and include counseling and education to help parents: behave in nurturing ways when children are distressed; be able to target and understand children's self-regulatory issues; create secure attachment with the child; and improve child behavioral and biological regulation.

Limitations: eligible beneficiaries are limited to one (1) standard course of ABC sessions per child that would benefit from ABC. The standard length of ABC services are one-hour sessions once a week for ten (10) weeks. Limitations may be exceeded with prior authorization if medically necessary.

**Qualified Provider Specifications:**
Parent Coaches must be at least 18 years of age, possess a high school diploma or equivalent, and possess an active certification from an ABC training program approved by the Department of Health Care Finance.

14. Services for Individuals Age 65 or Older in Institutions for Mental Diseases

a. Inpatient hospital services are limited to services certified as medically necessary by the Quality Improvement Organization.

b. Skilled nursing facility services are limited to services certified as medically necessary by the Quality Improvement Organization.

c. Intermediate care facility services are limited to services certified as medically necessary by the Quality Improvement Organization.

15. Intermediate Care Facility Services

a. Intermediate Care Facility Services (other than such services in an institution for mental diseases) for persons determined in accordance with section 1902(a)(31)(a) of the Act, to be in need of such care are provided with no limitations.

b. Including such services in a public institution (or distinct part thereof) for persons with an Intellectual Disability or related conditions in need of such services are provided with no limitations.

16. Inpatient Psychiatric Facility Services for individuals under 22 years of age are provided with no limitations.

**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. Screening: Initial evaluation to identify clients who are at risk of having BH disorders that warrant immediate attention or intervention, or to identify the need for further assessment.
ii. Initial Assessment: Determination of an individual's need for MHRS or other types of behavioral health treatment or support services.
iii. 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.
iv. 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 Management**

a. Definition: Medication Management 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 Management 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 Management 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, 2) Qualified Practitioners who may provide Medication Management services but not diagnostic services: 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

**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). These services are available twenty-four (24) hours a day, seven (7) days a week.

Community based intervention includes services that: diffuse the current situation to reduce the likelihood of the need for more intensive therapeutic interventions; provide referrals to other social, mental and physical health services; provide mental health service and support interventions that develop and improve the ability of parents, legal guardians, or significant others to provide care; and support transitions of care for consumers beginning or ending CBI.

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

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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

facility). These services are available twenty-four (24) hours a day, seven (7) days a week.

Community based intervention includes services that: diffuse the current situation to reduce the likelihood of the need for more intensive therapeutic interventions; provide referrals to other social, mental and physical health services; provide mental health service and support interventions that develop and improve the ability of parents, legal guardians, or significant others to provide care; and support transitions of care for consumers beginning or ending CBI.

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.

a. Limitations: Authorization is required in accordance with applicable regulations.

b. 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

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of Medicaid services set forth below. DHCF's fee schedule rate was set as of October 1, 2023 and is effective for services provided on or after that date. All rates are published on DHCF's website at https://www.dc-medicaid.com/dcwebportal/nonsecure/feeScheduleDownload.

I. The DHCF fee schedule for dentist and orthodontist services, referenced at subparagraph iii.b. of paragraph 21. Fee-for-Service Providers, was set as of June 1, 2018 and is effective for services provided on or after that date.

II. The DHCF fee schedule for transportation services, referenced at subparagraph iii.l. of paragraph 21. Fee-for-Service Providers, was set as of October 1, 2018 and is effective for services provided on or after that date.

III. The DHCF fee schedule for home health services, referenced at subparagraph iii.h. of paragraph 21. Fee-for-Service Providers, was set as of January 1, 2024 and is effective for services provided on or after that date.

IV. The DHCF fee schedule for medical supplies and equipment services, referenced at subparagraph iii.i. of paragraph 21. Fee-for-Service Providers, was set as of January 1, 2024 and is effective for services provided on or after that date.

V. The DHCF fee schedule for physician services, referenced at subparagraph iii.a. of paragraph 21. Fee-for-Service Providers, was set as of December 1, 2020 and is effective for services provided on or after that date.

VI. The DHCF fee schedule for Independently Licensed Behavioral Health Practitioners, referenced at 3.1-A Independently Licensed Behavioral Health Practitioners, was set as of January 1, 2022 and is effective for services provided on or after that date.

VII. The DHCF fee schedule for Clinic services, referenced at paragraph 9 was set as of February 1, 2024 and is effective for services provided on or after that date.

Doula Services: Reimbursement

Doula services may be reimbursed from the date of confirmed pregnancy through one hundred and eighty (180) days (six months) after the end of a pregnancy, contingent on the client maintaining Medicaid eligibility, and if medically necessary. The District will reimburse up to twelve (12) perinatal and postpartum visits, including attendance at delivery. The twelve (12) visits include a maximum of one (1) doula consultation and can be allocated across the perinatal and postpartum period.

Each perinatal service visit (before, during, and up to six (6) weeks after delivery) shall be billed and reimbursed per visit, regardless of the length of time. Postpartum service visits shall be billed and reimbursed separately as a unit of service and shall be billed in fifteen (15) minute increments and reimbursed at a per-unit rate. A postpartum service visit shall not exceed twenty-four (24) units or six (6) hours per visit.

During the postpartum period, there will be an additional value-based incentive payment made to the Doula if the Doula performs at least one (1) postpartum service visit and the client is seen by an obstetric clinician for one (1) postpartum visit after a labor and delivery claim.

The Agency's fee schedule rates for doula services are set as of October 1, 2022 and are effective for services on or after that date. The rates are the same for both governmental and private providers. All applicable rates are published on the District's website at https://dhcf.dc.gov/page/rates-and-reimbursements. Reimbursement rates shall be adjusted annually based on the Centers for Medicare & Medicaid Services (CMS), Medicare Economic Index (MEI).

Attachment and Biobehavioral Catchup: Reimbursement

Attachment and Biobehavioral Catchup will be reimbursed using an hourly rate. Eligible beneficiaries are limited to one (1) standard course of ABC sessions per child that would benefit from ABC. The standard length of ABC services are one-hour sessions once a week for ten (10) weeks.

The Agency's fee schedule rates for Attachment and Biobehavioral Catchup are set as of February 1, 2024 and are effective for services on or after that date. The rates are the same for both governmental and private providers. All applicable rates are published on the District's website at https://dhcf.dc.gov/page/rates-and-reimbursements. Reimbursement rates shall be adjusted annually based on the Centers for Medicare & Medicaid Services (CMS), Medicare Economic Index (MEI).

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 Management
   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. Psychosocial Rehabilitative Services ("Clubhouse")
   12. 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 February 1, 2024. All rates are published on the state agency's website at 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 the Annual Medicaid Basket Index for the year or analysis of the providers' reported or audited cost. Rates shall be reviewed as needed, beginning January 1, 2025.

D. The reimbursable unit of service for:

   1. Screening, Assessment, and Diagnosis Medication Management and Counseling/Therapy services shall be per occurrence.

   2. Community Support, Crisis/Emergency Services, Clinical Care Coordination, and Community Based Intervention, and Clubhouse shall be fifteen (15) minutes. Separate reimbursement rates shall be established for services eligible to be rendered either off-site or in group settings.

   3. Rehabilitation Day Services shall be one (1) hour.

4. Intensive Day Treatment shall be one (1) day.

5. 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. Medication Management
   6. Recovery Support Services
   7. Methadone Services in Opioid Treatment Programs
   8. 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 February 1, 2024. All rates are published on the state agency's website at www.dc-medicaid.com/dcwebportal/home.

III. Behavioral Health Stabilization Services

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 rates 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 April 1, 2022. All rates are published on the state agency's website at www.dc-medicaid.com/dcwebportal/home. Effective February 1, 2024 rates shall be increased by the Market Basket Medicare Economic Index established by the Centers for Medicare and Medicaid Services.

E. The reimbursable unit of service for the Transition Planning Service shall be one (1) unit per eligible discharge.