

DEPARTMENT OF HEALTH CARE FINANCE

NOTICE OF THIRD EMERGENCY AND PROPOSED RULEMAKING

The Director of the Department of Health Care Finance (DHCF), pursuant to the authority set forth in An Act to enable the District of Columbia (District) to receive federal financial assistance under Title XIX of the Social Security Act for a medical assistance program, and for other purposes approved December 27, 1967 (81 Stat. 744; D.C. Official Code § 1-307.02 (2016 Repl. & 2019 Supp.)) and Section 6(6) of the Department of Health Care Finance Establishment Act of 2007, effective February 27, 2008 (D.C. Law 17-109; D.C. Official Code § 7-771.05(6) (2018 Repl.)), hereby gives notice of the adoption, on an emergency basis, of a new Chapter 86 (Behavioral Health Transformation Demonstration Program) of Title 29 (Public Welfare) of the District of Columbia Municipal Regulations (DCMR).

This third emergency and proposed rulemaking sets forth requirements governing beneficiary eligibility, provider participation, and Medicaid fee-for-service reimbursement for behavioral health services authorized under the Medicaid Section 1115 Behavioral Health Transformation Demonstration program (demonstration program). Services and program changes authorized under the demonstration program will be phased in during the first demonstration year. This third emergency and proposed rulemaking retains requirements for services and programs that were implemented beginning January 2020 through June 2020, while also adding requirements for a new Transition Planning service set to begin September 2020. This rulemaking also corresponds to changes to the District's local authority to oversee behavioral health services being proposed by the Department of Behavioral Health under Title 22-A DCMR.

An initial Notice of Emergency and Proposed Rulemaking was published in the *D.C. Register* on November 29, 2019, at 66 DCR 015883. The public comment period closed on December 30, 2019. The District received comments from the DC Behavioral Health Association and AmeriHealth Caritas. The District carefully considered all comments received and made technical and substantive changes in response. A Second Notice of Emergency and Proposed Rulemaking was published in the *D.C. Register* on May 08, 2020, at 67 DCR 004918. The District received no comments, but is making substantive changes to two (2) sections to implement new transition planning service authority: (1) Section 8612 is being amended to establish a service definition, beneficiary eligibility criteria, and reimbursement requirements for transition planning services; and (2) Section 8699 is being amended to define transition planning services.

Transition planning services are the final service approved under the demonstration program to be incorporated into this rulemaking. Transition planning services are for beneficiaries stepping down from an inpatient hospital or residential Substance Use Disorder treatment setting. Transition planning service providers will identify needed treatment and support services that support beneficiary recovery, reduce the chances of avoidable hospital or residential treatment readmissions, and connect beneficiaries to identified treatment and support services.

Finally, this rulemaking proposes to amend Section 8608 to clarify the District's authority to interpret provider requirements for institutions for mental disease (IMDs) established in the Special Terms and Conditions governing the demonstration program through guidance or transmittals published to the DHCF website at www.dhcf.dc.gov. As amended, Subsection

8608.24 clarifies that the Special Terms and Conditions, as well as the corresponding implementation plans, governing the demonstration program set forth milestones and goals that both the District and IMD providers must meet. In order to ensure IMDs are meeting program requirements and the demonstration program is able to meet its goals, the proposed rule also amends Subsection 8608.24 to clarify that the District may also interpret these requirements though guidance or transmittals published to the DHCF website.

Emergency action is necessary for the immediate preservation of the health, safety, and welfare of District residents. This demonstration program was conceived, in large part, as a response to the crisis unfolding in the District relating to opioid use and abuse. DHCF and the Department of Behavioral Health expect implementation of the proposed changes to improve the quality of health outcomes for individuals diagnosed with serious mental illness/serious emotional disturbance and increase access to potentially life-saving treatment for individuals diagnosed with SUD.

This emergency rulemaking was adopted on October 14, 2020, and shall become effective on the date of publication of this notice in the *D.C. Register*. The emergency rules will remain in effect for one hundred and twenty (120) days from the adoption date, or until February 11, 2021, unless superseded by publication of a Notice of Final Rulemaking in the *D.C. Register*.

The Director also gives notice of the intent to take final rulemaking action to adopt this emergency and proposed rule not less than thirty (30) days from the date of publication of this notice in the *D.C. Register*.

**CHAPTER 86 BEHAVIORAL HEALTH TRANSFORMATION
DEMONSTRATION PROGRAM**

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8600 GENERAL PROVISIONS

8600.1 The purpose of this chapter is to establish standards governing the administration of the Medicaid Section 1115 Behavioral Health Transformation Demonstration Program (demonstration program) as authorized by the United States Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS) under Section 1115 of the Social Security Act (SSA).

8600.2 Services and requirements set forth in this chapter shall be effective January 1, 2020 through December 31, 2024, in accordance with the Special Terms and Conditions (STCs), as set forth by CMS, in its approval of the demonstration program. The STCs are available on the Department of Health Care Finance's (DHCF) website at <https://dhcf.dc.gov/1115-waiver-initiative>.

8600.3 Except for services identified in § 8608, expenditure authority under this demonstration program will expire on December 31, 2021.

8600.4 Medicaid services authorized under this chapter are subject to evaluation and monitoring requirements consistent with the STCs interpreted by DHCF via guidance published to the DHCF website at www.dhcf.dc.gov.

8600.5 The demonstration program may be terminated by CMS, or withdrawn, extended, or amended by DHCF in accordance with the requirements set forth in the approved STCs.

8600.6 DHCF shall publish and maintain provider guidance that supports implementation of the demonstration program on the DHCF website at www.dhcf.dc.gov.

8601 ELIGIBILITY REQUIREMENTS

8601.1 The demonstration program does not amend or change District of Columbia Medicaid eligibility requirements, standards, or methodologies set forth under the District of Columbia Medicaid State Plan and applicable regulations under Title 29 of the District of Columbia Municipal Regulation (DCMR).

8601.2 Services outlined in this chapter shall be available to individuals enrolled in District of Columbia Medicaid Program to the extent that the individual meets the criteria established for the service in this chapter.

8602 REIMBURSEMENT

- 8602.1 In order to receive Medicaid reimbursement, each demonstration program services provider shall enter into a provider agreement with DHCF and comply with the screening and enrollment requirements set forth in Chapter 94 (Medicaid Provider and Supplier Screening, Enrollment, and Termination) of Title 29 DCMR.
- 8602.2 Effective January 1, 2020, reimbursement for services set forth in this chapter shall be made according to the District of Columbia Medicaid fee schedule available online at www.dc-medicaid.com. All future updates to Medicaid reimbursement rates for demonstration program services shall comply with the public notice and comment requirements set forth under Section 988 of Chapter 9 of Title 29 DCMR and be posted to the DHCF website at www.dhcf.dc.gov.
- 8602.3 A public notice of demonstration program rate changes shall be published in the D.C. Register at least thirty (30) calendar days in advance of any changes and shall include a link to the Medicaid fee schedule and shall provide a opportunity for public comment.
- 8602.4 For services outlined in this chapter, the Department of Behavioral Health (DBH) shall be responsible for payment of the non-federal share of total expenditures in accordance with the terms and conditions set forth in the Memoranda of Understanding between DHCF and DBH.

8603 PROGRAM SERVICES: PSYCHOSOCIAL REHABILITATION (CLUBHOUSE)

- 8603.1 Psychosocial rehabilitation (also known as “Clubhouse”) services are behavioral, cognitive, or supportive interventions that assist individuals with the development of social networking, independent living, budgeting, self-care, and other skills to enable independent living and ongoing employment. Services under this section shall become effective January 1, 2020.
- 8603.2 Medicaid beneficiaries, at least eighteen (18) years of age, who meet the requirements set forth in Chapter 34 and Chapter 39 of Title 22-A DCMR are considered individuals eligible to receive psychosocial rehabilitation services.
- 8603.3 Psychosocial rehabilitation services shall be delivered in accordance with the requirements set forth in Chapters 34 and 39 of Title 22-A DCMR.
- 8603.4 Psychosocial rehabilitation service providers shall be certified in accordance with the requirements set forth in Chapters 34 and 39 of Title 22-A DCMR.

8604 PROGRAM SERVICES: TRAUMA RECOVERY AND EMPOWERMENT MODEL

8604.1 The Trauma Recovery and Empowerment Model (TREM) is a structured group therapy intervention for individuals who have survived trauma and have substance use disorders or mental health conditions.

8604.2 Effective March 1, 2020, Medicaid beneficiaries who meet requirements set forth in Chapter 34 or Chapter 63 of Title 22-A DCMR shall be eligible to receive TREM services.

8604.3 Medicaid reimbursable TREM services shall include therapy sessions focused on:

- (a) Empowerment, self-comfort, and accurate self-monitoring, as well as ways to establish safe physical and emotional boundaries;
- (b) The trauma experience and its consequences; and
- (c) Skills building, including emphases on communication style, decision-making, regulating overwhelming feelings, and establishing safer, more reciprocal relationships.

8604.4 TREM services shall be furnished by a TREM provider certified in accordance with the requirements set forth in Chapter 34 or Chapter 63 of Title 22-A DCMR. TREM provider staff must complete DBH-approved TREM training.

8605 PROGRAM SERVICES: TRAUMA SYSTEMS THERAPY

8605.1 Trauma Systems Therapy (TST) is a comprehensive, phase-based treatment program for children and adolescents, aged six (6) to eighteen (18), who have experienced traumatic events or who live in environments with ongoing stress or traumatic reminders.

8605.2 Effective March 1, 2020, Medicaid reimbursable TST services shall include:

- (a) Psychotherapy;
- (b) Home or community-based stabilization;
- (c) Emotion regulation skills training; and
- (d) Consultation with the psychopharmacologic treatment team.

8605.3 Children and adolescents who meet the requirements set forth in Chapter 34 of Title 22-A DCMR shall be eligible to receive Trauma Systems Therapy (TST) services, as provided under the Demonstration Program.

8605.4 TST services shall be furnished by providers that have been certified by DBH in accordance with requirements set forth in Chapter 34 of Title 22-A DCMR. TST provider staff must complete DBH-approved TST training.

8606 PROGRAM SERVICES: RECOVERY SUPPORT SERVICES

8606.1 Recovery support services are non-clinical services and supports designed to support and maintain ongoing recovery from a substance use disorder (SUD). Services under this section shall become effective January 1, 2020.

8606.2 Medicaid reimbursable recovery support services shall include services set forth under Chapter 63 of Title 22-A DCMR.

8606.3 Medicaid beneficiaries eligible to receive recovery support services shall meet criteria set forth in Chapter 63 of Title 22-A DCMR.

8606.4 Recovery support services shall be furnished by Medicaid-enrolled providers certified as recovery support service providers in accordance with Chapter 63 of Title 22-A DCMR.

8606.5 Recovery support provider qualified staff include:

- (a) Certified recovery coaches;
- (b) Certified peer specialists; and
- (c) Other qualified providers authorized under Chapter 63 of Title 22-A DCMR.

8607 PROGRAM SERVICES: SUPPORTED EMPLOYMENT SERVICES FOR INDIVIDUALS WITH SERIOUS MENTAL ILLNESS

8607.1 Supported employment is an evidence-based practice that:

- (a) Provides ongoing work-based vocational assessment, job development, job coaching, treatment team coordination, and vocational and therapeutic follow-along supports;
- (b) Involves community-based employment, consistent with the strengths, resources, priorities, concerns, abilities, capabilities, interests, and informed choice of the consumer;
- (c) Provides services at various work sites; and
- (d) Provides part-time and full-time job options that: are diverse, competitive, and integrated with co-workers without disabilities; are based in business or employment settings that have permanent status rather than temporary

or time-limited status; and which pay at least minimum wage of the jurisdiction in which the job is located.

8607.2 Effective February 1, 2020, Medicaid reimbursable vocational supported employment services shall include the following, as defined in Chapter 37 of Title 22-A DCMR:

- (a) Intake;
- (b) Vocational Assessment;
- (c) Individualized Work Plan Development;
- (d) Treatment Team Coordination;
- (e) Disclosure Counseling;
- (f) Job Development;
- (g) Job Coaching; and
- (h) Vocational Follow-Along Supports for the beneficiary and employer.

8607.3 In accordance with the eligibility requirements set forth in Chapter 37 of Title 22-A of the DCMR, individuals eligible for vocational supported employment services shall:

- (a) Be a Medicaid beneficiary at least eighteen (18) years of age;
- (b) Indicate an interest in employment;
- (c) Have supported employment identified as a needed service on a current, person-centered plan of care that has been reviewed by DBH;
- (d) Not be concurrently receiving Assertive Community Treatment (ACT) services, as defined in Chapter 34 of Title 22-A of the DCMR; and
- (e) Be determined by DBH as meeting the needs-based criteria set forth in Chapter 37 of Title 22-A DCMR.

8607.4 Individuals shall be assessed for supported employment services by an entity designated by DBH.

8607.5 The designated assessment entity shall conduct the needs-based assessment in accordance with the requirements set forth in Chapter 37 of Title 22-A DCMR and shall conduct a reassessment at least every one hundred and eighty (180) days or upon significant change in the beneficiary's condition.

- 8607.6 The designated assessment entity shall also be responsible for developing the person-centered plan of care, as identified in § 8607.3(c), in accordance with federal regulations under 42 CFR § 441.725 and requirements set forth in Chapter 37 of Title 22-A of the DCMR.
- 8607.7 The person-centered plan of care must be reviewed and revised by the designated assessment entity in accordance with the requirements set forth in Chapter 37 of Title 22-A of the DCMR.
- 8607.8 The designated assessment entity shall also assist the Medicaid beneficiary in identification and selection of a supported employment provider.
- 8607.9 The assessment and the person-centered plan of care shall be reviewed by DBH, consistent with the requirements set forth in Chapter 37 of Title 22-A of the DCMR prior to initiation of supported employment services.
- 8607.10 Following review and approval of the assessment information and person-centered plan of care, DBH shall issue an authorization for the initiation of supported employment services by the beneficiary-selected supported employment provider, in accordance with the requirements set forth in Chapter 37 of Title 22-A DCMR.
- 8607.11 The designated assessment entity shall inform the beneficiary of his or her eligibility for supported employment services.
- 8607.12 Supported employment providers shall be certified in accordance with the requirements set forth in Chapter 37 of Title 22-A DCMR.
- 8607.13 A supported employment provider shall develop an Individualized Work Plan for each Medicaid beneficiary receiving supported employment services, in accordance with the requirements set forth in Chapter 37 of Title 22-A DCMR.
- 8607.14 Medicaid reimbursement shall not be made available for supported employment services provided to a Medicaid beneficiary residing in an institutional setting or any setting that is not in compliance with the Home and Community-Based Services (HCBS) setting requirements consistent with 42 CFR § 441.301.
- 8608 PROGRAM SERVICES: SERVICES PROVIDED IN INSTITUTIONS FOR MENTAL DISEASE FOR MEDICAID BENEFICIARIES AGED 21-64**
- 8608.1 Medicaid reimbursable treatment provided in inpatient or residential treatment settings that qualify as institutions for mental disease (IMD) shall include services which are:
- (a) Medically necessary to diagnose, treat, or stabilize the underlying illness, condition, or disease;

- (b) Identified within and provided in accordance with an individualized plan of care; and
 - (c) Authorized under the District of Columbia Medicaid State Plan or a waiver thereof.
- 8608.2 Medicaid beneficiaries are eligible for services provided within an IMD under the demonstration program, if they meet the following criteria:
- (a) Are aged twenty-one (21) to sixty-four (64); and
 - (b) Require short-term inpatient or residential treatment to resolve or ameliorate the symptoms associated with the acute phase of a behavioral health crisis or symptoms associated with SMI or SUD, as determined by a qualified practitioner practicing in accordance with licensure requirements, as set forth under 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 *et seq.*) and its implementing regulations.
- 8608.3 The individualized plan of care, identified in § 8608.1(b) shall be developed by a multi-disciplinary team of practitioners following diagnosis of the beneficiary's underlying condition and comprehensive assessment of the beneficiary's treatment needs.
- 8608.4 District SUD residential providers shall comply with plan of care requirements set forth in Chapter 63 of Title 22-A DCMR.
- 8608.5 District inpatient and residential behavioral health service providers shall be licensed or certified in accordance with the Health-Care and Community Residence Facility, Hospice and Home Care Licensure Act of 1983, effective February 24, 1984 (D.C. Law 5-48; D.C. Official Code §§ 44-501 *et seq.*) or otherwise applicable licensure or certification requirements as set forth under District law.
- 8608.6 District SUD residential treatment providers shall be certified in accordance with requirements set forth under Chapter 63 of Title 22-A DCMR.
- 8608.7 Eligible providers must meet the definition of an institution for mental disease as set forth at 42 CFR § 435.1010 and interpreted by DHCF via guidance on its website at www.dhcf.dc.gov.
- 8608.8 Inpatient mental health and SUD treatment shall be delivered by a facility that meets the conditions of participation set forth in 42 CFR § 482 and be either:
- (a) A licensed or certified facility that meets the conditions of participation; or

- (b) Accredited by nationally recognized accreditation entity by a national accrediting organization whose psychiatric hospital accreditation program or acute hospital accreditation program has been approved by CMS.
- 8608.9 Residential SUD treatment providers shall deliver care consistent with American Society of Addiction Medicine criteria or other nationally recognized, SUD-specific program standards for residential treatment facilities. Residential SUD treatment delivered by a District certified facility shall be provided in accordance with requirements set forth under Chapter 63 of Title 22-A DCMR.
- 8608.10 Residential mental health treatment shall be delivered by a facility that, as assessed by the District or a nationally recognized accreditation organization, delivers care consistent with nationally recognized, mental health-specific program standards for residential treatment facilities.
- 8608.11 To be eligible for Medicaid reimbursement, inpatient and residential SUD treatment providers must provide Medication Assisted Treatment (MAT) services directly or facilitate the provision of MAT services by ensuring transportation for beneficiaries to obtain medications at a MAT providing and participating in the coordination of care in conjunction with MAT providers.
- 8608.12 Effective January 1, 2020, Medicaid reimbursement for services provided in an IMD located in the District of Columbia shall be made according to the District of Columbia Medicaid fee schedule available online at <https://www.dc-medicaid.com/dcwebportal/home>.
- 8608.13 DHCF shall reimburse IMD providers located outside the District of Columbia at the rate established by the Medicaid State Agency where the IMD is located.
- 8608.14 For Medicaid beneficiaries enrolled in a District Medicaid Managed Care Plan, DHCF shall only provide fee-for-service reimbursement to eligible providers for IMD stays that exceed the stays reimbursed by the Medicaid Managed Care Plan, pursuant to “in lieu of” requirements set forth under 42 CFR § 438 and interpreted by DHCF in guidance on its website at www.dhcf.dc.gov.
- 8608.15 DHCF will provide services for a targeted statewide average length of stay of thirty (30) days in inpatient and residential treatment settings.
- 8608.16 IMD stays for the treatment of SMI that exceed sixty (60) days are not Medicaid reimbursable.
- 8608.17 Medicaid fee-for-service reimbursement for IMD stays shall be authorized by DHCF or its designee. DHCF or its designee shall provide oversight of total length of stay by conducting concurrent utilization reviews.
- 8608.18 Inpatient SUD and SMI treatment services shall be reimbursed in accordance with the District of Columbia Medicaid fee schedule available online at <https://www.dc-medicaid.com/dcwebportal/home>. Information to assist providers

billing Medicaid for these services is available on the DHCF website at dhcf.dc.gov.

8608.19 Residential SUD services shall be shall be reimbursed in accordance with the District of Columbia Medicaid fee schedule available online at <https://www.dc-medicaid.com/dcwebportal/home>. Information to assist providers billing Medicaid for these services is available on the DHCF website at dhcf.dc.gov.

8608.20 Reimbursement under this section is available for acute inpatient or residential treatment provided in settings that qualify as IMDs. Medicaid reimbursement for long-term residential or long-term inpatient treatment is not available under this section.

8608.21 Effective July 1, 2020, IMD providers are required, as a condition of reimbursement for services authorized under this chapter, to participate through a formal agreement with a registered HIE entity of the DC Health Information Exchange (DC HIE), defined in Chapter 87 of Title 29 DCMR. Once they become a participating provider, IMD providers must also participate in a reporting process via the DC HIE throughout the demonstration period. DHCF shall publish guidance interpreting these requirements on the DHCF website at www.dhcf.dc.gov.

8608.22 Medicaid reimbursement for services provided in general hospitals, intermediate care facilities, nursing facilities, or skilled nursing facilities is not governed or authorized under this section.

8608.23 Medicaid reimbursement is not available for services provided to beneficiaries who are involuntarily residing in an inpatient or residential treatment facility by operation of criminal law.

8608.24 IMD providers must meet provider requirements, goals, and milestones established in the STCs and the corresponding implementation plans governing the demonstration program. DHCF shall publish guidance interpreting these provider requirements on its website at dhcf.dc.gov.

8609 PROGRAM SERVICES: LICENSED BEHAVIORAL HEALTH PRACTITIONERS

8609.1 Effective January 1, 2020, the following licensed behavioral health providers shall be eligible to enroll in the District of Columbia Medicaid Program and provide behavioral health services, regardless of program affiliation:

- (a) Psychologists;
- (b) Licensed Independent Clinical Social Workers;
- (c) Licensed Professional Counselors; and

(d) Licensed Marriage and Family Therapists.

8609.2 Medicaid reimbursement will be available for the following services, when provided to an eligible Medicaid beneficiary by a licensed behavioral health practitioner identified in § 8609.1, practicing within the scope of their licensure, in accordance with requirements set forth under the District of Columbia Health Occupations Revision Act of 1985, District of Columbia Official Code Title 3, Chapter 12 §§ 3-1201.01-3-1213.13, 3-1251.01-3.1251.16 and implementing regulations:

(a) Assessment, Diagnostic, and Screening services; and

(b) Psychological Testing.

8609.3 Medicaid reimbursement will be available for the following services, when provided to an eligible Medicaid beneficiary diagnosed with a serious emotional disturbance, SMI, or SUD by a licensed behavioral health practitioner identified in § 8609.1 by a licensed behavioral health practitioner, practicing within the scope of their licensure, in accordance with requirements set forth under the District of Columbia Health Occupations Revision Act of 1985 District of Columbia Official Code Title 3, Chapter 12 §§ 3-1201.01-3-1213.13, 3-1251.01-3.1251.16 and implementing regulations:

(a) Counseling and Psychotherapy; and

(b) Treatment Planning and Care Coordination.

8609.4 Medicaid reimbursement rates for fee-for-service behavioral health services provided in accordance with this section shall be eighty percent (80%) of the rates paid by the Medicare Program. The reimbursement rates for behavioral health services shall be posted on Department of Health Care Finance's website at www.dc-medicaid.com and updated annually.

8609.5 For services identified in §§ 8609.2 and 8609.3, where the procedure code does not fall within the Medicare fee schedule, the methodology set forth § 8609.6 shall be used to establish the Medicaid reimbursement rate.

8609.6 DHCF shall consider the following factors to establish the Medicaid reimbursement rate for procedure codes that do not fall within the Medicare fee schedule:

(a) Practitioner fees;

(b) Fee schedules from other states;

(c) Similar procedures with established fees; or

- (d) Private insurance payments.

8610 CRISIS STABILIZATION SERVICES

8610.1 Crisis stabilization services address an unplanned event requiring a response when an individual struggles to manage their psychiatric or substance use related symptoms without de-escalation or other intervention. This also includes situations in which daily life challenges result in or put an individual at risk of an escalation in symptoms.

8610.2 Effective June 1, 2020, Medicaid reimbursable crisis stabilization services shall include interventions in the following programs:

- (a) Comprehensive Psychiatric Emergency Program;
- (b) Psychiatric Stabilization Program;
- (c) Youth Mobile Crisis Intervention Program; and
- (d) Adult Mobile Crisis and Outreach Program.

8610.3 Medicaid beneficiaries who meet the requirements set forth in Chapter 80 of Title 22-A DCMR shall be eligible to receive crisis stabilization services.

8610.4 Crisis stabilization services shall be delivered in accordance with the requirements set forth in Chapter 80 of Title 22-A DCMR.

8610.5 Crisis stabilization service providers shall be certified in accordance with the requirements set forth in Chapters 80 of Title 22-A DCMR.

8611 SUPPORTED EMPLOYMENT SERVICES FOR BENEFICIARIES WITH A SUBSTANCE USE DISORDER

8611.1 Supported employment services for beneficiaries with an SUD shall:

- (a) Provide ongoing work-based vocational assessment, job development, job coaching, treatment team coordination, and vocational and therapeutic follow-along supports;
- (b) Involve community-based employment, consistent with the strengths, resources, priorities, concerns, abilities, capabilities, interests, and informed choice of the consumer;
- (c) Provide services at various work sites; and
- (d) Provide part-time and full-time job options that are:

- (1) Diverse, competitive, and integrated with co-workers without disabilities;
 - (2) Based in business or employment settings that have permanent status rather than temporary or time-limited status; and
 - (3) Pay minimum wage, or greater, of the jurisdiction in which the job is located.
- 8611.2 Effective March 27, 2020, Medicaid reimbursable supported employment services for individuals with SUD are those set forth in Chapter 37 of Title 22-A DCMR.
- 8611.3 In accordance with the eligibility requirements set forth in Chapter 37 of Title 22-A DCMR, an individual eligible for supported employment services shall:
- (a) Be a Medicaid beneficiary at least eighteen (18) years of age;
 - (b) Indicate an interest in employment;
 - (c) Have supported employment identified as a needed service on a current, person-centered plan of care that has been reviewed by DBH;
 - (d) Not be concurrently receiving Assertive Community Treatment (ACT) services, as defined in Chapter 34 of Title 22-A DCMR;
 - (e) Be receiving services in one of the following SUD levels of care, as defined in Chapter 63 of Title 22-A DCMR:
 - (1) Level ??: Opioid Treatment Program (OTP) on an outpatient basis;
 - (2) Level 1: Outpatient;
 - (3) Level 2.1: Intensive Outpatient; or
 - (4) Level 2.5: Day Treatment;
 - (f) Be assessed as being able to benefit from and meaningfully engage in SUD supported employment services; and
 - (g) Be determined by DBH as meeting the following needs-based criteria set forth in Chapter 37 of Title 22-A DCMR.
- 8611.4 Individuals shall be assessed for supported employment services by an entity designated by DBH.
- 8611.5 The designated assessment entity shall conduct the needs-based assessment in accordance with the requirements set forth in Chapter 37 of Title 22-A DCMR

and shall conduct a reassessment at least every one-hundred eighty (180) days or upon significant change in the beneficiary's condition.

- 8611.6 The designated assessment entity shall also be responsible for developing the person-centered plan of care, as identified in § 8607.3(c), in accordance with federal regulations under 43 CFR § 441.725 and requirements set forth in Chapter 37 of Title 22-A DCMR.
- 8611.7 The person-centered plan of care shall be reviewed and revised by the designated assessment entity in accordance with the requirements set forth in Chapter 37 of Title 22-A DCMR.
- 8611.8 The designated assessment entity shall also assist the Medicaid beneficiary in identification and selection of a supported employment provider.
- 8611.9 The assessment and the person-centered plan of care shall be reviewed by DBH, consistent with the requirements set forth in Chapter 37 of Title 22-A DCMR prior to initiation of supported employment services.
- 8611.10 Following review and approval of the assessment information and person-centered plan of care, DBH shall issue an authorization for the initiation of supported employment services by the beneficiary-selected supported employment provider, in accordance with the requirements set forth in Chapter 37 of Title 22-A DCMR.
- 8611.11 The designated assessment entity shall inform the beneficiary of his or her eligibility for supported employment services.
- 8611.12 Supported employment providers shall be certified in accordance with the requirements set forth in Chapter 37 of Title 22-A DCMR.
- 8611.13 A supported employment provider shall develop an Individualized Work Plan for each Medicaid beneficiary receiving supported employment services, in accordance with the requirements set forth in Chapter 37 of Title 22-A DCMR.
- 8611.14 Medicaid reimbursement is not available for supported employment services provided to beneficiaries that reside in an institutional setting or any setting that is not in compliance with HCBS setting requirements consistent with 42 CFR § 441.301.

8612 TRANSITION PLANNING SERVICES

- 8612.1 Transition planning services for beneficiaries stepping down from certain institutional treatment settings identify needed treatment and support services that support recovery and reduce the chances of avoidable hospital or residential treatment readmissions. Transition planning services also connect beneficiaries to these identified treatment and support services.

8612.2 Effective September 1, 2020, Medicaid reimbursable transition planning services shall include the following activities:

- (a) Assessment of beneficiary's post-discharge needs;
- (b) Development of a discharge plan; and
- (c) Care coordination and case management related to implementation of the discharge plan.

8612.3 Medicaid beneficiaries who meet the requirements set forth in Chapter 65 of Title 22-A of the DCMR shall be eligible to receive transition planning services.

8612.4 Transition planning services shall be delivered in accordance with the requirements set forth in Chapter 65 of Title 22-A of the DCMR.

8612.5 Transition planning service providers shall be certified in accordance with the requirements set forth in Chapters 65 of Title 22-A of the DCMR.

8613 MEDICATION ASSISTED TREATMENT BENEFICIARY COST SHARING

8613.1 Medicaid amount, duration and scope requirements, as set forth under § 1902(a)(10)(B) of the SSA, and comparability requirements, as set forth under §§ 1902(a)(10) and 1902(a)(17), are waived under this demonstration program to enable the DHCF to exempt beneficiaries receiving SUD treatment under this demonstration from one-dollar (\$1) pharmacy cost-sharing requirements when they are receiving prescriptions associated with MAT.

8613.2 There shall be no Medicaid beneficiary cost-sharing for prescriptions associated with the provision of MAT services.

8613.3 Medicaid reimbursement for prescriptions associated with the provision of MAT services shall increase by the cost-sharing amount set forth in the District of Columbia Medicaid State Plan fee-for-service pharmacy services.

8613.4 Effective January 1, 2020, DHCF shall increase fee-for-service pharmacy provider reimbursement rates for prescriptions associated with provision of MAT services by the cost-sharing amount identified in § 8613.3.

8614 RECORDKEEPING

8614.1 Each provider of demonstration program services shall establish and implement a privacy plan to protect the privacy and confidentiality of a beneficiary's records.

8614.2 The disclosure of information by a provider of demonstration program services shall be subject to all provisions of applicable District and federal laws governing the privacy and security of health and personal information.

8614.3 Each provider of demonstration program services shall maintain complete beneficiary records, financial records covering its operations, and individual treatment plans, in accordance with the service requirements set forth in this chapter, and shall maintain each record for at least ten (10) years.

8615 ACCESS TO RECORDS

8615.1 Each Medicaid-enrolled provider of waiver services shall maintain beneficiary records and individual treatment plans in a manner that will render them amenable to audit and review by the U.S. Department of Health and Human Services, DHCF, DBH, and their authorized designees or agents. Providers must allow appropriate DHCF personnel, DBH personnel, representatives of the U.S. Department of Health and Human Services, and other authorized designees or officials of the District of Columbia government and federal government full access to all records upon request and during announced or unannounced audits or reviews.

8616 AUDITS AND REVIEWS

8616.1 This section sets forth the requirements for audits and reviews of demonstration program services set forth in this chapter. DHCF, or its designee, shall perform regular audits of eligible providers to ensure that Medicaid payments are consistent with efficiency, economy and quality of care, and made in accordance with federal and District conditions of payment. The audits shall be conducted at least annually and when necessary to investigate and maintain program integrity.

8616.2 DHCF, or its designee, shall perform routine audits of claims, by statistically valid scientific sampling, to determine the appropriateness of demonstration program services rendered and billed to Medicaid to ensure that Medicaid payments can be substantiated by documentation that meets the requirements set forth in this rule, and made in accordance with federal and District rules governing Medicaid.

8616.3 The audit process may utilize statistically valid sampling methods to ensure that a statistically valid sample is drawn when the audit is based on claims sampling. The audit process may review all claims by type, time-period, or other criteria established by DHCF or other entities. Statistically valid and commonly accepted standards methods for calculating overpayments will be followed. If DHCF denies a claim during an audit, DHCF shall recoup, by the most expeditious means available, those monies erroneously paid to the provider for denied claims, following the process for administrative review as outlined below:

- (a) DHCF shall issue a Notice of Proposed Medicaid Overpayment Recovery (NPMOR), which sets forth the reasons for the recoupment, including the

specific reference to the particular sections of the statute, rules, or provider agreement, the amount to be recouped, and the procedures for requesting an administrative review;

- (b) The Provider shall have thirty (30) days from the date of the NPMOR to submit documentary evidence and written argument to DHCF against the proposed action;
- (c) The documentary evidence and written argument shall include a specific description of the item to be reviewed, the reason for the request for review, the relief requested, and documentation in support of the relief requested;
- (d) Based on review of the documentary evidence and written argument, DHCF shall issue a Final Notice of Medicaid Overpayment Recovery (FNMOR);
- (e) Within fifteen (15) days of receipt of the FNMOR, the Provider may appeal the written determination by filing a written notice of appeal with the Office of Administrative Hearings (OAH), 441 4th Street, N.W., Suite 450 North, Washington, D.C. 20001; and
- (f) Filing an appeal with the OAH shall not stay any action to recover any overpayment.

8616.4 All participant, personnel, program, administrative, and fiscal records shall be maintained so that they are accessible and readily retrievable for inspection and review by authorized government officials or their agents, as requested. DHCF shall retain the right to conduct audits or reviews at any time and audits or reviews may be announced or unannounced.

8616.5 All records and documents required to be kept under this chapter and other applicable laws and regulations which are not maintained or accessible in the operating office visited during an audit shall be produced for inspection within twenty-four (24) hours, or within a shorter reasonable time if specified, upon the request of the auditing official.

8616.6 The failure of a provider to release or to grant access to program documents and records to the DHCF auditors in a timely manner, after reasonable notice by DHCF to the provider to produce the same, shall constitute grounds to terminate the Medicaid Provider Agreement. This provision in no way limits DHCF's ability to terminate any Medicaid Provider Agreement for any other reason.

8616.7 As part of the audit process, documents providers shall grant access, which may include, at a minimum, the following:

- (a) Relevant financial records;

- (b) Statistical data to verify costs previously reported;
- (c) Program documentation;
- (d) A record of all service authorization and prior authorizations for services;
- (e) A record for all request for change in services;
- (f) Any records listed in § 8614, in addition to any other records relating to the adjudication of claims, including, the number of units of the delivered service, the period during which the service was delivered and dates of service, and the name, signature, and credentials of the service provider(s); and
- (g) Any record necessary to demonstrate compliance with rules, requirements, guidelines, and standards for implementation and administration of demonstration program services.

8616.8 Nothing in this rule effects a provider's independent legal obligation under this chapter and federal and District law to self-identify overpayments and repay within sixty (60) days of discovery.

8617 QUALITY OVERSIGHT AND PROVIDER REPORTING

8617.1 Medicaid reimbursement for services provided under this chapter are authorized under Section 1115(a)(2) of the SSA and are subject to evaluation and monitoring requirements consistent with the terms and conditions of the authorized demonstration.

8617.2 As a condition of reimbursement for services authorized under this chapter, providers are required to report any clinical, billing, or utilization information related to provision of service authorized under this chapter to DHCF, its designee, or CMS upon request.

8617.3 DHCF shall interpret provider guidance with regard to quality oversight and provider reporting requirements, or subsequent changes, on the DHCF website at www.dhcf.dc.gov.

8699 DEFINITIONS

8699.1 For purposes of this chapter, the following terms shall have the meanings ascribed:

Case Management – A collaborative process of assessment, planning, facilitation, and advocacy for options and services to meet the beneficiary's behavioral health needs through communication and available resources.

Clubhouse – See Psychosocial Rehabilitation Services.

Counseling - 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.

Department of Behavioral Health – The executive department that is the successor in interest to the Department of Mental Health pursuant to the Department of Behavioral Health Establishment Act of 2013, effective December 24, 2013 (D.C. Law 20-61; D.C. Official Code §§ 7-1141.01 *et seq.*).

Department of Health Care Finance - The executive department responsible for administering the Medicaid program within the District of Columbia effective October 1, 2008.

Institutions for Mental Disease – Shall have the same meaning as set forth in 42 CFR § 435.1010.

Medication Assisted Treatment - The use of FDA-approved medications, in combination with counseling and behavioral therapies, to provide a "whole-patient" approach to the treatment of substance use disorders.

Medicaid Fee Schedule - A comprehensive list of fee maximums used to reimburse providers on a fee-for-service basis located at www.dc-medicaid.com.

Psychosocial Rehabilitation Services – Behavioral health, cognitive, or supportive interventions assisting individuals with the development of life skills. Also known as Clubhouse services.

Recovery Support Services (RSS) - Non-clinical services provided to a beneficiary by a certified RSS provider to assist the beneficiary in achieving or sustaining recovery from an SUD. RSS are available to individuals with an SUD who are currently in treatment or have moved into recovery from substance use/abuse, and individuals who have self-identified with SUD, but are assessed as not needing treatment.

Substance Use Disorder (SUD) – A chronic relapsing disease characterized by a cluster of cognitive, behavioral, and psychological symptoms indicating that the client continues using a substance despite significant substance-related problems. A diagnosis of SUD requires a client to have had persistent, substance related problem(s) within a twelve (12)-month period in accordance with the most recent version of the DSM.

Transition Planning Services - Services for beneficiaries stepping down from certain institutional treatment settings that identify needed treatment and

support services o support recovery, reduce the chances of avoidable hospital or residential treatment readmissions, and connect beneficiaries to identified treatment and support services.

Trauma Recovery and Empowerment Model (TREM) - A structured group therapy intervention for individuals who have survived trauma and have substance use disorders or mental health conditions. TREM draws on cognitive restructuring, skills training, and psychoeducational and peer support to address recovery and healing from sexual, physical, and emotional abuse.

Trauma System Therapy (TST) - A comprehensive, phase-based model for treating traumatic stress in children and adolescents that adds to individually-based approaches, by specifically addressing the child's or youth's social environment and/or system of care. TST is designed to provide an integrated, highly coordinated system of services guided by the specific understanding of the nature of child or youth traumatic stress.

Vocational Services – Services necessary to enable an individual with a disability to engage in competitive employment.

Comments on this proposed rulemaking shall be submitted in writing to Melisa Byrd, Medicaid Director, Department of Health Care Finance, 441 4th Street, N.W., 9th Floor, Washington, D.C. 20001, via email to DHCFPublicComments@dc.gov, online at www.dcregs.dc.gov, or by telephone to (202) 442-8742, within thirty (30) days after the date of publication of this notice in the *D.C. Register* or online at DHCF's website. Additional copies of these rules may be obtained from the above address.