

**STATE PLAN FOR MEDICAL ASSISTANCE UNDER
TITLE XIX OF THE SOCIAL SECURITY ACT**

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

- a. Diagnostic Services must be prior authorized.
- b. Screening Services are limited to eligible EPSDT recipients.
- c. Preventive Services must be prior authorized.
- d. Rehabilitative Services are covered for Medicaid eligible individuals who are in need of mental health or substance abuse services due to mental illness, serious emotional disturbance, or substance use disorder. Covered services include: 1) Mental Health Rehabilitation Services and 2) Adult Substance Abuse Rehabilitative Services.

1. **MENTAL HEALTH REHABILITATION SERVICES (“MHRS”)** are provided to all Medicaid eligible individuals who are mentally ill or seriously emotionally disturbed and in need of mental health services; and elect to receive, or have a legally authorized representative select on their behalf, mental health Rehabilitation Option services (“mental health rehabilitation services”). Services include:

- i. Diagnostic/Assessment
- ii. Medication/Somatic Treatment (Individual and Group)
- iii. Counseling (Individual On-Site, Individual Off-Site and Group)
- iv. Community Support (Individual and Group)
- v. Crisis/Emergency
- vi. Day Services
- vii. Intensive Day Treatment
- viii. Community-Based Intervention
- ix. Assertive Community Treatment

Services are intended for maximum reduction of mental disability and restoration of a recipient to his or her best possible functional level. Services are recommended by a physician or a licensed practitioner of the healing arts, and are rendered by, or under the supervision of, Qualified Practitioners in certified community MHRS agencies, in accordance with standards established by the Department of Mental Health (“DMH”) as set forth in the District of Columbia Code of Municipal Regulations. Those standards include, but are not limited to, the following:

- Each MHRS provider shall be certified as a Community MHRS Agency by DMH;
- Each MHRS provider shall demonstrate the administrative and financial management capability to meet District of Columbia and federal requirements;
- Each MHRS provider shall demonstrate the clinical capacity and ability to provide services to individuals needing MHRS;
- Each MHRS provider shall develop policies and procedures for handling routine, urgent and emergency situations, including referral procedures to local emergency departments, staff assignments to cover emergency walk-in hours and on-call arrangements for clinical staff and physicians;

- Each MHRS provider shall maintain individual case records in accordance with District of Columbia and federal requirements;
- Each MHRS provider shall have policies and procedures that require treatment to be provided in accordance with DMH-established service specific standards. Such policies and procedures shall be approved by the DMH;
- Each MHRS provider shall have a well-publicized complaint and grievance system, which includes policies and procedures for handling consumer, family and practitioner complaints and grievances, methods for accessing the District of Columbia's Medicaid fair hearings system, and monitoring of the incidents and appeals resolutions; and
- Each MHRS provider shall promote and demonstrate consumer progress and graduation towards recovery.

Eligible MHRS practitioners, practicing within their scope of licensure or under required supervision, and in DMH-certified Community Mental Health Rehabilitation Service agencies, include:

Qualified Practitioners eligible to diagnose mental illness. Qualified Practitioners eligible to diagnose include board-eligible Psychiatrists, Psychologists, Licensed Independent Clinical Social Workers ("LICSW"), and Advance Practice Registered Nurses ("APRN") with psychiatry as an area of practice, working in a collaborative protocol with a Psychiatrist when providing Diagnostic/Assessment and Medication Somatic Treatment services.

Qualified Practitioners eligible to render MHRS, but who are ineligible to diagnose mental illness, include board-eligible Psychiatrists, Psychologists, LICSWs, APRNs, Registered Nurses ("RN"), Licensed Professional Counselors ("LPC"), Licensed Independent Social Workers ("LISW") and Addiction Counselors.

MHRS may also be rendered by Mental Health Support Specialists who are not Qualified Practitioners but who have been credentialed by an MHRS provider, according to standards set forth by DMH, to perform certain aspects of MHRS under the clinical supervision of a Qualified Practitioner.

Reimbursement for MHRS is not available for:

- Room and board residential costs;
- inpatient services (including hospital, nursing facility, ICF/MR services, and Institutions for Mental Diseases ("IMD") services);
- Transportation services;
- Vocational services;
- School and educational services;
- Services rendered by parents or other family members;
- Socialization services;
- Screening and prevention services (other than those provided under EPSDT requirements);
- Services which are not medically necessary as recommended in an approved Individualized Recovery Plan for adults or an Individualized Plan of Care for children and youth;

- Services which are not provided and documented in accordance with DMH-established MHRS service-specific standards; and
- Services furnished to persons other than the consumer when those services are not directed exclusively to the well-being and benefit of the consumer.

Services and Definitions

1. Diagnostic/Assessment

- A. Definition: A Diagnostic/Assessment is an intensive clinical and functional evaluation of a consumer's mental health condition that results in the issuance of a Diagnostic Assessment Report with recommendation for service delivery that provides the basis for the development of an Individualized Recovery Plan ("IRP") for adults or an Individualized Plan of Care ("IPC") for children and youth. A Diagnostic/Assessment shall determine whether the consumer is appropriate for and can benefit from MHRS, based upon the consumer's diagnosis, presenting problems and recovery goals. The Diagnostic/Assessment shall also evaluate the consumer's level of readiness and motivation to engage in treatment.
- B. Unit of Service: An assessment, which is at least 3 hours in duration, pursuant to criteria set forth in DMH-established billing procedures.
- C. Limitations: One Diagnostic/Assessment is allowed every 6 months. Additional units shall be allowable for periodic assessment and pre-hospitalization screening. If prior authorized by DMH, additional units of Diagnostic/Assessment may be allowable for neuropsychological assessments and re-admission to Intensive Day Treatment services. Diagnostic/Assessment shall not be billed on the same day as Assertive Community Treatment.
- D. Locations/Settings: Community Mental Health Rehabilitation Services Agency, Home or other Community Setting, Residential Facility of sixteen (16) beds or less.
- E. Qualified Practitioners: Psychiatrist, Psychologist, LICSW and APRN, working in a collaborative protocol with a Psychiatrist, (may both diagnose and assess, in accordance with applicable District of Columbia professional licensing laws). RN, LISW, LPC, Addiction Counselor and Mental Health Support Specialist may provide assessment services only, under the supervision of a Qualified Practitioner permitted to diagnose mental illness and to the extent permitted by and in accordance with District of Columbia law.

2. Medication/Somatic Treatment (Individual and Group)

- A. Definition: Medication/Somatic Treatment services are medical interventions including: physical examinations; prescription, supervision or administration of mental health-related medications; monitoring and interpreting results of laboratory diagnostic procedures related to mental health-related medications; and medical interventions needed for effective mental health treatment provided as either an individual or group intervention. Medication/Somatic

Treatment services include monitoring the side effects and interactions of medications and the adverse reactions a consumer may experience, and providing education and direction for symptom and medication self-management. Group Medication/Somatic Treatment shall be therapeutic, educational and interactive with a strong emphasis on group member selection, facilitated therapeutic peer interaction and support.

- B. Unit of Service: Fifteen (15) minutes, pursuant to criteria set forth in DMH-established billing procedures.
- C. Limitations: No annual limits. Medication/Somatic Treatment shall not be billed on the same day as Assertive Community Treatment.
- D. Locations/Settings: DMH certified Community Mental Health Rehabilitation Services Agency, Home or other Community Setting, Residential Facility of sixteen (16) beds or less.
- E. Qualified Practitioners: Psychiatrist and APRN working in a collaborative protocol with a Psychiatrist. RN may provide Medication Somatic Treatment services to the extent permitted by and in accordance with District of Columbia law.

3. Counseling (Individual On-Site, Individual Off-Site and Group)

- A. Definition: Counseling services are individual, group or family face-to-face services for symptom and behavior management; development, restoration or enhancement of adaptive behaviors and skills; and enhancement or maintenance of daily living skills. Adaptive behaviors and skills and daily living skills include those skills necessary to access community resources and support systems, interpersonal skills and restoration or enhancement of the family unit and/or support of the family. Mental health support and consultation services provided to consumers' families are reimbursable only when such services and supports are directed exclusively to the well-being and benefit of the consumer.
- B. Unit of Service: Fifteen (15) minutes, pursuant to criteria set forth in DMH-established billing procedures.
- C. Limitations:
 - i. Prior authorization is required after 160 units.
 - ii. Counseling shall not be billed on the same day as Day Services, intensive Day Treatment, Community-Based Intervention, or Assertive Community Treatment.
- D. Locations/Settings: DM1-I certified Community Mental Health Rehabilitation Services Agency, Home or other Community Setting, Residential Facility of sixteen (16) beds or less.
- E. Qualified Practitioners: Psychiatrist, Psychologist, LICSW, LISW, LPC, APRN, RN, Addiction Counselor. Licensed Graduate Social Workers may provide Counseling services under the supervision of an LICSW or LISW, to the extent permitted by and in accordance with District of Columbia law. Mental Health Support Specialists may provide Counseling

under the supervision of a Qualified Practitioner, to the extent permitted by and in accordance with District of Columbia law.

4. **Community Support (Individual and Group)**

- A. **Definition:** Community Support services are rehabilitation supports considered essential to assist the consumer in achieving rehabilitation and recovery goals. Community Support services focus on building and maintaining a therapeutic relationship with the consumer. Community Support activities include (1) participation in the development and implementation of a consumer's IRP/IPC and Community Support Individualized Service Specific Plan ("ISSP"); (2) assistance and support for the consumer in stressor situations; (3) mental health education, support and consultation to consumers' families and/or their support system, which is directed exclusively to the well-being and benefit of the consumer; (4) individual mental health service and support intervention for the development of interpersonal and community coping skills, including adapting to home, school and work environments; (5) assisting the consumer in symptom self-monitoring and self-management for the identification and minimization of the negative effects of psychiatric symptoms which interfere with the consumer's daily living, financial management, personal development or school or work performance; (6) assistance to the consumer in increasing social support skills and networks that ameliorate life stresses resulting from the consumer's mental illness or emotional disturbance and are necessary to enable and maintain the consumer's independent living; (7) developing strategies and supportive mental health interventions for avoiding out-of-home placement for adults, children and youth and building stronger family support skills and knowledge of the adult, child or youth's strengths and limitations and (8) developing mental health relapse prevention strategies and plans.
3. **Unit of Service:** Fifteen (15) minutes, pursuant to criteria set forth in DMH-established billing procedures.
- C. **Limitations:**
- i. No annual limits.
 - ii. Community Support shall not be billed on the same day as Assertive Community Treatment.
- D. **Locations/Settings:** DMH certified Community Mental Health Rehabilitation Services Agency, Home or other Community Setting, Residential Facility of sixteen (16) beds or less.
- E. **Qualified Practitioners:** Psychiatrist, Psychologist, LICSW, LISW, LPC, APRN, RN, and Addiction Counselor. Mental Health Support Specialists may provide Community Support under the supervision of a Qualified Practitioner, to the extent permitted by and in accordance with District of Columbia law.

5. Crisis/Emergency

- A. Definition: Crisis/Emergency is a face-to-face or telephone immediate response to an emergency situation involving a consumer with mental illness or emotional disturbance that is available twenty-four (24) hours per day, seven (7) days per week. Crisis/Emergency services are provided to consumers involved in an active mental health crisis and consist of immediate response to evaluate and screen the presenting mental health situation, assist in immediate crisis stabilization and resolution and ensure the consumer's access to mental health care at the appropriate level. Crisis/Emergency services may be delivered in natural settings and the Crisis/Emergency provider shall adjust its staffing to meet the requirements for immediate response. Each Crisis/Emergency provider shall obtain consultation, locate other mental health rehabilitation services and resources, and provide written and oral information to assist the consumer in obtaining follow-up mental health rehabilitation services. Each Crisis/Emergency provider shall also be a DM1-I-certified provider of Diagnostic/Assessment or have an agreement with a Core Services Agency or a Core Services Agency's affiliated Subprovider to assure the provision of necessary hospital pre-admission screening.
 - B. Unit of Service: Fifteen (15) minutes, pursuant to criteria set forth in DMH-established billing procedures.
 - C. Limitations: No annual limits.
 - D. Locations/Settings: DMH certified Community Mental Health Rehabilitation Services Agency, Home or other Community Setting.
3. Qualified Practitioners: Psychiatrist, Psychologist, LICSW and APRN. LISWs, LPCs, RNs, Addiction Counselors, Mental Health Support Specialists may provide Crisis/Emergency under the supervision of a Qualified Practitioner to the extent permitted by and in accordance with District of Columbia law.

6. Day Services

- A. Definition: Day Services is a structured clinical program intended to develop skills and foster social role integration through a range of social, psychoeducational, behavioral and cognitive mental health interventions. Day Services are rendered only in the setting of a DMH-certified Community Mental Health Rehabilitation Services Agency and are not eligible for reimbursement when provided in the home, community setting or any residential facility. Day Services are curriculum-driven and psychoeducational and assist the consumer in the retention or restoration of community living, socialization and adaptive skills. Day Services include cognitive-behavioral interventions and diagnostic, psychiatric, rehabilitative, psychosocial, counseling and adjunctive treatment. Day Services are offered most often in group settings, and may be provided individually.

Day Services shall facilitate the development of a consumer's independent living and social skills, including the ability to make decisions regarding: self care, management of illness, life, work and community participation. The services promote the use of resources to integrate the consumer into the community.

Day Services shall be founded on the principles of consumer choice and the active involvement of persons in their mental health recovery and provide both formal and informal structures through which consumers can influence and shape service development.

Day Services shall include education on self-management of symptoms, medications and side effects; identification of rehabilitation preferences; setting rehabilitation goals; and skills teaching and development.

- B. Unit of Service: One day (consumer's participation shall consist of at least three (3) hours), pursuant to criteria set forth in DMH-established billing procedures.
- C. Limitations:
 - i. Prior authorization is required for more than ninety (90) days of Day Services within a twelve (12) month period.
 - ii. Day Services may not be billed during a Community Support or Counseling encounter. Day Services may not be billed on the same day as Assertive Community Treatment.
- D. Location/Setting: DMH Certified Community Mental Health Rehabilitation Services Agency
- E. Qualified Practitioners: Psychiatrist, Psychologist, LICSW, LISW, LPC, APRN, RN and Addiction Counselor. Mental Health Support Specialists may provide Day Services under the supervision of a Qualified Practitioner to the extent permitted by and in accordance with District of Columbia law.

7. Intensive Day Treatment

- A. Definition: Intensive Day Treatment is a structured, intensive and coordinated acute treatment program that serves as an alternative to acute inpatient treatment or as a step-down service from inpatient care, rendered by a inter-disciplinary team to provide stabilization of psychiatric impairments. Intensive Day Treatment services are rendered only in the setting of a DMH-certified Community Mental Health Rehabilitation Services Agency and are not eligible for reimbursement when provided in the home, community setting or any residential facility. Intensive Day Treatment shall be time-limited and provided in an ambulatory setting for no less than five hours a day, seven days a week. Daily physician and nursing services are essential components of this service.

Intensive Day Treatment offers short-term, day programming consisting of therapeutically intensive, acute and active treatment. The Intensive Day Treatment provider shall provide services that closely resemble the intensity and comprehensiveness of inpatient services. Intensive Day Treatment shall include psychiatric, medical, nursing, social work, medication and somatic treatment and psychology services

focusing on timely crisis intervention and psychiatric stabilization so that consumers can return to their normal daily lives. Intensive Day Treatment services shall only be provided to consumers who are not at danger but have behavioral health issues that are incapacitating and interfering with their ability to carry out daily activities.

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

- B. Unit of Service: One day (consumer participation shall consist of at least five (5) hours), pursuant to criteria set forth in DMH-established billing procedures.
- C. Limitations
 - i. Prior authorization is required after seven (7) days or for the second and any additional episodes of care within a twelve (12) month period.
 - ii. Shall not be billed on the same day as any other service, except for Crisis/Emergency, Community Support or Community Based Intervention. Additional units of Diagnostic/Assessment may be billed for each additional episode of care, with prior authorization from DMH, when Diagnostic/Assessment pre-hospital screening occurs for purposes of determining re-admission to Intensive Day Treatment services.
- D. Location/Setting: DM11 Certified Community Mental Health Rehabilitation Services Agency.
- E. Qualified Practitioners: Psychiatrist, Psychologist, LICSW, LISW, LPC, APRN, RN and Addiction Counselor. Mental Health Support Specialists may provide Intensive Day Treatment services under the supervision of a Qualified Practitioner to the extent permitted by and in accordance with District of Columbia law.

8. Community-Based Intervention

- A. Definition: Community-Based Intervention services are time-limited intensive mental health intervention services delivered to children, youth and adults and intended to prevent the utilization of an out-of-home therapeutic resource by the consumer (i.e., psychiatric hospital or residential treatment facility). Community-Based Intervention is primarily focused on the development of consumer skills and is delivered in the family setting in order for the consumer to function in a family environment. These services are available twenty-four hours a day, seven days a week. The basic goals of Community-Based Intervention services are to: 1) diffuse the current situation to reduce the likelihood of a recurrence, which

if not addressed could result in the use of more intensive therapeutic interventions; 2) coordinate access to covered mental health services; 3) provide mental health service and support interventions for consumers that develop and improve the ability of parents, legal guardians or significant others to care for the person with mental illness or emotional disturbance. Community-Based Intervention services shall be multi-faceted in nature and include situation management, environmental assessment, interventions to improve consumer and family interaction, skills training, self and family management, and coordination and linkage with covered mental health rehabilitation services and supports and other covered Medicaid services in order to prevent the utilization of more restrictive residential treatment. Community-Based Intervention services shall be delivered primarily in natural settings and shall include in-home services. In-home services regarding medications and behavior management skills; dealing with the responses of the consumer, other caregivers and family members; and coordinating with other mental health rehabilitation treatment providers include support and consultation to the consumer's families and/or their support system, which is directed exclusively to the well-being and benefit of the consumer.

- B. Unit of Service: Fifteen (15) minutes, pursuant to criteria set forth in DMH-established billing procedures.
- C. Limitations: Prior authorization is required for enrollment. Shall not bill Community-Based Intervention and Assertive Community Treatment, Counseling or Intensive Day Treatment on the same day.
- D. Location/Setting: DMH certified Community Mental Health Rehabilitation Services Agency, Home or other Community Setting.
- E. Qualified Practitioners: Qualified Practitioners: Psychiatrist, Psychologist, LICSW, LISW, LPC, APRN, RN and Addiction Counselor. Mental Health Support Specialists may provide Community-Based Intervention services under the supervision of a Qualified Practitioner to the extent permitted by and in accordance with District of Columbia law.

9. Assertive Community Treatment

- A. Definition: Assertive Community Treatment (ACT) is an intensive integrated rehabilitative, crisis, treatment and mental health rehabilitative community support provided by an interdisciplinary team to children and youth with serious emotional disturbance and to adults with serious and persistent mental illness. ACT services are provided to consumers in accordance with the IRP/IPC with dedicated staff time and specific staff to consumer ratios. Service coverage by the ACT Team is required twenty-four (24) hours per day, seven (7) days per week. The consumer's ACT Team shall complete a comprehensive or supplemental assessment and develop a self care-oriented Individualized Service Specific Plan (ISSP) (if a current and effective one does not already exist). Services offered by the ACT team shall include: (1) mental health-related medication prescription, administration and monitoring; (2) crisis assessment and intervention; (3) symptom assessment, management and individual supportive therapy; (4) substance abuse treatment for consumers with a co-occurring addictive disorder; (5) psychosocial rehabilitation and

addictive disorder; (5) psychosocial rehabilitation and skill development; (6) interpersonal social and interpersonal skill training; and (7) education, support and consultation to consumers' families and/or their support system, which is directed exclusively to the well-being and benefit of the consumer.

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

- B. Unit of Service: Fifteen (15) minutes, pursuant to criteria set forth in DMH-established billings procedures.
- C. Limitations: Prior authorization is required for enrollment; ACT shall not be billed on the same day as any other service, except for Crisis/Emergency for which retrospective authorization is required.
- D. Locations/Settings: DMH certified Community Mental Health Rehabilitation Services Agency, Home or other Community Setting.
- E. Qualified Practitioners: Psychiatrist, RN and Addiction Counselor. Mental Health Support Specialists may provide Assertive Community Treatment services under the supervision of a Qualified Practitioner to the extent permitted by and in accordance with District of Columbia law.

10. Child-Parent Psychotherapy for Family Violence

- A. Definition: Child-Parent Psychotherapy for Family Violence (CPP-FV) is a relationship-based treatment intervention to address children's exposure to trauma or maltreatment. CPP-FV sessions are conjoint with the child's parent(s) or caregiver(s) focusing on improving the child's development trajectory. CPP-FV helps restore developmental functioning in the wake of violence and trauma by focusing on restoring the attachment relationship that was negatively affected by trauma. CPP-FV is geared toward young children, ages zero (0) through six (6), who suffer from traumatic stress and often have difficulty regulating their behaviors and emotions during distress. These children may be easily frightened, difficult to console, aggressive, impulsive, or exhibit fearfulness of new situations. These children may also have difficulty sleeping, fail to maintain recently acquired developmental skills, and show regression in functioning and

behavior. Consistent with EPSDT requirements, CPP-FV services are available to individuals over age six (6) and under age twenty-one (21) who meet the clinical criteria for coverage under the CPP-FV MHRS program and also meet the criteria for program enrollment, but for their age.

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

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

- B. Unit of Service: One (1) unit of service shall be one (1) fifteen (15) minute increment. A typical CPP-FV service session shall be sixty (60) to ninety (90) minutes, one (1) time per week, for a period of fifty-two (52) weeks, based on medical need, and may be exceeded with authorization. CPP-FV sessions are longer in the first six (6) months of treatment (i.e., ninety (90) minutes) and decrease over time (i.e., to sixty (60) minutes), as the child improves his/her coping skills.
- C. Limitations: CPP-FV services shall not exceed two hundred and sixty (260) unless the Department of Behavioral Health (DBH) prior authorizes the service in accordance with the established medical necessity criteria.
- D. Locations/Settings: Natural settings including birth family home; child's home; adoptive home; foster home; or other community setting. Mental Health Rehabilitation Services (MHRS) provider service site. Community-based group home facility of sixteen (16) beds or fewer; or other community setting.
- E. Qualified Practitioner: Psychiatrist, Psychologist, Licensed Independent Clinical Social Worker (LICSW), Advanced Practice Registered Nurse (APRN), Registered Nurse (RN), or Licensed Professional Counselor (LPC).

11. Trauma-Focused Cognitive-Behavioral Therapy

A. Definition: Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) is a psychotherapeutic intervention designed to address significant emotional and behavioral difficulties related to traumatic life events. TF-CBT sessions focus on addressing the child's posttraumatic stress disorder, depression, anxiety, externalizing behaviors, sexualized behaviors, feelings of shame, and mistrust. – TF-CBT also provides parents or caregivers with the tools needed to reinforce the content covered with the child between sessions and after treatment has ended. Consistent with EPSDT requirements, TF-CBT services are available to individuals under age four (4) and through ages eighteen (18) to twenty (20) who meet the clinical criteria for coverage under the TF-CBT MHRS program and also meet the criteria for program enrollment, but for their age.

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

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

B. Unit of Service: One (1) unit of service shall be one (1) fifteen (15) minute increment. A typical course of TF-CBT treatment requires children to participate in sixty (60) to ninety (90) minute individual and joint child/parent/caregiver sessions, one (1) time per week, over an average period of twelve (12) to sixteen (16) weeks in accordance with the evidence-based practice requirements and medical necessity criteria, and may be exceeded with authorization.

C. Limitations: TF-CBT services shall not exceed one hundred and sixty (160) unless DBH prior authorizes the service in accordance with the established medical necessity criteria. TF-CBT shall not be billed on the same day as Rehabilitation/Day services, Intensive Day Treatment, CBI, ACT; or Other Counseling Services.

- D. Locations/Settings: Natural settings that include child's home, foster home, or other community setting including a clinic or MHRS provider service site or community-based group home facility of sixteen (16) beds or fewer.
- E. Qualified Practitioners: Psychiatrist, Psychologist, LICSW, APRN, RN, and LPCs. Qualified providers of TF-CBT shall be certified in TF-CBT and licensed by the District or another state.

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2. **ADULT SUBSTANCE ABUSE REHABILITATIVE SERVICES (“ASARS”)** are available to Medicaid eligible individuals who elect to receive, have legally authorized representatives select on their behalf, or are otherwise legally obligated to seek medically necessary treatment for Substance Use Disorder (“SUD”). SUD is comprised of: 1) Substance Abuse and 2) Substance Dependence.

Substance Abuse is a maladaptive pattern of substance use, including alcohol, illicit drugs, and pharmaceuticals. Substance Abuse is manifested by recurrent and significant adverse consequences, including: 1) failure to fulfill obligations; 2) repeatedly subjecting one’s self to physical hazards; 3) multiple legal problems; and 4) social and interpersonal issues. A Substance Abuse diagnosis requires a beneficiary to have had persistent, substance-related problem(s) within a 12-month period.

Substance Dependence is a cluster of cognitive, behavioral, and physiological symptoms that indicate persistent use of a substance. Substance Dependence is manifested by a repeated pattern of self-administration of substances that results in physical tolerance, withdrawal symptoms, and compulsive substance consumption. A diagnosis of Substance Dependence requires a beneficiary to have had persistent, substance-related problem(s) within a 12-month period.

ASARS are intended to reduce or ameliorate both forms of SUD through therapeutic interventions that assist a beneficiary to restore maximum functionality. ASARS treatment includes the following services:

- i. Assessment/Diagnostic
- ii. Clinical Care Coordination
- iii. Crisis Intervention
- iv. Substance Abuse Counseling
- v. Medically Managed Intensive Inpatient Detoxification
- vi. Medication Management
- vii. Medication Assisted Treatment

ASARS PROGRAM ASSURANCES

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

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

A facility where residential ASARS treatment is delivered shall be limited to having sixteen (16) beds or less, and be sufficiently geographically disparate as to not be considered an institution for mental diseases (“IMD”).

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ASARS PROGRAM EXCLUSIONS

Medicaid Reimbursement for ASARS treatment is not available for the following:

- Treatment for inmates in public institutions, as defined in 42 C.F.R. § 435.1010;
- Services provided in nursing facilities, ICFs/ID, and IMDs;
- Room, board, and transportation costs;
- Services delivered as a component of human subjects research and/or clinical trials;
- Educational, vocational and job training services;
- Services rendered by parents or other family members;
- Legal services;
- Strictly social or recreational services;
- Services covered elsewhere in the District’s State Plan, including habilitative and mental health rehabilitative services; and
- Services which are not medically necessary.

ASARS PROVIDER QUALIFICATIONS

In accordance with 42 C.F.R. § 440.130(d), ASARS shall be recommended by qualified physicians or other practitioners of the healing arts who are qualified to deliver substance abuse treatment services as defined by the scope of practice in the state in which the individual is licensed.

Qualified practitioners *eligible to diagnose SUD* include: Qualified Physicians; Psychologists; Licensed Independent Clinical Social Workers (“LICSWs”); and Advanced Practice Registered Nurses (“APRNs”) when working collaboratively with a Physician to provide Assessment/Diagnostic services.

Qualified practitioners *eligible to deliver non-diagnostic ASARS services* include: Qualified Physicians; Psychologists; LICSWs; APRNs; Licensed Independent Social Workers (“LISWs”); Licensed Professional Counselors (“LPCs”); and Certified Addiction Counselors (“CACs I and II”).

Licensed Professional Counselors (“LPCs”) shall be licensed by the District of Columbia Department of Health (“DOH”), pursuant to Chapter 66 of Title 17 of the District of Columbia Municipal Regulations (“DCMR”).

Certified Addiction Counselors (“CACs I and II”) shall be licensed by DOH, pursuant to Chapter 87 of Title 17 DCMR.

- Licensure requirements for CACs include educational and experiential components, as well as certification by the National Association of Alcohol and Drug Abuse Counselors – National Certification Commission (“NAADAC-NCC”).
- Supervisory CACs shall be advanced practice addiction counselors, LPCs, clinical psychologists, clinical social workers, marriage and family therapists, physicians, or registered nurses; and hold one of the following: 1) current CAC II certification in substance abuse counseling; 2) certification through the NAADAC-NCC or National Board of Certified Counselors (“NBCC”); or 3) have documentation of a minimum of one (1) year of experience in substance abuse counseling and at least one hundred (100) hours of didactic training.

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ASARS FACILITIES/PROGRAM REQUIREMENTS

In accordance with § 2331.4 of Title 29 DCMR, all substance abuse treatment facilities and programs shall be enrolled as Medicaid providers in order to be eligible for reimbursement.

The DOH Addiction Prevention and Recovery Administration (“APRA”) is the state agency responsible for regulating and certifying substance abuse treatment facilities and programs. ASARS shall be delivered in substance abuse treatment facilities and programs that are APRA-certified in one or more of the following categories:

- Non-hospital Inpatient Detoxification, as defined in § 2399 of Title 29 DCMR, and subject to ASARS Program Exclusions described above;
- Non-hospital Residential Treatment;
- Intensive Outpatient Treatment;
- Narcotic/Opioid Outpatient Treatment; and/or
- Outpatient Treatment

Non-hospital facilities and programs delivering ASARS to Medicaid beneficiaries shall be subject to both DHCF and APRA policies, which include, but are not limited to, maintaining standards for:

- Administrative operations in areas such as: practice ethics; quality improvement; policies and procedures; relationships with external entities and contractors; health and safety management; patient rights and privileges;
- Clinical operations in areas such as: levels of patient care standards; intake and screening; rehabilitation/treatment planning; crisis intervention; clinical emergencies; referrals; staff development;
- Protection of patient rights and privileges, including a well-publicized complaint/grievance system; and
- Space, staffing, and financial management, including one (1) mandatory cardiopulmonary resuscitation (“CPR”) certified staff member to be present during all hours of operation.

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ASARS: TREATMENT FRAMEWORK

The treatment framework for ASARS is based on four (4) levels of care established by the American Society for Addiction Medicine (“ASAM”). A typical course of treatment anticipates continuity of services across multiple levels of care, and assumes two factors: 1) that a beneficiary enters treatment at the level of care most consistent with the presenting needs and 2) that subsequent authorizations include all lower levels of care in a graduated fashion.

Delivery of ASARS is based on the treatment episode. The treatment episode is the period between a beneficiary’s admission to treatment for SUD and the termination or discharge from services prescribed in the rehabilitation (or treatment) plan, as defined in D.C. Official Code § 7-3002(10). A single treatment episode may include multiple levels of care, subject to the limitations described in “ASARS: Descriptions of Services”.

The average lengths of treatment episodes at each level of care are as follows:

- A. **Level IV:** From three (3) to five (5) days (i.e., Medically Managed Intensive Inpatient Detoxification)
- B. **Level III:** Approximately twenty-eight (28) days (i.e., Residential Substance Abuse Treatment)
- C. **Level II:** Thirty (30) to forty-five (45) days
- D. **Level I:** Approximately one hundred twenty (120) days (excluding Medication Assisted Treatment)

A course of ASARS treatment incorporates interdisciplinary approaches to rehabilitation (treatment) plan development, excluding mental health services. Comprehensive clinical care coordination (CCC) services are intended to improve outcomes by linking a beneficiary to health, medical, and social services that aid addiction recovery.

Due to the chronic nature of SUD, a beneficiary may relapse during a 12-month period after having already completed one (1) full course of treatment (i.e., at least two (2) of the above levels of care). ASARS treatment is organized to allow a beneficiary to access a second course of treatment, in addition to services related to higher levels of care, if relapse occurs. Prior authorization from DHCF is required if relapse requires a beneficiary to repeat treatment in a level of care that was previously received in the same 12-month period.

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ASARS: DESCRIPTIONS OF SERVICES

- i. **Assessment/Diagnostic** services represent initial evaluation, as well as initial and ongoing collection of relevant information about a beneficiary who may require access to ASARS treatment. The assessment instrument shall incorporate ASAM patient placement criteria.

An Assessment/Diagnostic may be 1) Initial; 2) Comprehensive; 3) Ongoing; or 4) Brief. Initial, Comprehensive, and Ongoing Assessment/Diagnostic services include the development and refinement of treatment plans in addition to providing referrals. Brief Assessment/Diagnostic may be used for minor updates to a beneficiary's diagnosis or treatment plan prior to transfer into a different level of care as indicated by progress with ASARS treatment. Brief Assessment/Diagnostic may also be used as a pre-screening for hospitalization and prior to a beneficiary's discharge from ASARS treatment. Initial and Comprehensive Assessment/Diagnostic shall be performed once per treatment episode. Clinical Care Coordinators shall determine the frequency of Ongoing and Brief Assessment/Diagnostic services.

- A. **Unit of Service**: A unit of service is one 15-minute increment, pursuant to billing criteria established by DHCF
- B. **Limitations**: Additional units require prior authorization from DHCF, obtained by submitting a request through APRA. Limitations for Assessment/Diagnostic services, per treatment episode, are as follows:
1. *Initial Assessment/Diagnostic services* are required to determine an individual's need for substance abuse treatment, and shall not exceed four (4) units;
 2. *Comprehensive Assessment/Diagnostic services* are required in order to initiate a treatment episode, and shall not exceed sixteen (16) units;
 3. *Ongoing Assessment/Diagnostic services* shall not exceed ninety-two (92) units; and
 4. *Brief Assessment/Diagnostic services* shall not exceed eight (8) units.
- C. **Location/Setting**: APRA-certified substance abuse treatment facilities/programs
- D. **Qualified Practitioners**: Assessment/Diagnostic services may be provided by qualified practitioners as follows:
1. *Initial Assessment/Diagnostic services* shall be provided by the following: Qualified RNs, LISWs, LPCs, and CACs I and II.
 2. *Comprehensive, Ongoing, and Brief Assessment/Diagnostic services* shall be provided by the following: Qualified Physicians, Psychologists, LICSWs and APRNs.

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- ii. **Clinical Care Coordination (“CCC”)** is the initial and ongoing process of identifying, planning, coordinating, implementing, monitoring, and evaluating options and services to best meet a beneficiary’s health needs during ASARS treatment. CCC focuses on linking beneficiaries across the levels of care indicated in the treatment plan, and is intended to facilitate specified outcomes that will restore a beneficiary’s functional status in the community. CCC includes the identification of interventions that are consistent with the diagnosis, and monitoring compliance with appointments and participation in activities defined in the treatment plan.

Each Medicaid beneficiary receiving ASARS treatment shall be assigned a Clinical Care Coordinator. Clinical Care Coordinators are required to participate in a beneficiary’s interdisciplinary team meetings in order to identify opportunities to further develop and/or update the treatment plan.

- A. **Unit of Service:** A unit of service is one 15-minute increment, pursuant to billing criteria established by DHCF
- B. **Limitations:** Limitations for CCC, per treatment episode, are as follows:
1. **Level IV:** Sixteen (16) units;
 2. **Level III:** Sixty-four (64) units;
 3. **Level II:** Ninety-six (96) units;
 4. **Level I:** One-hundred ninety two (192) units
Beneficiaries at level I and receiving long-term Medication Assisted Treatment (MAT) (methadone/buprenorphine) are allowed an additional sixteen (16) units during a treatment episode.
- C. **Location/Setting:** APRA-certified substance abuse treatment facilities/programs or community-based setting otherwise approved or designated by APRA
- D. **Qualified Practitioners:** Qualified substance abuse counselors, limited to: Qualified Physicians, Psychologists, LICSWs, APRNs, RNs, LISWs, LPCs, and CACs II.

Clinical Care Coordinators, except Qualified Physicians and Psychologists, shall provide CCC under the supervision of the following practitioners: 1) LICSW; 2) APRN or RN certified in chemical dependency; 3) a supervisory CAC II; or 4) an individual with a Bachelor’s degree from an accredited college or university in social work, counseling, psychology, or a closely related field, and at least two (2) full years of experience.

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iii. **Crisis Intervention** is an immediate, short-term substance abuse treatment approach that is intended to assist a beneficiary to resolve a personal crisis. Crises are events that significantly jeopardize treatment, recovery progress, health, and/or safety.

- A. **Unit of Service**: A unit of service is one 15-minute increment, pursuant to billing criteria established by DHCF
- B. **Limitations**: Allowable units per 12-month period are based on the following level of care structure:
 - 1. **Level IV**: Thirty-two (32) units;
 - 2. **Level III**: One hundred sixty (160) units;
 - 3. **Level II**: One hundred twenty (120) units;
 - 4. **Level I**: Eighty (80) units
- C. **Location/Setting**: APRA-certified substance abuse treatment facilities/programs and community-based setting otherwise approved or designated by APRA
- D. **Qualified Practitioners**: Qualified substance abuse counselors, including: Qualified Physicians, Psychologists, LICSWs, APRNs, RNs, LISWs, LPCs, and CACs I and II

iv. **Medically Managed Intensive Inpatient Detoxification (“MMIID”), or Level IV Care**, is 24-hour, medically directed evaluation and withdrawal management. The service is for beneficiaries with sufficiently severe signs and symptoms of withdrawal from psychoactive substances such that primary medical and nursing care services are necessary.

Beneficiaries discharged from MMIID treatment shall be directly admitted into a residential substance abuse program through a “bed-to-bed” transfer unless APRA previously authorized an exception, or the client refuses admission to a residential program.

- A. **Unit of Service**: A unit of service is equivalent to one (1) day as an inpatient
- B. **Limitations**: An MMIID stay shall not exceed five (5) days without prior authorization from DHCF. The maximum for MMIID services is ten (10) units per treatment episode. Additional units shall be requested through APRA and prior authorized by DHCF.
- C. **Location/Setting**: Free-standing, non-hospital, APRA-certified substance abuse treatment facilities/programs meeting the standards for medical detoxification personnel, as set forth in § 2364 of Title 29 DCMR.
- D. **Qualified Practitioners**:
 - 1. Licensed Physicians; or
 - 2. Psychologists, RNs, LICSWs, APRNs, LPCs, or CACs II under the direction and supervision of a Qualified Physician and in accordance with applicable District of Columbia professional licensing laws

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- v. **Substance Abuse Counseling (Individual, Group, and Family)** is a face-to-face, interactive process conducted in individual, group, or family settings and focused on assisting a beneficiary who is manifesting SUD.

The aim of Substance Abuse Counseling is to cultivate the awareness, skills, and supports to facilitate long-term recovery from substance abuse. Substance Abuse Counseling addresses the specific issues identified in a treatment plan. Substance Abuse Counseling shall be conducted in accordance with the requirements established in 29 DCMR §§ 2340, 2341, and 2343 as follows:

Individual Substance Abuse Counseling is face-to-face interaction with a beneficiary for the purpose of assessment or supporting the patient's recovery. 29 DCMR § 2340

Group Substance Abuse Counseling facilitates disclosure of issues that permit generalization to a larger group; promotes help-seeking and supportive behaviors; encourages productive and positive interpersonal communication; and develops motivation through peer pressure, structured confrontation and constructive feedback. 29 DCMR § 2341

Family Substance Abuse Counseling is planned, goal-oriented therapeutic interaction between a qualified practitioner, the beneficiary, and his or her family. A family member is an individual who lives in the same household as the beneficiary and has a significant relationship with him/her. 29 DCMR § 2343

- A. **Unit of Service**: A unit of service is one 15-minute increment, pursuant to billing criteria established by DHCF
- B. **Limitations**: Substance Abuse Counseling shall not be provided in conjunction with Medication Management. Group and Family Counseling services shall be directed exclusively toward the recovery of a Medicaid beneficiary enrolled in ASARS treatment. Limitations for Substance Abuse Counseling, per treatment episode, are as follows:
1. **Level IV**: *Individual*: Not to exceed twenty (20) units; *Group*: Not to exceed twelve (12) units; *Family*: Not to exceed four (4) units
 2. **Level III**: *Individual*: Not to exceed thirty-two (32) units; *Group*: Not to exceed eight hundred ninety-six (896) units; *Family*: Not to exceed sixteen (16) units
 3. **Level II**: *Individual*: Not to exceed twenty-four (24) units; *Group*: Not to exceed two hundred sixteen (216) units; *Family*: Not to exceed twenty-four (24) units
 4. **Level I** (Beneficiaries also receiving methadone maintenance or buprenorphine): *Individual*: Not to exceed forty-eight (48) units; *Group*: Not to exceed one hundred ninety-two (192) units; *Family*: Not to exceed twelve (12) units
 5. **Level I**: *Individual*: Not to exceed thirty-two (32) units; *Group*: Not to exceed three hundred eighty-four (384) units; *Family*: Not to exceed sixteen (16) units

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Additional allowances for Substance Abuse Counseling services shall be established by the Clinical Care Coordinator, subject to the beneficiary's level of care.

- C. **Location/Setting:** APRA-certified substance abuse treatment facilities/programs; community-based setting otherwise approved or designated by APRA; and private practices with qualified practitioners authorized to provide substance abuse counseling according to their licensure pursuant to the District of Columbia Health Occupations Revision Act of 1985, effective March 25, 1986 (D.C. Law 6-99; D.C. Official Code § 3-1201.01 *et seq.*)
- D. **Qualified Practitioners:** Substance abuse counselors, including: Qualified Physicians, Psychologists, LICSWs, APRNs, RNs, LISWs, LPCs, and CACs I and II
- vi. **Medication Management** is the coordination and evaluation of medications consumed by beneficiaries. It includes monitoring of potential side effects, drug interactions, compliance with doses, and efficacy of medications. Medication Management includes the evaluation of a patient's need for MAT, the provision of prescriptions, and ongoing medical monitoring/evaluation related to the use of the psychoactive drugs.
- A. **Unit of Service:** A unit of service is one 15-minute increment, pursuant to billing criteria established by DHCF
- B. **Limitations:** Medication Management shall not be conducted in conjunction with Substance Abuse Counseling. The maximum for Medication Management is ninety-six (96) units per treatment episode.
- C. **Location/Setting:** Substance abuse treatment facility program certified by APRA; or community-based setting otherwise approved or designated by APRA; private practice offices of individuals authorized to provide medication management services according to their licensure pursuant to the District of Columbia Health Occupations Revision Act of 1985, effective March 25, 1986 (D.C. Law 6-99; D.C. Official Code § 3-1201.01 *et seq.*)
- D. **Qualified Practitioners:** Licensed practitioners, including: Qualified Physicians or APRNs and PAs who are supervised by qualified physicians
- vii. **Medication Assisted Treatment ("MAT")** is the use of pharmacotherapy as long-term treatment for opiate or other forms of dependence. MAT includes medication dosing used in conjunction with Substance Abuse Counseling. Beneficiaries enrolled in MAT shall also be enrolled in Substance Abuse Counseling. MAT is described in Supplement 1 to Attachment 3.1-A, page 20.