DEPARTMENT OF BEHAVIORAL HEALTH

NOTICE OF EMERGENCY AND PROPOSED RULEMAKING

The Director of the Department of Behavioral Health (Department), pursuant to the authority set forth in Sections 5113, 5115, 5117 and 5118 of the Department of Behavioral Health Establishment Act of 2013, effective December 24, 2013, D.C. Law 20-61, D.C. Official Code § 7-1141.07, and the Department of Mental Health Establishment Act of 2001, effective December 18, 2001 (D.C. Law 14-56; D.C. Official Code §§ 7-1131.04 and 7-1131.12 (2018 Repl.)), hereby gives notice of the adoption, on an emergency basis, of a new Chapter 30 to be entitled "Free Standing Mental Health Clinic Certification Standards", of Subtitle A (Mental Health) of Title 22 (Health) of the District of Columbia Municipal Regulations (DCMR).

The Department is responsible for coordinating and monitoring publicly funded mental health services for the residents of the District of Columbia. Currently the Department of Health Care Finance (DHCF), upon the recommendation of the Department, certifies and monitors Free Standing Mental Health Clinics (FSMHCs) to provide publicly-funded clinic-based mental health services under Title 29 DCMR, Chapter 8. The Department of Behavioral Health Establishment Act of 2013 and Department of Mental Health Establishment Act of 2001 granted the Department of Behavioral Health exclusive authority to certify and regulate FSMHCs providers upon promulgation of regulations in accordance with D.C. Official Code §§ 2-501, *et seq.* This rulemaking implements the statutory authority that established the Department as the monitoring and certifying agency for FSMHCs.

The chapter allows FSMHCs currently certified through DHCF to continue operating as long as they submit a new certification application to the Department within one hundred and twenty (120) calendar days of publication of this notice in the *D.C. Register* and become a certified FSMHC, in accordance with the rules set forth in this chapter, within two hundred and seventy (270) calendar days of publication of this notice in the *D.C. Register*. The proposed chapter also establishes the certification requirements for FSMHCs and services they provide.

This emergency rulemaking is necessary for the immediate preservation of the health, safety, and welfare of District residents by decreasing barriers to access for vital behavioral health services provided by FSMHCs. These actions are needed to ensure FSMHC services are delivered in accordance with the quality and oversight provisions set forth in this chapter.

This rule was adopted on June 12, 2020, and shall become effective on the date of publication of this notice in the *D.C. Register.* The emergency and proposed rules shall remain in effect for not longer than one hundred and twenty (120) days from the adoption date or until October 10, 2020, unless superseded by publication of a Notice of Final Rulemaking in the *D.C. Register*.

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

Title 22-A DCMR, MENTAL HEALTH, is amended by adding a new Chapter 30 to read as follows:

CHAPTER 30 FREE STANDING MENTAL HEALTH CLINIC CERTIFICATION STANDARDS

3000 GENERAL PROVISIONS

3000.1 Free Standing Mental Health Clinic (FSMHC) services are services provided by behavioral health practitioners within a clinic setting to eligible individuals (consumers) living in the community. The purpose of these rules is to set forth the requirements for:

(a) Certification by the Department of Behavioral Health (Department) of organizations to provide Free Standing Mental Health Clinic (FSMHC) services;

(b) Eligibility of individuals to receive treatment at FSMHCs;

(c) Services to be provided at FSMHCs; and

(d) Administrative requirements for an FSMHC.

3000.2 A FSMHC shall be certified by the Department in accordance with the rules set forth in this chapter. No person or entity shall operate a FSMHC without a valid FSMHC certification.

3000.3 The transition timeline from the Department of Health Care Finance (DHCF) certification to Department of Behavioral Health certification is as follows:

(a) Providers who were certified as an FSMHC by the Department of Health Care Finance (DHCF) prior to the publication of this rule in the *D.C. Register* may retain certification under DHCF for one hundred and twenty (120) calendar days.

(b) All DHCF certifications will expire one hundred and twenty (120) calendar days following publication of this rule in the *D.C. Register*.

(c) Any provider wishing to continue to provide services as a FSMHC must submit a complete certification application with the Department prior to the expiration of the one hundred and twenty (120) calendar day grace period and obtain full certification by the Department within two hundred and seventy (270) calendar days following publication of this rule in the *D.C. Register*.

(d) Failure to complete the certification process within that time frame will result in the loss of certification to provide FSMHC services.

(e) The Department will grant provisional certification to any existing FSMHC provider that submits a complete certification application prior to the expiration of the one hundred and twenty (120) calendar day grace period. The provisional certification will expire upon full certification under this chapter, the end of the two hundred and seventy (270) calendar day certification window, or upon denial or decertification in accordance with this chapter, whichever occurs first.

3000.4 An FSMHC shall meet the requirements of this chapter in order to obtain certification.

3000.5 Each certified FSMHC shall treat all consumers who meet the eligibility guidelines in § 3001.2 and require treatment. A FSMHC that seeks reimbursement for providing services to individuals eligible for local funding under § 3001.2 shall enter into a Human Care Agreement (HCA) with the Department prior to providing any services to those individuals.

3000.6 Upon certification, but prior to providing services, each FSMHC shall enter into a Medicaid Provider Agreement with DHCF. All Medicaid reimbursement for FSMHC services shall be through DHCF. All local dollar reimbursement for FSMHC services shall be through an HCA with the Department.

3000.7 Entities certified as an FSMHC in accordance with the requirements set forth in this chapter are eligible to apply for certification as a Health Home in accordance with the requirements set forth in 22-A DCMR §§ 2500, *et seq*.

3000.8 An FSMHC that is certified as a Health Home is eligible to receive reimbursement

for the provision of Health Home services in accordance with the requirements set forth in 29 DCMR §§ 6900, *et seq.*

3001 ELIGIBLE CONSUMERS

3001.1 Consumers eligible for Medicaid-funded FSMHC services must meet the following requirements:

(a) Are enrolled in Medicaid, or be eligible for enrollment and have an application pending; and

(b) Are children youths, or adults with a mental health condition or diagnosis, or at risk of developing a mental health diagnosis.

3001.2 Consumers eligible for locally-funded FSMHC services are those individuals who are not eligible for Medicaid or are not enrolled in any other third-party insurance program, except the D.C. Healthcare Alliance or Immigrant Children's Program, and who meet the following requirements:

(a) Are bona fide residents of the District pursuant to D.C. Official Code § 7-1131.02(29) (2018 Repl.);

(b) Are children, youth, or adult with a mental health condition or diagnosis, or at risk of developing a mental health diagnosis; and

(c) For individuals eighteen (18) years of age and older, live in households with a countable income of less than two hundred percent (200%) of the federal poverty level, and for individuals under eighteen (18) years of age, live in households with a countable income of less than three hundred percent (300%) of the federal poverty level.

3001.3 Neither Medicaid nor the Department shall reimburse providers for FSMHC services provided to any consumer that does not meet the eligibility requirements set forth above.

3002 CERTIFICATION PROCESS

3002.1 Subject to the initial transition period in § 3000.3, FSMHC providers shall be certified in accordance with the requirements of this Section.

3002.2 Each applicant seeking certification as an FSMHC shall submit a certification application in the format required by the Department.

3002.3 The Department shall review the certification application upon receipt to determine if it is complete. If a certification application is incomplete, the Department shall return the incomplete certification application to the applicant. An incomplete

certification application shall not be regarded as a certification application. The Department shall deny any application that contains false representations or documents and the applicant shall be barred from resubmitting an application for twelve (12) months.

3002.4 Following the Department's review and acceptance of the documentation contained in the certification application, the Department shall determine whether the applicant's services and activities meet the certification standards described in this chapter. The Department shall schedule and conduct an on-site survey of the applicant's services to determine whether the applicant satisfies all certification standards.

3002.5 An FSMHC seeking recertification shall submit a recertification application at least ninety (90) calendar days prior to the termination of its current certification. A FSMHC that timely submits a renewal application may continue to provide FSMHC services until the Department takes action to renew or deny renewal of certification.

3002.6 The Department may also conduct an on-site survey at the time of certification renewal, or at any other time during the period of certification.

3002.7 Upon request, the Department shall be provided access to all FSMHC records, including but not limited to consumer records, claims and billing records, and FSMHC employee records, to verify compliance with certification standards, and may conduct interviews with FSMHC staff. All FSMHC shall cooperate with the Department's certification and compliance reviews.

3002.8 Certification as an FSMHC shall be for one (1) calendar year for new applicants, and two (2) calendar years for existing providers seeking renewal. Certification shall start from the date of issuance of certification by the Department, subject to the FSMHC's continuous compliance with these certification standards. Certification shall remain in effect until it expires, is renewed, or is revoked pursuant to § 3003. The Certification shall specify the effective date of the certification and the date the certification expires.

3002.9 A Certification is not transferable from one organization to another.

3002.10 An applicant or FSMHC that fails to comply with these Department certification standards may receive a Statement of Deficiencies (SOD) from the Department. The SOD shall describe the areas of non-compliance, identify actions needed to bring operations into compliance, and establish a timeframe for the provider's submission of a written Corrective Action Plan (CAP). The Department may, at its discretion, proceed directly to denial or decertification without issuing an SOD when the deficiencies relate to the health or safety of consumers, or constitute a material misrepresentation, fraud, or abuse.

3002.11 When the Department issues a SOD, the applicant or FSMHC shall submit a CAP. The CAP shall describe the actions to be taken and specify a timeframe for correcting the areas of non-compliance. The CAP shall be submitted to the Department no later than (10) business days from the date of receipt of the Department's SOD.

3002.12 The Department shall notify the applicant or FSMHC whether the applicant or FSMHC's CAP is accepted within ten (10) business days after receipt. Failure to comply with the CAP shall be grounds for denial or decertification.

3002.13 The Department may issue certification after it verifies that the applicant or FSMHC has complied with its CAP and meets all the certification standards.

3002.14 These rules do not create any rights or entitlements. Certification as a FSMHC depends upon the Director's assessment of the need for additional providers(s) and availability of funds. No certifications shall be issued during the period of time that the Department has imposed a moratorium via published notice in the *District of Columbia Register*.

3002.15 The Director may deny or revoke certification if the applicant or FSMHC fails to comply with any certification standard, or if the FSMHC fails to maintain a provider agreement with DHCF.

3002.16 Certification shall be considered terminated and invalid if the FSMHC fails to apply for renewal of certification with a complete application ninety (90) calendar days prior to the expiration date of the current certification, voluntarily relinquishes certification or goes out of business.

3002.17 The FSMHC shall notify the Department within forty-eight (48) hours of any changes in its operation that affect the FSMHC's continued compliance with these certification standards, including changes in:

(a) Ownership or control;

(b) Services;

(c) Key clinical staff, *e.g.*, psychiatrist, therapists, or the FSMHC Clinical Administrator; and

(d) Any affiliation and referral arrangements.

3002.18 Each certification application shall contain the following information:

(a) A list of the services to be provided, target population for its services and potential referral sources;

(b) Identification of the psychiatrist(s) who will provide clinical and administrative direction, and provide direct services;

(c) Personnel documentation including:

(1) Staff roster that includes for each individual the name, position, license/degree, full or part time status, and the services provided. Roster must include a full time Clinical Administrator, although one or more persons may share part time duties to equal full-time coverage.

(2) A signed contract for each clinical staff member, or a letter signed by each clinician that attests to his/her intention to become an employee with the organization. Documents must include the time frame of the commitment and the scope of service and responsibilities that will be expected as a condition of employment.

(3) Completed background checks on all personnel to ensure none of the individuals employed by, or affiliated with, the administration or governing board or body, if any, are excluded from participation in federal reimbursements or as a District contractor.

(4) Completed criminal background checks as outlined in D.C. Official Code § 44-551 and Title 22-B Chapter 47 for all unlicensed individuals employed or contracted with the FSMHC.

(5) Completed child protection registry check for all staff.

(6) A copy of the current license and resume for each licensed practitioner and a copy of the resume(s) for the designated full-time equivalent Clinical Administrator(s).

(d) A program manual that contains all policies listed in § 3006;

(e) An organizational chart that clearly indicates all clinical and administrative positions within the FSMHC.

(1) If the FSMHC is contained within a larger parent organization, the chart must clearly show how the FSMHC program fits administratively and clinically into the larger organizational structure; and

(2) The chart shall clearly define the agency structure, staff responsibilities, lines of authority, and clinical process flow.

(f) A job description for the psychiatrist(s) that includes a description of how the psychiatrist(s) will provide clinical and administrative direction for all services provided by the FSMHC.

3003 DENIAL AND DECERTIFICATION PROCESS

3003.1 The Director may deny initial certification if the applicant fails to comply with any certification standard or the application fails to demonstrate the applicant's capacity to deliver high quality FSMHC services on a sustained and regular basis. The Director may also deny certification if the applicant proposes to operate a facility in an area already served by one or more providers. The Department's priority shall be to grant certification to applicants with the demonstrated capacity to deliver high quality FSMHC services that will address unmet needs of the behavioral health system.

3003.2 While applicants may make minor corrections and substitutions to their applications during the certification process, evidence of one or more of the following shall constitute good cause to deny the application for certification when the circumstances demonstrate deliberate misrepresentations, organizational instability, or the lack of preparedness or capacity to meet and sustain compliance with this chapter:

(a) An incomplete application;

(b) False information provided by applicant or contained in an application;

(c) One or more changes to an organizational chart during the application process;

(d) A facility that is inadequate in health, safety, size or configuration to provide FSMHC services consistent with high quality care and privacy standards;

(e) The lack of demonstrated experience providing FSMHC services by the applicant's clinical leadership, practitioners, or staff;

(f) An applicant's lack of financial resources to carry out its commitments and obligations under this chapter for the foreseeable future;

(g) An applicant's failure to timely respond to the Department's requests for information; or

(h) History of poor performance.

3003.3 Upon written request submitted by the applicant and received by the Department within fifteen (15) days of the certification denial, the Department shall provide an applicant an impartial administrative review of the decision. The Department shall conduct the administrative review to determine whether the certification denial

complied with §§ 3003.1-3003.2. Each request for an administrative review shall contain a concise statement of the reason(s) why the certification denial was in error. The Director shall issue a written decision within fifteen (15) days. The Director's decision is final and not subject to further appeal. An applicant, its principals, and successor in interests shall not be allowed to reapply for certification for twelve (12) months following the date of denial.

3003.4 The Department shall decertify existing providers who fail to comply with the certification requirements contained in this chapter. Evidence of one or more of the following shall constitute good cause to decertify:

(a) An incomplete recertification application;

(b) False information provided by provider or contained in a recertification application;

(c) High staff turnover during the certification period demonstrating organizational instability;

(d) One or more documented violations of the certification standards during the certification period that evidence a provider's lack of capacity to meet and sustain compliance with this chapter;

(e) Claims audit error rate in excess of twenty-five percent (25%);

(f) Poor quality of care;

(g) A provider's lack of financial resources to carry out its commitments and obligations under this chapter for the foreseeable future; or

(h) Failure to cooperate with Department investigations or lack of timely response to information requests.

3003.5 Any written notice of revocation shall include the factual basis for the revocation, the effective date, and describe the FSMHC's right to request an administrative review.

3003.6 Within fifteen (15) business days of the date on the notice of revocation, the FSMHC may request an administrative review from the Director.

3003.7 Each request for an administrative review shall contain a concise statement of the reason(s) why the FSMHC asserts that it should not have its certification revoked and include any relevant supporting documentation.

3003.8 Each administrative review shall be conducted by the Director and shall be completed within fifteen (15) business days of the receipt of the provider's request.

3003.9 The Director shall issue a written decision and provide a copy to the FSMHC. If the Director approves the revocation of the FSMHC's certification, the FSMHC may, within fifteen (15) business days of the receipt of the Director's written decision, request a hearing under the D.C. Administrative Procedure Act, effective October 21, 1968 (Pub. L. 90-614, D.C. Official Code §§ 2-501 *et seq.*) The administrative hearing shall be limited to the issues raised in the administrative review request.

3003.10 Once certification is revoked, the FSMHC shall not be allowed to reapply for certification for a period of two (2) years following the date of the order of revocation. If an FSMHC reapplies for certification, the FSMHC must reapply in accordance with the established certification standards for the type of services provided, and show evidence that the grounds for the revocation have been corrected.

3004 CERTIFICATION REQUIREMENTS: GENERAL

3004.1 The purpose of certification is to ensure that FSMHC have the necessary qualifications and capacity to provide high quality mental health services to District residents.

3004.2 The FSMHC shall conform with Federal and local laws and regulations pertaining to health and fire safety, drug procurement and distribution, disposal of medications and controlled substances, building construction, maintenance and equipment standards, sanitation, and communicable and reportable diseases.

3004.3 The FSMHC setting shall have sufficient and appropriate office space to conduct individual and group interventions including intake, therapy, and assessment in such way that the confidentiality of the consumer is maintained and preserved.

3004.4 The FSMHC shall operate and provide services in accordance with all applicable provisions of the D.C. Human Rights Act, effective June 28, 1994 (D.C. Law 2-38; D.C. Official Code §§ 2-1401.01, *et seq*.).

3004.5 The FSMHC shall ensure that all services, as set forth in § 3010.8 of this chapter, are provided by or under the direction of a psychiatrist. Health Home services provided by a FSMHC shall be provided in accordance with requirements set forth in 29 DCMR §§ 6900 *et seq.* and 22-A DCMR §§ 2500 *et seq.*

3004.6 The FSMHC shall comply with its Medicaid Provider Agreement and provide services to all eligible consumers who have been determined by the independently licensed behavioral health practitioner to be clinically appropriate to receive services in an outpatient mental health setting.

3004.7 The FSMHC shall comply with all requirements of the Health Insurance Portability and Accountability Act (HIPAA) and its implementing regulations, and the D.C.

Mental Health Information Act (MHIA), effective March 3, 1979 (D.C. Law 2-136; D.C. Official Code § 7-1201.01).

3004.8 The FSMHC shall have the technological and administrative capacity to electronically submit claims to DHCF, the Department, and third-party payers.

3004.9 The FSMHC shall provide evidence of Commercial General Liability insurance coverage of at least one million ($1,000,000) per occurrence limits, three million ($3,000,000) aggregate; Bodily Injury and Property Damage including: premises-operations; broad form property damage, Products and Advertising Injury; contractual liability and independent providers. The provider shall maintain Completed Operations coverage for five (5) years following final acceptance of the work performed.

3005 STAFFING AND ADMINISTRATION

3005.1 Each FSMHC shall be staffed with licensed behavioral health practitioners who shall be professionally responsible for the provision of the mental health services delineated in its approved provider agreement.

3005.2 Each FSMHC shall have a psychiatrist on staff who is available on a regular and emergency basis and who shall be responsible for the provision of the mental health services provided by the FSMHC.

3005.3 Each participating FSMHC's approved organizational chart and program manual shall clearly show that its services will be provided by or under the direction of a psychiatrist. The psychiatrist shall spend as much time on site as necessary to ensure consumers are getting services in a safe and efficient manner in accordance with accepted standards of medical care. "Under the direction of a psychiatrist" means the psychiatrist shall:

(a) Assure that the services provided are medically necessary; and

(b) Assume professional responsibility for the services provided.

3005.4 The supervision and management of consumer care shall be the responsibility of the psychiatrist, and the psychiatrist shall be available for advice and consultation with the treating staff as often as necessary to ensure adequate supervision and quality of care.

3005.5 Each participating FSMHC shall have a full-time equivalent Clinical Administrator who shall have the authority and responsibility for the conduct of the affairs of the FSMHC, except for those matters committed by the provisions of this chapter to the authority of the psychiatrist. The Clinical Administrator shall be an independently licensed behavioral health practitioner.

3005.6 The Clinical Administrator's qualifications, authority, and duties shall be defined in writing.

3005.7 The organizational chart shall also show relationships between the clinic and outside entities, such as the following:

(a) The Board of Directors;

(b) Steering committees;

(c) Advisory boards; and

(d) Professional health or service association affiliations.

3006 PROGRAM MANUAL

3006.1 Each FSMHC shall have a current program manual that outlines all of its policies and procedures.

3006.2 The program manual shall, at a minimum, include, the following:

(a) A mission statement reflecting the goals and mission of the Department;

(b) The range of services to be provided, and a description of the service delivery model;

(c) Fee schedules;

(d) The population to be served;

(e) Operational schedules;

(f) Personnel policies as listed in § 3006.3;

(g) Other policies as listed in § 3006.4;

(h) Financial and record-keeping procedures;

(i) Compliance and integrity program that complies with § 3011; and

(j) Consumer rights statement that complies with the District of Columbia Mental Health Consumer Protection Act, effective December 18, 2001 (D.C. Law 14-56; D.C. Official Code § 7-1231.04).

3006.3 Minimum personnel administration requirements include the following:

(a) Written job descriptions of all staff positions, procedures for employee

hiring, evaluations, grievances, and in-service training;

(b) A minimum of one (1) hour per week of supervision for all behavioral health practitioners who deliver services with supervision, as described in § 3010.9, furnished by an independently licensed behavioral health practitioner designated as the supervisor. Supervision shall cover consumer related and other activities;

(c) An up-to-date listing of professional staff licensure information; and

(d) Written policies and procedures for emergency care.

3006.4 The program manual shall include the following policies:

(a) Admission, Waitlist, Transfer, and Discharge Policy, which describes pre-admission, intake, screening, assessment, referral, transfer, and discharge procedures and inform all consumers of the right to freely choose the provider(s) from whom they will receive services;

(b) Training Policy, which incorporates a written plan for staff development and organizational onboarding, including the training and performance improvement needs of all employees working in the FSMHC;

(c) Anti-Discrimination Policy, which complies with the D.C. Human Rights Act;

(d) Billing and Payment Policy, which requires the FSMHC provider to have the necessary operational capacity to verify the eligibility for Medicaid and other third-party payers, submit Medicaid and third-party claims timely and accurately, document information on services provided, and track payments received;

(e) Care Coordination Policy, which establishes the roles and responsibilities of FSMHC staff in the coordination of care across behavioral health treatment and primary care treatment settings, especially in regards to transitions into or from more intensive levels of care or institutional settings;

(f) Clinical Records Maintenance and Storage Policy, which at a minimum meets the requirements in § 3007 of this chapter;

(g) Complaint and Grievance Policy, which establishes a well-publicized complaint and grievance system, including written policies and procedures for handling consumer, family, and practitioner complaints and grievances that conforms to the requirements in 22-A DCMR § 306;

(h) Consent to Treatment Policy, which shall establish and adhere to policies and procedures for obtaining written informed consent to treatment from consumers which comply with applicable Federal and District laws and regulations, including 22-A DCMR Chapter 1;

(i) Cultural Competence Policy, which shall define the set of values, principles, attitudes, policies and demonstrative behaviors that will enable the FSMHC to work effectively cross-culturally;

(j) Disaster Recovery Plan, which shall establish policies and procedures for maintaining the security and privacy of protected health information and data. Each plan shall also stipulate back-up and redundant systems and measures that are designed to prevent the loss of data and information and to enable the recovery of data and information lost due to disastrous events;

(k) Infection Control Policy, which shall establish policies and procedures governing infection control that comply with applicable Federal and District laws and regulations, including, but not limited to, the blood borne pathogens standard set forth in 29 CFR § 1910.1030;

(l) Interpreter Policy, which, at a minimum, requires using a professional interpreter or interpretation service including qualified sign language interpreters in order to effectively communicate with deaf consumers and those with limited English proficiency;

(m) Medication Storage and Administration Policy, which complies with applicable Federal and District laws and regulations regarding the purchasing, receipt, storage, distribution, dispensing, administering, return, and destruction of medications and require the FSMHC to maintain all medications and prescription blanks in a secured and locked area;

(n) Consumer Choice Policy, which shall establish policies and procedures governing the means by which consumers shall be informed of the full choices of FSMHC providers and other mental health service providers available;

(o) On-Call Policy, which shall require the FSMHC to adopt procedures for handling routine, urgent, and emergency situations that include referral procedures to local emergency departments and on-call arrangements for clinical staff and physicians. The policy shall describe the availability of timely access to face-to-face crisis support services, specify how the FSMHC provider will interact and coordinate services with Department-designated crisis and emergency services, and include procedures for triaging consumers who require crisis services or psychiatric hospitalization;

(p) Staff Performance Review Policy, which shall require at a minimum annual evaluations of clinical and administrative staff performance that includes an assessment of clinical competence, as well as general organizational work requirements and an assessment of key functions as described in the job description;

(q) Primary Care Provider Communication Policy, which shall establish policies and procedures governing communication with the consumer's primary care providers, including the FSMHC provider's interface with primary health care providers, managed health care plans, and other providers of mental health services. This policy shall also describe the FSMHC provider's activities which will enhance consumer access to primary health care and the coordination of mental health and primary health care services;

(r) Quality Improvement ("QI") Policy, which shall describe the objectives and scope of its QI program and require provider staff, consumer and family involvement in the QI program. The QI program shall ensure and measure the following: access and availability of services; coordination of care with behavioral health treatment and primary care treatment settings; compliance with FSMHC certification standards; adequacy, appropriateness and quality of care; efficient utilization of resources; and consumer and family satisfaction with services. The FSMHC shall submit a written report to the Department annually on the outcomes identified in the QI program.

(s) Consumer Privacy and Release of Information Policy, which shall outline how the FSMHC will protect consumer's health information and ensure compliance with the HIPAA and the MHIA. The program shall develop policies and procedures to disclose protected behavioral health information to other certified providers, primary health care providers, and other health care organizations when necessary to coordinate the care and treatment of its consumers. These procedures shall include entering into an agreement with the District's Health Information Exchange (HIE). The program shall advise each consumer of the program's notice of privacy practices that authorizes this disclosure to other providers and shall afford the consumer the opportunity to opt-out of that disclosure in accord with the MHIA. The program shall document the individual's decision;

(t) Supervision and Peer Review Policy, which shall meet the requirements of § 3006.3(b) and require personnel files of clinical staff working under supervision to contain evidence that the Supervision Policy is observed;

(u) Bullying Prevention Policy, which conforms to the requirements of 4 DCMR Chapter 15; and

(v) Plan of Care Policy, which shall adhere to § 3009 of this chapter and follow

best industry practices.

3006.5 The Department shall review and approve each FSMHC provider's policies during the certification process. The FSMHC provider shall submit any policies that have been revised to the Department for review and approval during recertification.

3007 RECORDS

3007.1 In order to ensure that the treatment provided and reimbursed by the District is of the highest quality and fully meets all standards for certification and reimbursement, each participating FSMHC shall maintain consumer records and individual plans of care in a manner that will render them amenable to audit and review by authorized Federal, District, and Department personnel.

3007.2 The requirements of § 3007.1 shall comply with mandated access requirements in federal and local law.

3007.3 The participating FSMHC shall maintain, and make immediately available upon request by the Department and local Medicaid personnel, complete financial, claims, and medical records. Failure to cooperate may result in suspension of payment(s), referral to the Medicaid Fraud Control Unit, and termination of the provider's contract.

3007.4 All required financial and treatment records and information shall be properly maintained for a period of at least ten (10) years following the date of treatment for which a claim for reimbursement was made, or the date at which the consumer turns eighteen (18), or until an audit or litigation has been completed, whichever is the latest date.

3007.5 All medical records shall be retained in accordance with Federal and District law.

3008 MEDICAL RECORDS

3008.1 All phases of the consumer's treatment and related information shall be entered in the consumer's medical record. The FSMHC shall use electronic medical records. Each FSMHC shall participate in the District's Health Information Exchange (HIE). The Department may only waive the requirement to interface with the District's HIE during the initial period of certification.

3008.2 The medical records shall include, but are not limited to, the following:

(a) Complete identification data, including Medicaid number and other third-party payer information;

(b) Medical history, initial psychiatric evaluation, psychosocial assessment, and histories, and, if appropriate, social service and nursing care plans for

meeting current and future personal, financial, social, and nursing needs of the consumer;

(c) A record of a screening for the presence of a co-occurring substance use disorder at intake and upon any treatment plan revision;

(d) Individual plan of care, completed in accordance with § 3009 of this chapter;

(e) Psychiatrist's, Physician's Assistant, or APRN's medication orders that shall include:

(1) The name of the drug(s);

(2) The dosage, route and frequency of administration;

(3) The quantity given;

(4) The number of refills; and

(5) The signature of the authorized staff rendering the service.

(f) Documentation of all behavioral health-related medical treatment received during treatment at the FSMHC and appropriate encounter notes related to it. Consumers on medications should have, where indicated, routine blood or other examinations to detect irregularities duly recorded;

(g) Encounter notes, to include sufficient written clinical documentation to support each therapy, service, activity, or session for which billing is made which, at a minimum, consists of:

(1) The specific service type rendered;

(2) The date, duration, and actual beginning and ending time (denoting a.m. or p.m.) during which the services were rendered;

(3) Name, title, credentials and signature of the person providing the services;

(4) A description of each encounter or service sufficient to document that the service was provided; and

(5) A description of the consumer's response to the intervention.

3009 INDIVIDUAL PLAN OF CARE

3009.1 Each FSMHC shall develop an individual plan of care for each consumer. Copies of individual plans of care shall be filed in consumer records.

3009.2 The plans of care shall include the following:

(a) A written assessment of the consumer's current mental condition, co-occurring substance use, and physical co-morbidity;

(b) A diagnosis by a licensed behavioral health practitioners able to diagnose in accordance with his or her professional license, using the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM) currently in use by the Department;

(c) The names of the behavioral health practitioner(s) involved in the approval and direction of the plan of care;

(d) The treatment goals, strengths, challenges, objectives, and interventions;

(e) The name and title of other staff who shall participate in carrying out the plan of care; and

(f) The independently licensed behavioral health practitioner's certification, by dated signature: (1) of the medical necessity for all mental health services detailed in the plan, and (2) that outpatient treatment is an appropriate level of care for the identified consumer.

3009.3 The plan of care shall be reviewed and amended, as needed in case of a change in the consumer's status and at least annually by the independently licensed behavioral health practitioner. The consumer's continuing need for treatment and medical necessity of treatment shall be clearly documented. The independently licensed behavioral health practitioner shall certify by his or her signature:

(a) That the review occurred;

(b) The medical necessity for all mental health services detailed in the plan; and

(c) That outpatient treatment is an appropriate level of care for the identified consumer.

3009.4 The Consumer, and/or the parent or guardian, if applicable, shall sign his or her plan of care.

3010 REIMBURSEMENT

3010.1 In order to be reimbursed, FSMHC services shall be medically necessary, reasonable in duration, and in full compliance with this chapter. A participating FSMHC shall agree to accept as payment in full the amount determined by DHCF or the Department, as appropriate, as the fee for the authorized services provided to Medicaid consumers and other eligible consumers for whom the District of Columbia is reimbursing the provider for services. No additional charge may be made to the consumer, any member of the family, or to any other source.

3010.2 A participating FSMHC shall agree to bill any and all other known third-party payers prior to billing Medicaid or the District.

3010.3 The payment and satisfaction of any FSMHC claim will be from federal and District funds. Any false claims, statements, documents, or concealment of material facts by the FSMHC shall be referred to the DHCF Office of Program Integrity and considered grounds for denial of claims, recoupment of false claims previously paid, and decertification. These remedies are in addition to any other remedies that the law may provide for false claims.

3010.4 DHCF and the Department shall establish rates and reimburse for only those services outlined in § 3010.8 and provided under the direction of a psychiatrist. Reimbursement for Medicaid-funded and locally-funded FSMHC services shall be at the rate contained in the District of Columbia Medicaid fee schedule available online at www.dc-medicaid.com. All future updates to the service codes and rates will be included in the District of Columbia Medicaid fee schedule pursuant to the procedures established in 29 DCMR § 988. Health Home services provided by a FSMHC shall be provided in accordance with the requirements set forth in 29 DCMR §§ 6900 *et seq.* and 22-A DCMR §§ 2500 *et seq*.

3010.5 Treatment-related services, such as information and referral services, charting, internal case conferences, transportation, person and agency conferences, and similar charges shall not be reimbursable under these rules. FSMHCs certified as a Health Home shall be reimbursed for the provision of Health Home services in accordance with the requirements set forth in 29 DCMR §§ 6900 *et seq.* and 22-A DCMR §§ 2500 *et seq.*

3010.6 Recreational therapy shall not be reimbursed as an FSMHC service.

3010.7 Excluding Health Home services provided in accordance with requirements set forth in 29 DCMR §§ 6900 *et seq.* and 22-A DCMR §§ 2500 *et seq.*, a participating FSMHC may be reimbursed for no more than one individual therapy session, one group therapy session, and one psychiatrist visit per person on the same day. Any other service combinations require prior approval from the Department before service delivery.

3010.8 The following services shall be reimbursable if the independently licensed behavioral health practitioner certifies that the services are medically necessary, a current plan of care outlines the required services, and the services are provided by a behavioral health practitioner acting within applicable Federal and District laws and regulations:

(a) Diagnostic Evaluation - behavior assessment procedures used to identify the psychological, behavioral, emotional, cognitive, and social factors important to the treatment planning process;

(b) Psychiatric Diagnostic Evaluation - integrated biophysical assessments, including history, mental status, and recommendations;

(c) Comprehensive Psychological Testing - up to five (5) hours of psychometric and projective tests with a written report done under the direction of a psychologist;

(d) Therapy:

(1) Individual Psychotherapy - verbal, drug augmented, or other therapy methods provided by a behavioral health practitioner in a face-to-face involvement with one (1) consumer to the exclusion of other consumers and duties. Session length is pursuant to the Current Procedural Terminology (CPT) Manual (most current edition);

(2) Family therapy - therapy with or without the consumer and one (1) or more family members present. Verbal or other therapy methods by a behavioral health practitioner in a personal involvement with the consumer and family to the exclusion of other consumers and duties. Session length is pursuant to the CPT Manual (most current edition). The clinic may bill Medicaid only for the Medicaid consumer; and

(3) Group therapy - verbal or other therapy methods provided by a behavioral health practitioner in face-to-face involvement with at least three (3) and no more than twelve (12) consumers. Session length is pursuant to the Current Procedural Terminology (CPT) Manual (most current edition);

(e) Prescription visits - a visit with a physician for review and evaluation of the medication history of the consumer and the writing or renewal of prescriptions as necessary. A minimum of ten (10) minutes shall be allotted to the visit; and

(f) Family conferences - meeting with the family or other significant persons (school, court, or other agency officials) to interpret or explain: medical,

psychiatric, or psychological examinations and procedures; other accumulated data; and advice on how to assist the patient. A minimum of fifty (50) minutes shall be allotted to personal involvement with the family or other significant persons. The clinic may bill Medicaid only for the Medicaid patient.

3010.9 Behavioral health practitioners for FSMHC are described below:

	INDEPENDENTLY LICENSED BEHAVIORAL HEALTH PRACTITIONER	LICENSED BEHAVIORAL HEALTH PRACTITIONER AND OTHER BEHAVIORAL HEALTH PRACTITIONER WITH SUPERVISION
Diagnostic Evaluation	• Psychiatrist • Psychologist • Licensed Independent Clinical Social Worker (LICSW) • Advance Practice Registered Nurse (APRN) • License Professional Counselor (LPC) • License Marriage and Family Therapist (LMFT)	• License Graduate Social Worker (LGSW) • License Graduate Professional Counselor (LGPC) • Licensed independent Social Worker (LISW) • Registered Nurse (RN) • Physician Assistant • Psychology Associate • Students, interns, or residents for any of the allowed licenses for examination and assessment
Psychiatric Diagnostic Evaluation	• Psychiatrist • APRN	• Physician Assistant
Comprehensive Psychological Testing	• Psychologist	• Psychology Associate • Psychology student/intern
Therapy	• Psychiatrist • Psychologist • LICSW • APRN • LPC • LMFT	• LGSW • LGPC • LISW • Psychology Associate • Students, interns, or residents for any of the allowed licenses for therapy
Prescription Visits	• Psychiatrist • APRN	• Physician Assistant
Family Conferences	• Psychiatrist • Psychologist	• LGSW • LGPC

	• LICSW • APRN • LPC • LMFT	• LISW • RN • Psychology Associate • Students, interns, or residents for any of the allowed licenses for therapy

3011 COMPLIANCE AND INTEGRITY PROGRAM

3011.1 Each provider shall establish and adhere to a plan for ensuring compliance with the Medicaid program and this regulation. Each provider shall submit its Corporate Compliance Plan and any modifications thereto to the Department as part of the certification or recertification process. At a minimum, the plan shall:

(a) Designate an officer or director with responsibility and authority to implement and oversee the operation of the Corporate Compliance Plan;

(b) Require initial, and, thereafter, quarterly exclusion checks on all employees to ensure no individual is excluded from participation in a federal health care program as found on the Department of Health and Human Services "List of Excluded Individuals/Entities" (http://oig.hhs.gov/fraud/exclusion.asp) or the General Services Administration "Excluded Parties List System" (http://www.wpls.gov) or the "District of Columbia Excluded Parties List" (http://ocp.dc.gov/DC/Excluded+Parties+List) maintained by the District's Debarment and Suspension Panel;

(c) Require that all officers, directors, managers, and employees enforce its provisions and receive annual compliance training;

(d) Include procedures designed to prevent and detect potential or suspected false claims, abuse or fraud in the administration and delivery of FSMHC services;

(e) Include procedures for the confidential reporting of violations of the Corporate Compliance Plan to the Department, including procedures for the investigation and follow-up of any reported violations;

(f) Require that the FSMHC conduct annual internal audit using RAT-STATS, a statistical software package provided free of charge by the U.S. Department of Health and Human Services Office of the Inspector General, or other comparable software program. The audit shall utilize statistically valid and random sampling and identify any overpayments. The error rate for each audit shall be calculated as provided in § 3012;

(g) Require the FSMHC provide a copy of the internal audit and all supporting documents to the Department and to repay any overpayments identified in the provider's internal audit within sixty (60) days;

(h) Ensure that the identities of individuals reporting suspected violations of the Corporate Compliance Plan are protected and that individuals reporting suspected violations, fraud, or abuse are not retaliated against;

(i) Require that confirmed violations of the compliance plan be reported to the Department within twenty-four (24) hours of confirmation;

(j) Require any confirmed or suspected fraud and abuse under District or Federal law or regulation be reported to the Department;

(k) Require cooperation with Department investigations of unusual incidents, consumer deaths related to suicide, and the death of a child or youth consumer; and

(l) Require data reporting regarding key performance indicators published annually in the *D.C. Register*.

3012 AUDITS AND REVIEWS

3012.1 This Section sets forth the requirements for audits and reviews of FSMHC services and provider records. The Department, DHCF, and the D.C. Office of the Inspector General Medicaid Fraud Control Unit, among other entities, may conduct audits and reviews of FSMHC operations, including billing and treatment. The Department and DHCF shall perform regular audits of FSMHC providers to ensure that payments are consistent with efficiency, economy, quality of care, and are made in accordance with Federal and District conditions of payment, including programmatic duties, documentation, and reimbursement requirements under this chapter.

3012.2 The audit process shall utilize statistically valid sampling methods when the audit is based on claims sampling. The audit process may review all claims by type, time-period, and/or other criteria established by the Department, DHCF, or other entities. Statistically valid and commonly accepted standards methods for calculating overpayments will be followed.

3012.3 If DHCF or the Department denies a Medicaid claim during an audit, DHCF or the Department 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 and the Department shall issue a joint 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 FSMHC 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 FSMHC 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.

3012.4 If DHCF or the Department denies a locally-funded claim during an audit, DHCF or the Department 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) The Department shall issue an overpayment demand letter which sets forth the reasons for the recoupment, including specific reference to the particular sections of the statute, rule, or provider agreement, the amount to be recouped and the procedures for requesting an Administrative review;

(b) The FSMHC shall have thirty (30) days from the date of the demand letter to request an Administrative Review and submit documentary evidence and written argument to DBH 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) The Department shall conduct an Administrative Review conducted by a group of independently licensed clinicians who have not previously examined the claims under review. The DBH Director will then make a

final determination regarding the claims under review;

(e) The Department shall mail a written determination relative to the Administrative Review not later than ten (10) days from the date of the written request for review. Any recoupment remaining after the Administrative Review will begin thirty (30) days following the date of the written determination;

(f) Within fifteen (15) days of receipt, the FSMHC may appeal the written determination by filing a written notice of appeal with OAH; and

(g) Filing an appeal with the OAH shall not stay any action to recover any overpayment.

3012.5 All participant, personnel, and 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 or the Department shall retain the right to conduct announced or unannounced audits or reviews at any time and audits or reviews.

3012.6 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.

3012.7 The failure of a provider to release or to grant access to program documents and records to auditors in a timely manner, after reasonable notice by DHCF or the Department 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, or for the Department to terminate an HCA for any other reason.

3012.8 As part of the audit process, providers shall grant access to necessary records to verify compliance with certification standards and conditions of payment, including but not limited:

(a) FSMHC 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 §§ 3008 and 3009 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 FSMHC services.

3012.9 Nothing in this rule affects a provider's independent legal obligation under this chapter and Federal and District law to implement and enforce an internal auditing program that self-identifies overpayments and reimburses DHCF or other payers within sixty (60) days of discovery.

3013 REPORTING UNUSUAL INCIDENTS

3013.1 An FSMHC shall immediately notify the Department of any unusual incident that may adversely affect the health, safety, or welfare of any enrolled consumer by submitting a completed Department Unusual Incident Report form to the Department's Division of Incident Management and Investigation email address.

3013.2 An FSMHC shall also provide a copy of the completed Unusual Incident Report form provided to the Department to the consumer's parent(s) or guardian(s) of each child or youth affected by the unusual incident.

3013.3 Unusual incidents may include, but are not limited to, the following:

(a) Death of a person occurring at the FSMHC;

(b) Death of a consumer related to suicide;

(c) Death of a child or youth in treatment at the FSMHC;

(d) Injury to or illness of any consumer that occurs while the consumer is at the FSMHC that requires hospitalization or emergency medical treatment;

(e) Damage to the FSMHC or to any FSMHC vehicle or equipment that interferes with the capability of the provider to protect the health, safety and welfare of the children and adults at the FSMHC;

(f) Outbreak of or a single occurrence of communicable disease at the FSMHC that is required to be reported to DC Health in accordance with Title 22 of the District of Columbia Municipal Regulations;

(g) Unauthorized departure of an enrolled child or youth consumer or any circumstances under which a child or youth consumer is deemed unaccounted for or missing;

(h) Any traffic accident involving a vehicle rented, owned, maintained, or contracted by the FSMHC and in which consumers were transported at the time of the accident;

(i) Any adverse or negative action that the provider takes against an employee, volunteer, or household member related to any substantiated crime against a consumer; and

(j) Any other incident at the FSMHC that requires a response by emergency service personnel, such as police, fire, ambulance, or poison control.

3013.4 In the case of a traffic accident or an incident involving perceived or actual criminal activity, the FSMHC shall also file a report with the appropriate law enforcement authorities.

3013.5 Any FSMHC staff member who knows or reasonably believes that an enrolled child consumer is, has been, or is in immediate danger of being abused or neglected shall, as required by the District of Columbia Prevention of Child Abuse and Neglect Act of 1977, effective September 23, 1977 (D.C. Law 2-22; D.C. Official Code §§ 4-1321.01 *et seq*.), make or cause to be made an immediate oral report to:

(a) The Child Protective Services Division of the Child and Family Services Administration (CFSA), via the CFSA twenty-four (24) hour Child Abuse and Neglect Hotline; and

(b) The Metropolitan Police Department (MPD).

3013.6 Any FSMHC staff member who knows or reasonably believes that an enrolled adult consumer is, has been, or is in immediate danger of being abused or neglected shall, as required by the Adult Protective Services Act of 1984, effective March 14, 1985 (D.C. Law 5-156; D.C. Official Code §§ 7-1901, *et seq*.), make or cause to be made an immediate oral report to:

(a) Adult Protective Services in the Department of Aging and Community Living (DACL), via the twenty-four (24) hour Adult Protective Services Hotline; and

(b) MPD.

3013.7 In the unusual incident reports required by this section, the staff member shall include:

(a) The name, age, sex, and household address of the consumer who is the subject of the report;

(b) A statement that the consumer who is the subject of the report is receiving services at the FSMHC;

(c) The name, address, and telephone number of the FSMHC;

(d) To the extent known, the name, age, and sex of each sibling or child living in the same household as the consumer who is the subject of the report;

(e) To the extent known, the name, age, and sex of each parent, guardian, or other caretaker of the consumer;

(f) The information that led the staff member to suspect that the consumer who is the subject of the report is being, or is at risk of being, abused or neglected, the nature and extent of the perceived or actual abuse or neglect, and the identity of the person(s) responsible for it;

(g) Any other information that may be helpful in establishing whether the consumer who is the subject of the report is being, or is at risk of being, abused or neglected, the cause of the suspected abuse or neglect, and the identity of the person(s) responsible for it;

(h) The name, title, or occupation, and contact information of the staff member making the report;

(i) Any actions taken by the staff member or the FSMHC concerning the consumer in response to the situation; and

(j) Any other information required by law.

3014 NOTICES OF INFRACTION

3014.1 The Department may issue a Notice of Infraction (NOI) for any violation of this chapter. The fine amount for any NOI issued under this chapter shall be as follows:

(a) For the first offense five hundred dollars ($500);

(b) For the second offense one thousand dollars ($1,000);

(c) For the third offense two thousand dollars ($2,000); and

(d) For the fourth and subsequent offenses for thousand dollars ($4,000).

3014.2 The administrative procedure for the appeal of an NOI issued under this chapter shall be governed by 16 DCMR §§ 3100 *et seq.*

3099 DEFINITIONS

3099.1 When used in this chapter, the following terms and phrases shall have the meanings ascribed:

Clinical Administrator – an independently licensed behavioral health practitioner, as defined in this chapter, who has the authority and responsibility for the conduct of the affairs of the FSMHC, except for those matters committed by the provisions of this chapter to the authority of the psychiatrist.

Consumer – a person eligible to receive FSMHC services as defined in this chapter.

Free Standing Mental Health Clinic – a formally organized psychiatric clinic furnishing psychiatric services, under the direction of a physician (psychiatrist) who is licensed in the District of Columbia, in a facility not administered by a hospital, but organized and operated to provide mental health services on an outpatient basis.

Independently Licensed Behavioral Health Practitioner – any person who is an APRN, LICSW, LMFT, LPC, psychiatrist, or psychologist, as defined in this chapter.

Medical history – a record of the following information, at a minimum, about the consumer:

(a) Major surgical procedures that have been performed on the consumer and any related complications;

(b) Any present, past, or recurring diseases; and

(c) The consumer's current medical condition and status, including the names of physician(s) rendering current medications or other ongoing treatments to the consumer.

Licensed Behavioral Health Practitioners – the following practitioners are licensed behavioral health practitioners for the purposes of this chapter.

(a) **"APRN"** – a person licensed as an advanced practice registered nurse in accordance with applicable District laws and regulations, and who has psychiatry as a specialty area of practice, works in a collaborative protocol with a psychiatrist, or demonstrates proficiency in mental health by having at least five (5) years of experience in psychiatric care delivery.

(b) **"LGPC"** – a person licensed as a graduate professional counselor in accordance with applicable District laws and regulations.

(c) **"LGSW"** – a person licensed as a graduate social worker in accordance with applicable District laws and regulations.

(d) **"LICSW"** – a person licensed as an independent clinical social worker in accordance with applicable District laws and regulations.

(e) **"LISW"** – a person licensed as an independent social worker in accordance with applicable District laws and regulations.

(f) **"LMFT"** – a person licensed as a marriage and family therapist in accordance with applicable District laws and regulations.

(g) **"LPC"** – a person licensed as a professional counselor in accordance with applicable District laws and regulations.

(h) **"RN"** – a person licensed as a registered nurse in accordance with applicable District laws and regulations with training and experience in mental health.

(i) **Physician's Assistant** – a person licensed as a physician's assistant in accordance with applicable District laws and regulations, and who works under supervision of a psychiatrist.

(j) **Psychiatrist** – a physician licensed in accordance with applicable District laws and regulations who has completed a residency program in psychiatry accredited by the Residency Review Committee for Psychiatry of the Accreditation Council for Graduate Medical Education and is eligible to sit for the psychiatric board examination.

(k) **Psychologist** – a person licensed as a psychologist in accordance with applicable District laws and regulations.

(l) **Psychology Associate** – a person registered to practice as a psychology associate under the supervision of a licensed psychologist in accordance with applicable District laws and regulations.

Medication Orders – sequential records of all medications prescribed, dispensed, or administered by appropriate clinic staff.

Mental Health Condition – having or being at risk of having a diagnosable mental or emotional disorder which impairs the mental health of the person or is of sufficient duration to meet diagnostic criteria specified within the DSM-5 or the ICD-10 equivalent (or any subsequent revisions), with the exception of intellectual disability, other developmental disorders, substance use disorders or seizure disorders, unless those exceptions co-occur with

another diagnosable mental illness.

Provider – a free standing mental health clinic certified by the Department of Behavioral Health as eligible to provide services under this chapter.

Residents of the District – persons who voluntarily live in the District and have no intention of presently removing themselves from the District. The term "residents of the District" shall not include persons who live in the District solely for a temporary purpose. Residency shall not be affected by temporary absence from and the subsequent return or intent to return to the District. Residency shall not depend upon the reason that persons entered the District, except to the extent that it bears upon whether they are in the District for a temporary purpose.

All persons desiring to comment on the subject matter of this proposed rule should file comments in writing not later than thirty (30) days after the date of publication of this notice in the *D.C. Register*. Comments should be filed with Trina Dutta, Director, Strategic Management and Policy Division, Department of Behavioral Health, 64 New York Ave, N.E., Second Floor, Washington, D.C. 20002, (202) 671-4075, trina.dutta@dc.gov, or DBHpubliccomments@dc.gov.