DEPARTMENT OF BEHAVIORAL HEALTH

NOTICE OF FINAL RULEMAKING

The Director of the Department of Behavioral Health (Department), pursuant to the authority set forth in §§ 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 §§ 7-1141.02, 7-1141.04, 7-1141.06 and 7-1141.07 (2018 Repl.)), hereby gives notice of the amendment of Chapter 34 (Mental Health Rehabilitation Services Provider Certification Standards) in Subtitle A (Mental Health) of Title 22 (Health) of the District of Columbia Municipal Regulations (DCMR), and amendments to Chapters 25 (Health Home Certification Standards); Chapter 39 (Psychosocial Rehabilitation Clubhouse Certification Standard); and Chapter 73 (Department of Behavioral Health Peer Specialist Certification), of Title 22-A DCMR, and Chapter 35 (Department of Mental Health (DMH) Infractions) of Title 16 DCMR (Consumers, Commercial Practices, and Civil Infractions).

The Final Rulemaking updates the Chapter 34 Mental Health Rehabilitation Services (MHRS) regulation to: (1) improve quality of care, accountability, and efficiency of MHRS; (2) implement requirements under the District's Section 1115 Behavioral Health Transformation Demonstration Program for Medicaid reimbursement of Trauma Systems Therapy and Trauma Recovery and Empowerment Model services; (3) clarify ambiguous or conflicting language, including in subsections related to qualified practitioners, prior authorization requirements, and same-day billing limitations; (4) update provisions to reflect the most current terminology and standards of care in use by the Department; (5) create consistency, where appropriate, between the MHRS certification standards and the Substance Use Disorder certification standards in Title 22-A DCMR, Chapter 63; (6) update core services agency requirements related to screening and assessment for Supported Employment services, to create consistency with changes made in the June 5, 2020 second emergency and proposed rulemaking for Chapter 37 (Mental Health and Substance Use Disorder Supported Employment Services And Provider Certification Standards); and (7) make conforming amendments to Chapters 25, 39, and 73 of Title 22-A DCMR and Chapter 35 of Title 16 DCMR.

A Notice of Second Emergency and Proposed Rulemaking was published in the *District of Columbia Register* on June 5, 2020 at 67 DCR 006839, amending a Notice of Emergency and Proposed Rulemaking published February 7, 2020 at 67 DCR 001269. The Department did not receive any comments about this rulemaking. The Department made technical changes to: (1) the prior authorization requirement terminology for Rehabilitation Day Services to clarify that an authorization for ninety (90) days of Rehabilitation Day Services means an authorization for ninety (90) units of Rehabilitation Day Services in §§ 3423.10; 3431.4; (2) the description of which credentialed staff is permitted to render Counseling under supervision, to clarify that the credentialed staff must be a licensed behavioral health clinician in § 3420.6; and (3) remove redundancies and align the definitions section with the other regulatory text §§ 3413.28(a)(1), 3414.6(c), 3499.1.

These rules were adopted as final on August 28, 2020, and will be effective upon the publication of this notice in the *District of Columbia Register*.

Chapter 34, MENTAL HEALTH REHABILITATION SERVICES PROVIDER CERTIFICATION STANDARDS, of Title 22-A DCMR, MENTAL HEALTH, is repealed and replaced by a new Chapter 34 to read as follows:

CHAPTER 34 MENTAL HEALTH REHABILITATION SERVICES AND PROVIDER CERTIFICATION STANDARDS

3400 GENERAL PROVISIONS

3400.1 The Department of Behavioral Health ("Department") is the state mental health authority with the responsibility to plan, develop, coordinate, and monitor comprehensive and integrated behavioral health systems of care for adults and for children, youth, and their families in the District, and arrange for authorized, publicly-funded behavioral health services and supports for the residents of the District. The Department entered into a Memorandum of Understanding with the Department of Health Care Finance ("DHCF") to implement a Medicaid Rehabilitation Option for the provision of mental health rehabilitative services ("MHRS").

3400.2 The purpose of these rules is to establish the MHRS program, including consumer eligibility, service standards, and provider certification requirements for providing MHRS.

3400.3 Each Department-certified MHRS provider shall meet and adhere to the terms and conditions of its Human Care Agreement ("HCA") with the Department and its Medicaid provider agreement with DHCF.

3401 MHRS PROVIDER CERTIFICATION PROCESS

3401.1 The Department shall utilize the certification process to thoroughly evaluate the applicant's capacity to provide high quality MHRS in accordance with this regulation and the needs of the District's behavioral health system.

3401.2 No person or entity shall provide MHRS unless certified by the Department. Each applicant seeking certification as an MHRS provider shall submit a certification application to the Department. An MHRS provider seeking renewal of certification shall submit a certification application at least ninety (90) calendar days prior to the termination of its current certification. The existing certification of an MHRS provider that has submitted a timely application for renewal of certification shall continue until the Department renews or denies renewal of the certification.

3401.3 Certification shall be considered terminated if the MHRS provider:

(a) Fails to submit a complete certification application ninety (90) calendar days prior to the expiration date of the current certification;

(b) Voluntarily relinquishes certification; or

(c) Terminates operations.

3401.4 Upon receipt of a certification application, the Department shall review the certification application 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. Absent good cause, a provider's failure to submit a complete certification application within ninety (90) calendar days prior to expiration of the current certification shall be deemed a voluntary relinquishment of certification and trigger the Department's closure protocol.

3401.5 Following the Department's acceptance of 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 the certification standards. The Department shall have access to all records necessary to verify compliance with certification standards and may conduct interviews with staff, others in the community, and consumers.

3401.6 The Department may conduct an on-site survey at the time of certification application or certification renewal, or at any other time during the period of certification.

3401.7 Applicant or MHRS provider interference with the on-site survey, submission of false or misleading information, or lack of candor by the applicant or provider shall be grounds for an immediate suspension of any prior certification or denial of a new certification application.

3401.8 A Statement of Deficiency ("SOD") is a written notice to an applicant or existing MHRS provider identifying non-compliance with certification standards. The intent of the SOD is to provide:

(a) Applicants with an opportunity to correct minor deficiencies during the certification application process; or

(b) Existing certified providers with an opportunity to correct minor deficiencies during the renewal of certification process or at any other time to avoid decertification and disruption of services to existing consumers.

3401.9 The Department will not normally issue an SOD to applicants who fail to demonstrate compliance with the standards. The Department will normally consider the applicant's failure to comply with the initial certification requirements as evidence that the applicant is ill-prepared to assume the responsibilities of providing MHRS to District residents and deny the application.

3401.10 When utilized, the SOD shall describe the areas of non-compliance, suggest actions needed to bring operations into compliance with the certification standards, and set forth a timeframe of no more than ten (10) business days for the applicant or existing MHRS provider's submission of a written Corrective Action Plan ("CAP").

3401.11 The issuance of an SOD is a separate process from the issuance of a Notice of Infraction ("NOI"). NOIs shall be issued promptly upon observation of violations of this chapter, especially when they are recurrent, endanger consumer or staff health or safety, or when there is a failure to comply with core requirements of this chapter.

3401.12 The Department is not required to utilize the SOD process. It may immediately deny certification or proceed with decertification.

3401.13 An applicant or certified MHRS provider's 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 within ten (10) business days after receipt of the SOD from the Department, or sooner if specified in the SOD.

3401.14 The Department shall notify the applicant or the certified MHRS provider whether the provider's CAP is accepted within ten (10) business days after receipt.

3401.15 The Department may only issue certification after the Department verifies that the applicant or the certified MHRS provider has remediated all of the deficiencies identified in the CAP and meets all the certification standards.

3401.16 A determination to grant full certification to a provider shall be based on the Department's review and validation of the information provided in the application, as well as facility survey findings, any CAP, and the provider's compliance with this chapter.

3401.17 Full certification as an MHRS provider 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 MHRS provider's continuous compliance with these certification standards. Certification shall remain in effect until it expires, is renewed, or is revoked pursuant to § 3403. The certification shall specify:

(a) The effective date of the certification;

(b) Whether the MHRS provider is certified as a:

(1) Core Services Agency ("CSA") serving adults and/or children and youth;

(2) Sub-provider, or

(3) Specialty provider; and

(c) The services the MHRS provider is certified to provide and in which facility.

3401.18 The Department may grant provisional certification to a new provider that:

(a) Has not previously held a certification issued by the Department;

(b) Is in the process of securing a facility within the District of Columbia at the time of application; and

(c) If applicable, has met initial requirements for the evidence-based practice ("EBP") certification process (*e.g.*, Multisystemic Therapy, Functional Family Therapy, Trauma-Focused Cognitive Behavioral Therapy, Child-Parent Psychotherapy).

3401.19 The purpose of provisional certification is to allow a provider new to the District an opportunity to identify a space for a facility within the District. Additionally, provisional certification allows a new provider the option of responding to a Request for Qualification while they continue to work on meeting the requirements of certification. Provisional certification shall not exceed a period of six (6) months and may be renewed only once for an additional period not to exceed ninety (90) calendar days. Upon receipt of a provisional certification, a provider may submit a response to the Department's Request for Qualification for an MHRS HCA.

3401.20 Certification is not transferable to any other organization.

3401.21 Prior to adding an MHRS service during the term of certification, the MHRS provider shall submit a certification application describing the service. Upon determination by the Department that the service is in compliance with certification standards, the Department may certify the MHRS provider to provide that service.

3401.22 Nothing in these rules shall be interpreted to mean that certification is a right or an entitlement. Certification as an MHRS provider depends upon the Director's assessment of the need for additional providers and availability of funds. An individual or entity that applies for certification during an open application period as published in the District of Columbia Register may appeal the denial of certification under this subsection by utilizing the procedures contained in §§ 3403.2 and 3403.3. The Department shall not accept any applications for which a notice of moratorium is published in the *District of Columbia Register*.

3401.23 In the event that a certification application is under review while a moratorium is put in place, the Department will continue to process the application for a time period of no more than thirty (30) calendar days. If, after thirty (30) calendar days, the application is deemed incomplete, the provider will be granted ten (10) business days to resolve all incomplete items. Any items not resolved or provided by the due date will result in the incomplete application being returned to the applicant and the Department will take no further action to issue certification. The applicant shall then wait until the moratorium is lifted in order to submit any subsequent certification applications.

3401.24 The MHRS provider shall notify the Department in writing thirty (30) calendar days prior to implementing any of the following operational changes, including all aspects of the operations materially affected by the changes:

(a) A proposed change in the name or ownership of an MHRS provider owned by an individual, partnership, or association, or in the legal or beneficial ownership of ten percent (10%) or more of the stock of a corporation that owns or operates the MHRS provider;

(b) A change in affiliation or referral arrangements;

(c) A proposed change in the provider's service location;

(d) The proposed addition or deletion of services, which is anything that would alter or disrupt services where the consumer would be impacted by the change, or any change that would affect compliance with this regulation;

(e) A change in the required staff qualifications for employment;

(f) A change in the staff filling positions required by this chapter, as well as any changes in Qualified Practitioners working for the agency;

(g) A proposed change in organizational structure; or

(h) A proposed change in the population served.

3401.25 MHRS providers shall forward to the Department within thirty (30) calendar days all inspection reports conducted by an oversight body and all corresponding corrective actions taken regarding cited deficiencies.

3401.26 MHRS providers shall immediately report to the Department any criminal allegations involving provider staff.

3402 EXEMPTIONS FROM CERTIFICATION STANDARDS

3402.1 Upon good cause shown, the Department may exempt an applicant or MHRS provider from a certification standard if the exemption does not jeopardize the health and safety of consumers, violates consumers' rights, or otherwise conflicts with the purpose and intent of these rules.

3402.2 If the Department approves an exemption, such exemption shall end on the expiration date of the provider certification or on an earlier date if specified by the Department; unless the provider requests renewal of the exemption prior to expiration of its certification or the earlier date set by the Department.

3402.3 The Department may revoke an exemption that it determines is no longer appropriate.

3402.4 All requests for an exemption from certification standards shall be submitted in writing to the Department.

3403 DENIAL OF CERTIFICATION OR DECERTIFICATION PROCESS

3403.1 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 MHRS on a sustained and regular basis.

3403.2 To avoid an over-concentration of providers in areas with existing providers and to encourage increased access to underserved areas of the District, the Director may 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 MHRS services that will address unmet needs of the behavioral health system.

3403.3 While applicants may make minor corrections and substitutions to its application 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 MHRS consistent with high quality care and privacy standards;

(e) The lack of demonstrated experience providing MHRS by the applicant's clinical leadership, practitioners, and/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; and

(h) History of poor performance.

3403.4 Within fifteen (15) business days of the date on the certification denial, an applicant may make a request for an administrative review of the decision from the Director. The Director shall conduct the administrative review to determine whether the certification denial complied with § 3403.1.

3403.5 Each request for an administrative review shall be in writing and contain a concise statement of the reason(s) why the applicant asserts that the certification denial was in error and any relevant supporting documentation.

3403.6 The Director shall complete the administrative review within fifteen (15) business days of receipt of the applicant's request.

3403.7 The Director shall issue a written decision and provide a copy to the provider. The Director's decision is final and not subject to further appeal.

3403.8 An applicant and its executive leadership shall not be allowed to reapply for certification for twelve (12) months following the date of the initial denial or, if applicable, the date of the denial pursuant to the Director's administrative review.

3403.9 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; and

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

3403.10 Nothing in this chapter requires the Director to issue a SOD prior to decertifying an MHRS provider. If grounds for decertification have been met, the Director will issue a written notice of decertification setting forth the factual basis for the decertification, the effective date, and right to request an administrative review.

3403.11 Within fifteen (15) business days of the date on the notice of decertification, the provider may request an administrative review from the Director. The Director shall conduct the administrative review to determine whether the decertification complied with § 3403.7.

3403.12 Each request for an administrative review shall contain a concise statement of the reason(s) why the provider asserts that decertification should not have occurred and any relevant supporting documentation.

3403.13 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.

3403.14 The Director shall issue a written decision and provide a copy to the provider. If the Director approves decertification, the provider may within fifteen (15) business days of receipt of the Director's written decision request a hearing under the D.C. Administrative Procedure Act, D.C. Official Code §§ 2-501, *et seq.* The administrative hearing shall be limited to the issues raised in the administrative review request. The decertification shall be stayed pending resolution of the hearing.

3403.15 Upon decertification, the MHRS provider and its executive leadership shall not be allowed to reapply for certification for any new services, including the service subject to decertification, for a period of two (2) years following the later of the date of the decertification letter or the date of the decertification order (if applicable). If a provider reapplies for certification, the provider shall 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.

3404 NOTICES OF INFRACTION

3404.1 The Department may issue a 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 ($500.00);

(b) For the second offense, one thousand dollars ($1,000.00);

(c) For the third offense, two thousand dollars ($2,000.00); and

(d) For the fourth and subsequent offenses, four thousand dollars ($4,000.00).

3404.2 The administrative procedure for the appeal of an NOI issued under this chapter shall be governed by 16 DCMR §§ 3100 *et seq*.

3405 PROVIDER DISCONTINUATION OF SERVICES, PROVIDER CLOSURES, AND CONTINUITY OF CONSUMER CARE

3405.1 An MHRS provider shall provide written notification to the Department at least ninety (90) calendar days prior to its impending closure or discontinuation of a subset of services, or immediately upon knowledge of an impending closure or discontinuation of a subset of services less than ninety (90) calendar days in the future. This notification shall include plans for continuity of care and preservation of consumer records.

3405.2 The Department shall review the continuity of care plan and make recommendations to the MHRS provider as needed. The plan should include provision for the referral and transfer of consumers, as well as for the provision of relevant treatment information, medications, and information to the new provider. The provider shall incorporate all Department recommendations necessary to ensure a safe and orderly transfer of care.

3405.3 Closure of a provider or discontinuation of a subset of services does not absolve a provider from its legal responsibilities regarding the preservation and the storage of consumer records as described in §§ 3413.16 and 3413.31 of these regulations and all applicable Federal and District laws and regulations. A provider shall take all necessary and appropriate measures to ensure consumer records are preserved, maintained, and made available to consumers upon request after closure of a provider or discontinuation of the applicable service.

3405.4 An MHRS provider shall be responsible for the execution of its continuity of care plan in coordination with the Department.

3406 SERVICE COVERAGE

3406.1 MHRS are those rehabilitative services rendered through Department-certified MHRS providers to eligible consumers who meet medical necessity for such services.

3406.2 MHRS offer a continuum of care for people with complex needs through intensive, community-based services to reduce the functional impact of mental illness or

serious emotional disturbance and support transitions to less intensive levels of care.

3406.3 MHRS are recommended by qualified practitioners licensed to diagnose mental illness or serious emotional disturbance. MHRS are rendered by qualified practitioners and credentialed staff, pursuant to the requirements in § 3416 and the applicable service specific standards set forth in this chapter.

3406.4 Rehabilitative services covered as MHRS are:

(a) Diagnostic Assessment;

(b) Medication/Somatic Treatment;

(c) Counseling;

(d) Community Support;

(e) Crisis/Emergency Services;

(f) Rehabilitation Day Services;

(g) Intensive Day Treatment ("IDT");

(h) Community Based Intervention ("CBI");

(i) Assertive Community Treatment ("ACT");

(j) Psychosocial Rehabilitation Clubhouse ("Clubhouse");

(k) Child-Parent Psychotherapy for Family Violence ("CPP-FV");

(l) Trauma-Focused Cognitive Behavioral Therapy ("TF-CBT");

(m) Trauma Recovery and Empowerment Model ("TREM"); and

(n) Trauma Systems Therapy ("TST").

3406.5 MHRS providers are CSAs, sub-providers, and specialty providers that are certified in compliance with the standards set forth in this chapter.

3406.6 MHRS coverage limitations are set forth in §§ 3431 and 3432. Coverage for any MHRS is contingent on whether all of the following criteria are met:

(a) The service shall be medically necessary;

(b) The service shall be delivered through a certified MHRS provider;

(c) The service shall be rendered by qualified practitioners or credentialed staff pursuant to the applicable service specific standards set forth in this chapter;

(d) The service shall be delivered in accordance with an approved plan of care; and

(e) The service shall be delivered in accordance with the applicable service specific standards set forth in this chapter.

3407 ELIGIBLE CONSUMERS

3407.1 Consumers eligible for Medicaid-funded MHRS shall meet the following requirements:

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

(b) Be a *bona fide* resident of the District, as defined in D.C. Official Code § 7-1131.02(29);

(c) Be a child or youth with mental health problems, as defined in D.C. Official Code § 7-1131.02(1F), or an adult with mental illness as defined in D.C. Official Code § 7-1131.02(24); and

(d) Be recommended as requiring MHRS by a qualified practitioner licensed to diagnose mental illness or serious emotional disturbance.

3407.2 Subject to § 3407.4, consumers eligible for locally-funded MHRS are those individuals who are not eligible for Medicaid or Medicare or are not enrolled in any other third-party insurance program except the D.C. HealthCare Alliance, and who meet the following requirements:

(a) Be a *bona fide* resident of the District, as defined in D.C. Official Code § 7-1131.02(29);

(b) Be a child or youth with mental health problems, as defined in D.C. Official Code § 7-1131.02(1F), or an adult with mental illness as defined in D.C. Official Code § 7-1131.02(24);

(c) Be recommended as requiring MHRS by a qualified practitioner licensed to diagnose mental illness or serious emotional disturbance; and

(d) 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.

3407.3 Eligible consumers of MHRS shall have a primary mental health diagnosis as described in the International Classification of Diseases ("ICD-10") and Diagnostic and Statistical Manual of Mental Health Disorders ("DSM-5"), or subsequent versions adopted by the Department pursuant to public notice in the *District of Columbia Register.*

3407.4 Consumers eligible for Medicare shall remain eligible for the following locally-funded MHRS only to the extent these services are not otherwise covered by Medicare:

(a) Community support; and

(b) Specialty services identified in § 3417.3.

3407.5 Providers shall not bill Medicaid and/or the Department for MHRS provided to any consumer that does not meet the eligibility requirements set forth above.

3407.6 For new enrollees and those enrollees whose Medicaid coverage has lapsed:

(a) There is an eligibility grace period of ninety (90) calendar days from the date of first service for new enrollees, or from the date of eligibility expiration for enrollees who have a lapse in coverage, until the date the Department of Human Services' Economic Security Administration ("ESA") makes an eligibility or renewal determination.

(b) In the event the consumer appeals a denial of eligibility or renewal by the ESA, the Director may extend the ninety (90) calendar day eligibility grace period until the appeal has been exhausted. The ninety (90) calendar day eligibility grace period may also be extended at the discretion of the Director for other good cause shown.

(c) Upon expiration of the eligibility grace period, MHRS services provided to the consumer are no longer reimbursable by the Department. Nothing in this section alters the District's timely-filing requirements for claim submissions.

3408 ENROLLMENT INTO AND AUTHORIZATION OF MHRS

3408.1 Enrollment is the process by which the Department ascertains a consumer's eligibility for MHRS, and, if eligible for services, adds a consumer to the MHRS system of care and assigns them to an MHRS provider.

3408.2 No later than seven (7) calendar days after enrollment, the MHRS provider shall conduct an intake appointment with the consumer. This is a face-to-face encounter that initiates the process for securing consent to treatment.

3408.3 If the MHRS provider is unable to contact the consumer, the provider shall document all steps taken in the consumer's clinical record.

3408.4 As part of the service authorization process, the Department may review the consumer's Plan of Care or other clinical material if additional clinical information is required in order to evaluate a consumer's needs and whether MHRS are medically necessary.

3409 CONSUMER PROTECTIONS

3409.1 Medicaid beneficiaries are entitled to Notice and Appeal rights pursuant to 29 DCMR § 9508 in cases of intended adverse action, such as an action to deny, discontinue, terminate, or change the manner or form of Medicaid-funded MHRS. The Department shall provide local-only beneficiaries the same Notice and Appeal rights.

3409.2 Each MHRS provider shall establish and adhere to a consumer rights policy authorized by its governing authority ("Consumer Rights Policy") that complies with the requirements of 22-A DCMR § 301.1.

3409.3 Each MHRS provider shall establish and adhere to a system for distributing the Consumer Rights Policy that complies with the requirements of 22-A DCMR § 301.3.

3409.4 Each MHRS provider shall establish and adhere to a well-publicized complaint and grievance system, which includes written policies and procedures for handling consumer, family, and practitioner complaints and grievances ("Complaint and Grievance Policy") that complies with 22-A DCMR § 306.

3409.5 Each MHRS provider shall establish and adhere to policies and procedures for obtaining written informed consent to treatment from consumers ("Consent to Treatment Policy"), which comply with applicable Federal and District laws and regulations, including 22-A DCMR Chapter 1.

3409.6 Each MHRS provider shall establish and adhere to policies and procedures governing the release of mental health information about consumers ("Release of Consumer Information Policy"), which comply with applicable Federal and District laws and regulations. For consumers with co-occurring mental health and substance use disorders (SUDs), the MHRS provider shall comply with the requirements of 42 CFR part 2 governing the confidentiality and release of SUD treatment records as applicable.

3409.7 Each MHRS provider shall establish and adhere to policies and procedures governing the use of advance instructions for mental health treatment, durable power of attorney for health care, and advance directives ("Advance Instructions

Policy") that comply with applicable Federal and District laws and regulations, including 22-A DCMR Chapter 1 and any applicable the Department policy.

3409.8 Each MHRS provider's Advance Instructions Policy shall incorporate the development of advance instructions for mental health treatment, durable power of attorney for health care, and advance directives into the assessment planning process.

3409.9 The Department shall review and approve each MHRS provider's Consumer Rights Statement, Complaint and Grievance Policy, Consent to Treatment Policy, Release of Consumer Information Policy, and Advance Instructions Policy, during the certification process and during recertification.

3410 CONSUMER CHOICE

3410.1 All consumers receiving MHRS shall have free choice of MHRS providers.

3410.2 Each MHRS provider shall establish and adhere to policies and procedures governing the means by which consumers shall be informed of the full choices of MHRS providers and other mental health service providers available, including information about peer support and family support services and groups and how to access these services ("MH Consumer Choice Policy").

3410.3 The Department shall review and approve each MHRS provider's MH Consumer Choice Policy during the certification process and during recertification.

3410.4 The MH Consumer Choice Policy shall comply with applicable Federal and District laws and regulations.

3410.5 Each MHRS provider shall:

(a) Make its MH Consumer Choice Policy available to consumers and their families; and

(b) Establish and adhere to a system for documenting that consumers and families receive the MH Consumer Choice Policy.

3410.6 Each CSA's MH Consumer Choice Policy shall ensure that each consumer:

(a) Requesting MHRS directly from the CSA is informed that the consumer may choose to have MHRS provided by any of the other the certified CSAs;

(b) Enrolled in the CSA is informed that the consumer may choose to have MHRS provided by any of the certified sub-providers; and

(c) Enrolled in the CSA is informed that the consumer may choose to have MHRS provided by any of the certified specialty provider.

3411 PLAN OF CARE DEVELOPMENT

3411.1 Each CSA shall coordinate the Plan of Care development for its enrolled consumers from the start of intake through discharge from the system of care, except that the Plan of Care development for consumers receiving:

(a) CBI, shall be coordinated by the consumer's CBI provider;

(b) ACT, shall be coordinated by the consumer's ACT provider; and

(c) Clubhouse services, shall be coordinated by the member's Clubhouse provider, if the member is not linked with a CSA, or a CBI or ACT provider. The Plan of Care development and implementation for such members shall be conducted in accordance with the requirements set forth in 22-A DCMR Chapter 39.

3411.2 The Plan of Care development process for consumers shall, at a minimum, include:

(a) The completion of a Diagnostic Assessment as described in § 3418;

(b) Development of a Plan of Care as described in § 3411;

(c) Consideration of the consumer's beliefs, values, and cultural norms in how, what, and by whom MHRS are to be provided;

(d) Consideration, screening, and assessment of the consumer for treatment using an appropriate evidence-based practice ("EBP") offered through a certified MHRS provider; and

(e) When coordinated by the CSA, assessment of the consumer for interest in and potential eligibility for Mental Health Supported Employment services, in accordance with the requirements set forth in 22-A DCMR Chapter 37.

3411.3 Court-appointed guardians for adults, children, and youth, and the parents/guardians or family members of children and youth shall be involved in the Plan of Care development process. The families and significant others of adult consumers may participate in the Plan of Care development process to the extent that the adult consumer consents to the involvement of family and significant others.

3411.4 The provider shall approve a Plan of Care within thirty (30) calendar days from when the provider obtains consent to treatment from the enrolled consumer.

Approval of a Plan of Care shall be demonstrated by the dated and authenticated signature of an independently licensed qualified practitioner.

3411.5 Each CSA, or when applicable pursuant to § 3411.1, each CBI or ACT provider, shall develop and maintain a complete and current Plan of Care for each enrolled consumer after completing intake and assessment. The Plan of Care shall at a minimum describe all of the MHRS the provider will deliver to the consumer, as well as any services to be provided by another CSA, sub-provider, or specialty provider. The CSA or, if applicable, the CBI or ACT provider, is responsible for coordinating the development of the Plan of Care with any CSA, sub-provider, or specialty provider involved in the provision of services.

3411.6 The Plan of Care shall be person-centered and include the following elements:

(a) Overall broad, long-term goal statement(s) that captures the consumer's and/or family's short- and long-term goals for the future, ideally written in first-person language. This shall include the consumer's self-identified recovery goals;

(b) List or statement of individual or family strengths that support goal(s) accomplishment. These include abilities, talents, accomplishments, and resources;

(c) List or statement of barriers that pose obstacles to the consumer's and/or family's ability to accomplish the stated goal(s). These include symptoms, functional impairments, lack of resources, consequences of behavioral health issues, and other challenges;

(d) Statement of objectives that identify the short-term consumer and/or family changes in behavior, function, or status that can help overcome the identified barriers and are building blocks toward the eventual accomplishment of the long-term goal(s). Objective statements describe outcomes that are measurable and include individualized target dates to be accomplished within the scope of the plan;

(e) Intervention statements that describe the treatment and recovery services to be utilized to reduce or eliminate the barriers identified in the plan and support objective and eventual goal(s) accomplishment. Interventions are specific to each objective and the consumer's and/or family's stage of change. Intervention statements identify who will deliver the service, what will be delivered, when it will be delivered, and the purpose of the intervention. Natural support interventions should also be included in the plan and include those non-billable supports delivered by resources outside of the formal behavioral health service-delivery system. When appropriate and applicable, EBP shall be incorporated into the intervention statement; and

(f) Provide for the delivery of services in the least restrictive environment that is appropriate for the consumer.

3412 PLAN OF CARE IMPLEMENTATION

3412.1 The consumer and assigned staff of the CSA, or when applicable pursuant to § 3411.1, staff of the CBI or ACT provider shall discuss the Plan of Care on an ongoing basis. The assigned staff shall record an encounter note describing the consumer's response to, participation in, and agreement to the Plan of Care in the consumer's clinical record.

3412.2 In situations where the consumer does not demonstrate the capacity to sign or does not sign the Plan of Care, the reasons the consumer does not sign shall be recorded in the consumer's clinical record, including each date when obtaining a signature was attempted.

3412.3 Staff shall document in the consumer's clinical record that a consumer's court-appointed guardian, family, and/or significant others participated in the development of the Plan of Care, as appropriate.

3412.4 Each MHRS provider shall develop policies and procedures for Plan of Care review ("Plan of Care Review Policy"). The Plan of Care Review Policy shall be part of the MHRS provider's Treatment Planning or Recovery Planning Policy as required by § 3413.12.

3412.5 The Plan of Care Review Policy shall require that the Plan of Care be reviewed and updated every one hundred eighty (180) calendar days and at any time there is a significant change in the consumer's condition or situation to reflect progress toward or the lack of progress toward the treatment or recovery goals. Each new Plan of Care should incorporate a review of what is working in treatment as well as challenges that have affected treatment. The Plan of Care may be reviewed more frequently, as necessary, based on the consumer's progress or circumstances.

3413 MHRS PROVIDER QUALIFICATIONS—GENERAL

3413.1 Each MHRS provider shall be established as a legally recognized entity in the District of Columbia and qualified to conduct business in the District. A certificate of good standing issued by the District of Columbia Department of Consumer and Regulatory Affairs shall be evidence of qualification to conduct business.

3413.2 Each MHRS provider shall maintain the clinical operations policies and procedures described in this section, and which shall be reviewed and approved by the Department, during the certification survey process.

3413.3 Each MHRS provider shall:

(a) Have a governing authority, which shall have overall responsibility for the functioning of the MHRS provider;

(b) Comply with all applicable Federal and District laws and regulations;

(c) Hire personnel with the qualifications necessary to provide MHRS and to meet the needs of its enrolled consumers;

(d) Ensure that independently licensed qualified practitioners are available to provide appropriate and adequate supervision of all clinical activities; and

(e) Employ qualified practitioners that meet all professional requirements as defined by the applicable licensing, certification, and registration laws and regulations of the District or the jurisdiction where services are delivered.

3413.4 Each MHRS provider shall establish and adhere to policies and procedures for selecting and hiring staff ("Staff Selection Policy"), which shall include:

(a) Evidence of each staff member's licensure, certification, or registration, as applicable and as required by the job being performed;

(b) For non-licensed staff, evidence of completion of an appropriate degree, appropriate training program, or appropriate credentials (*e.g.*, an academic transcript or a copy of degree);

(c) Evidence of all required criminal background checks, and for all non-licensed staff members, application of the criminal background check requirements contained in District Official Code §§ 44-551 *et seq.*, Unlicensed Personnel Criminal Background Check, as well as quarterly child abuse registry checks for both state of residence and state of employment;

(d) Evidence of quarterly checks that no individual is excluded from participation in a federally funded health care program as listed on the Department of Health and Human Services' "List of Excluded Individuals/Entities," the General Services Administration's "Excluded Parties List System," or any similar succeeding governmental list;

(e) Evidence of completion of all communicable disease testing required by the Department and District laws and regulations;

(f) A process by which all staff, as a condition of hiring, shall declare any present or past events that might raise liability or risk management concerns, such as malpractice actions, insurance cancellations, criminal convictions, Medicare/Medicaid sanctions, and ethical violations; and

(g) Evidence that the provider conducts each required screening at the frequency required by District law and regulations, including quarterly exclusion checks and unlicensed employee criminal background checks every four (4) years.

3413.5 Each MHRS provider shall establish and adhere to written job descriptions for all positions, including, at a minimum, the role, responsibilities, reporting relationships, and minimum qualifications for each position. The minimum qualifications for each position shall be appropriate for the scope of responsibility and clinical practice described for each position.

3413.6 Each MHRS provider shall establish and adhere to policies and procedures requiring a periodic evaluation of clinical and administrative staff performance ("Performance Review Policy") that require an assessment of clinical competence and competence in behavioral health issues, as applicable, as well as general organizational work requirements, and an assessment of key functions as described in the job description. The periodic evaluation shall also include an annual individual development plan for each staff member.

3413.7 Each MHRS provider shall establish and adhere to policies and procedures to ensure that clinical staff are licensed, certified (if applicable), or registered (if applicable) and, to the extent required by applicable laws, regulations, work under the supervision of another qualified practitioner ("Supervision and Peer Review Policy"). The Supervision and Peer Review Policy shall:

(a) Include procedures for clinical supervision, which require sufficient clinical supervision conducted by qualified practitioners permitted to supervise per applicable District laws and regulations;

(b) Require personnel files of non-licensed clinical staff and consumers' clinical records to contain evidence that the MHRS provider is observing the requirements of the Supervision and Peer Review Policy; and

(c) Include an active peer review process to monitor quality of care delivered by qualified practitioners and credentialed staff.

3413.8 Each MHRS provider shall establish and adhere to policies and procedures governing the credentialing or privileging of staff ("Credentialing Policy") consistent with the Department rules on privileging and competency-based credentialing systems. The Credentialing Policy shall:

(a) Allow staff who do not possess college degrees to be credentialed for direct service work, based on educational equivalent qualifications. These qualifications include experience that provides an individual with an understanding of mental illness, and which was acquired as an adult: (1) through personal experience with the mental health treatment system, or (2)

through the provision of significant supports to adults with mental illness, or children and youth with mental health problems or with serious emotional disturbance;

(b) Facilitate the employment of persons in recovery as peer counselors and members of community support teams; and

(c) Include an assessment of qualified practitioners' cultural and linguistic competence.

3413.9 Each MHRS provider shall have annual training that meets the federal Occupational Safety & Health Administration ("OSHA") regulations that govern behavioral health facilities and any other applicable infection control guidelines, including information on the use of universal precautions and on reducing exposure to hepatitis, tuberculosis, and HIV/AIDS.

3413.10 A provider shall have a current written plan for staff development and organizational onboarding, approved by the Department, which reflects the training and performance improvement needs of all employees working in that program. The plan shall address the steps the provider will take to ensure the recruitment and retention of highly qualified employees and the reinforcement of staff development through training, supervision, the performance management process, and activities such as shadowing, mentoring, skill testing, and coaching. The plan shall at a minimum include culturally competent training and onboarding activities in the following core areas:

(a) The provider's approach to addressing treatment or recovery services (as appropriate to certification), including philosophy, goals, and methods;

(b) The staff member's specific job description and role in relationship to other staff;

(c) Emergency preparedness plan and all safety-related policies and procedures;

(d) The proper documentation of services in individual consumer records, as applicable;

(e) Policies and procedures governing infection control, protection against exposure to communicable diseases, and the use of universal precautions;

(f) Laws, regulations and policies governing confidentiality of consumer information and release of information;

(g) Laws, regulations, and policies governing reporting abuse and neglect;

(h) Consumer rights; and

(i) Other trainings, as deemed necessary by the Department.

3413.11 Each MHRS provider shall establish and adhere to policies and procedures defining pre-admission, intake, screening, assessment, referral, transfer, and discharge procedures ("Admission, Transfer, and Discharge Policy") that comply with applicable Federal and District laws and regulations. The policies and procedures shall define the required documentation for screening or assessing consumers for admission to an EBP operated by the provider when the consumer's condition requires a modification in the Plan of Care.

3413.12 Each MHRS provider shall establish and adhere to policies and procedures governing the coordination of the treatment or recovery planning process ("Treatment Planning Policy or Recovery Planning Policy"), including procedures for designing, implementing, reviewing, and revising each consumer's Plan of Care that comply with the requirements of § 3411.

3413.13 Each MHRS provider shall establish and adhere to policies and procedures requiring that treatment be provided in accordance with the applicable service specific standards in this chapter ("Service Specific Policy"). The Service Specific Policy shall:

(a) Address supervision requirements and required caseload ratios that are appropriate to the population served and treatment modalities employed; and

(b) Include a written description of the services offered by the MHRS provider ("Service Description") describing the purpose of the service, the hours of operation, the intended population to be served, recovery modalities provided by the service, treatment or recovery objectives, and expected outcomes.

3413.14 Each MHRS provider shall establish and adhere to policies and procedures governing communication with the consumer's primary care providers ("Primary Care Provider Communication Policy"). The Primary Care Provider Communication Policy shall:

(a) Outline the MHRS provider's interface with primary health care providers, managed health care plans, and other providers of mental health services; and

(b) Describe the MHRS provider's activities which will enhance consumer access to primary health care and the coordination of mental health and primary health care services.

3413.15 Each MHRS provider shall establish and adhere to policies and procedures for handling routine, urgent, and emergency situations ("Unscheduled Service Access Policy"). The Unscheduled Service Access Policy shall:

(a) Include referral procedures to local emergency departments;

(b) Include staff assignment to cover walk-in hours for urgent care;

(c) Include arrangements for access to medication-somatic treatment practitioners and other clinical staff;

(d) Describe the availability of telephone access to an independently licensed qualified practitioner, for the consumer, or other person acting on behalf of the consumer making contact with the MHRS provider;

(e) Describe the availability of timely access to face-to-face crisis support services;

(f) Describe how the MHRS provider will interact and coordinate services with the Department-designated crisis and emergency service; and

(g) Include procedures for triaging consumers who require Crisis/Emergency services or psychiatric hospitalization.

3413.16 Each MHRS provider shall establish and adhere to policies and procedures for clinical record documentation, security, and confidentiality of consumer and family information; clinical records retention, maintenance, purging and destruction; disclosure of consumer and family information; and informed consent that comply with applicable Federal and District laws and regulations ("Clinical Records Policy"). The Clinical Records Policy shall:

(a) Require the MHRS provider to maintain all clinical records in a secured and locked storage area;

(b) Require that the MHRS provider utilize an electronic health records system to document all phases of the consumer's treatment and care. The MHRS provider shall comply with applicable Department policies on use and maintenance of an electronic health records system;

(c) Require the MHRS provider to maintain all clinical records for a period of ten (10) years;

(d) Require the MHRS provider to maintain and secure a current, clear, organized, and comprehensive clinical record for every individual assessed, treated, or served that includes information deemed necessary to provide

treatment, protect the MHRS provider, and comply with applicable Federal and District laws and regulations; and

(e) Require that the clinical record contain information to identify the consumer, support the diagnosis, justify the treatment, document the course and results of treatment, and facilitate continuity of care. The clinical record shall include, at a minimum:

(1) Consumer identification information, including enrollment information;

(2) Identification of a person to be contacted in the event of emergency;

(3) Basic screening and intake information;

(4) Documentation of internal or external referrals;

(5) Comprehensive diagnostic and psychosocial assessments;

(6) Pertinent medical information including the name, address, and telephone number of the consumer's primary care physician;

(7) Advance instructions and advance directives;

(8) The Plan of Care;

(9) For children and youth, documentation of family or legal guardian involvement in treatment planning and services or statement of reasons why it is not clinically indicated;

(10) Methods for addressing consumers' and families' special needs, especially those which relate to communication, cultural, linguistic, and social factors;

(11) Detailed description of services provided;

(12) Progress notes;

(13) Discharge planning information;

(14) Appropriate consents for service;

(15) Appropriate release of information forms; and

(16) Signed Consumer Rights Statement.

(f) Electronic records shall include a log function that dates, times, and authenticates each entry, access, and change to a record.

3413.17 Each MHRS provider shall participate in the District Health Information Exchange (HIE).

3413.18 Each MHRS provider shall comply with the Department's policy on supervision, including requirements for the documentation of supervision.

3413.19 Each MHRS provider shall enter encounter notes into the clinical record with sufficient written clinical documentation to support each therapy, service, activity, or session for which billing is made which, at a minimum, consists of:

(a) A dated, timed, and authenticated entry, entered by the person providing the service, which shall include the typed or legibly printed name of the author. The provider shall ensure all entries are authenticated by a process that verifies the author's identity (*e.g.*, a unique log-in used only by the author);

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

(c) The legal name, title, credentials, and signature of the person providing the services;

(d) The setting in which the services were rendered;

(e) The consumer's diagnosis and clinical impression recorded in the terminology of the ICD-10 CM (or any subsequent version adopted by the Department pursuant to written notice published in the *District of Columbia Register*);

(f) Confirmation that the services delivered are contained in the consumer's Plan of Care;

(g) A description of each service by a qualified practitioner or credentialed staff with the consumer that is sufficient to document that the service was provided in accordance with this chapter;

(h) A description of the consumer's response to the service that is sufficient to show, particularly in the case of group interventions, the consumer's unique participation in the service; and

(i) An easily accessible log identifying a complete history for each entry, including when the record was created, signed, and the time and dates of any subsequent access and amendments.

3413.20 Each MHRS provider shall ensure that all clinical records of consumers are completed promptly, filed, and retained in accordance with the MHRS provider's Clinical Records Policy.

3413.21 All CSA, ACT, and CBI providers shall operate an on-call system for enrolled consumers that is available twenty-four (24) hours a day, seven (7) days a week. Providers shall make the following services available five (5) days per week from 9:00 am to 6:00 pm, in the evening by appointment, and at least once a month on a Saturday for four (4) hours: Diagnostic Assessment, Medication/Somatic treatment, Counseling, and Community Support.

3413.22 Providers who deliver the following specialty services shall make their services available as follows:

MHRS SPECIALTY SERVICE	**HOURS OF OPERATION**	**OTHER AVAILABILITY REQUIREMENTS**
Crisis/Emergency Services	Twenty-four (24) hours per day, seven (7) days per week	Psychiatric consultation shall be available twenty-four (24) hours per day, seven (7) days per week.
Rehabilitation Day Services	Thirty (30) hours per week, no less than six (6) hours per day	Consumers authorized and referred for service shall be admitted within seven (7) business days of the referral from the CSA.
Intensive Day Treatment	Seven (7) days per week, no less than five (5) hours per day	Programs shall offer a minimum of thirty-five (35) hours of active programming per week. Consumers authorized and referred for Intensive Day Treatment shall be admitted within forty-eight (48) hours of referral by a CSA.

MHRS SPECIALTY SERVICE	HOURS OF OPERATION	OTHER AVAILABILITY REQUIREMENTS
Community Based Intervention	Levels I, II, III and IV - Twenty-four (24) hours per day, seven (7) days per week	Consumers authorized and referred for all levels of CBI shall be admitted within forty-eight (48) hours of referral by a CSA. A CBI Team member shall respond to a call from a family member or a significant other, either by telephone or face-to-face contact, within sixty (60) minutes of receiving the call. All CBI providers shall develop a crisis intervention plan for each consumer receiving CBI. Level IV providers shall develop a crisis intervention plan for after-hours response, which shall include a Mobile Crisis Response Team.
Assertive Community Treatment	Twenty-four (24) hours per day, seven (7) days per week, with emergency response coverage to include psychiatric availability	Consumers authorized and referred for ACT shall be admitted within forty-eight (48) hours of referral by a CSA. At least sixty percent (60%) of ACT Services shall be provided in locations other than the office, according to consumer need, preference, and clinical appropriateness. An ACT team member shall respond to a call from family or a significant other, either by telephone or face-to-face contact within sixty (60) minutes of receiving the call.

3413.23 Each MHRS provider shall establish and adhere to policies and procedures requiring the MHRS provider to make language access services available at no cost as needed for Limited or Non-English proficient consumers, ("Language Access Policy"). The Language Access Policy shall:

(a) Document primary language information in a consumer's clinical record at the point of entry, if known, with notations on how to engage the person in communication if unknown;

(b) Arrange for the provision of language access services at no cost to Limited or Non-English proficient consumers;

(c) Ensure public notices regarding language access services are posted in regularly encountered waiting rooms, reception areas, and other areas of initial contact.

(d) Ensure that the public is aware of language interpretation services;

(e) Provide a quarterly report on the number of enrolled consumers who receive language access services to the DBH Language Access Coordinator. The information shall include the following information:

(1) The number of individuals who have Limited or Non-English proficiency, and the languages spoken;

(2) The frequency with which Limited or Non-English proficient consumers come into contact with the provider;

(3) The number and types of languages spoken by agency staff.

(f) Provide annual training to all public access staff on how to provide ongoing language services; and

(g) Ensure immediate notification of the DBH Language Access Coordinator when unable to meet language access needs.

3413.24 The Language Access Policy shall allow staff and contractors who do not possess valid certification from the Registry of Interpreters for the Deaf to be credentialed based on skills in mental health interpreting gained through supervised experience. For purposes of this rule, supervised experience shall include supervision by an interpreter certified by the National Registry of Interpreters for the Deaf and ongoing training in sign language interpreting, preferably related to mental health, and may include on-the-job learning prior to employment by the MHRS provider.

3413.25 Each MHRS provider shall utilize a TTY communications line (or an equivalent) to enhance the MHRS provider's ability to respond to service requests and needs of consumers and potential consumers. MHRS provider staff shall be trained in the use of such communication devices as part of the annual language access training.

3413.26 Each MHRS provider shall establish and adhere to policies and procedures which govern the provision of services in natural settings ("Natural Settings Policy"). The Natural Settings Policy shall require the MHRS provider to document how it respects consumers' and families' rights to privacy and confidentiality when services are provided in natural settings.

3413.27 Each MHRS provider shall establish and adhere to anti-discrimination policies and procedures relative to hiring, promotion, and provision of services to consumers that comply with applicable Federal and District laws and regulations ("Anti-Discrimination Policy").

3413.28 Each MHRS provider shall establish a quality improvement program ("QI program") and adhere to policies and procedures governing quality improvement ("Quality Improvement Policy"). The Quality Improvement Policy shall require the MHRS provider to adopt a written Quality Improvement ("QI") plan describing the objectives and scope of its QI program and requiring MHRS provider staff, consumer, and family involvement in the QI program. The Department shall review and approve each MHRS provider's QI program at a minimum as part of the certification process. The QI program shall submit data to the Department, upon request. The QI program shall be:

(a) Directed by a coordinator ("QI Coordinator") who has direct access to the Chief Executive Officer or Program Director, if applicable. In addition to directing the QI program's activities, the QI Coordinator shall also review unusual incidents, deaths, and other sentinel events; monitor and review utilization patterns; and track consumer complaints and grievances. The QI Coordinator shall be:

(1) An individual licensed as one of the following practitioner types: Psychiatrist, Psychologist, Licensed Independent Clinical Social Worker ("LICSW"), Advanced Practice Registered Nurse ("APRN"), Licensed Professional Counselor ("LPC"), Licensed Marriage and Family Therapist ("LMFT"), Registered Nurse ("RN"), Licensed Independent Social Worker ("LISW"), Licensed Graduate Professional Counselors ("LGPC"), Licensed Graduate Social Worker ("LGSW"), or Physician Assistant under the supervision of a psychiatrist; or registered as a Psychology Associate; or

(2) An individual with a Bachelors' Degree and a minimum of two (2) years of relevant, qualifying experience, such as experience in behavioral health care delivery or health care quality improvement initiatives.

(b) The QI program shall measure and ensure at least the following:

(1) Timely access to and availability of services;

(2) Adequacy, appropriateness, and quality of care, including treatment and prevention of acute and chronic conditions;

(3) Close monitoring of high-volume services, consumers with high risk conditions, and services for children and youth;

(4) Coordination of care among behavioral health treatment providers, and between behavioral health providers and primary and other specialty care providers;

(5) Compliance with all MHRS certification standards;

(6) Consumer and family satisfaction with services; and

(7) Any other indicators that are part of the Department QI program for the larger system.

3413.29 Each MHRS provider shall comply with the following requirements for facilities management:

(a) Each service site of an MHRS provider shall be an adequate and appropriate facility with:

(1) A reception area;

(2) Consumer interview rooms for private, confidential individual and group counseling sessions and private areas for other individual treatment services;

(3) Appropriate space for group activities and educational programs; and

(4) Restrooms available to consumers and their families and significant others.

(b) All areas of the MHRS provider's service site(s) shall be kept clean and safe, and shall be appropriately equipped and furnished for the services delivered.

(c) In-office waiting time shall be less than one (1) hour from the scheduled appointment time. Each MHRS provider shall demonstrate that it can document the time period for in-office waiting.

(d) Each MHRS provider shall comply with applicable provisions of the Americans with Disabilities Act in all business locations.

(e) Each MHRS provider's main service site shall be located within reasonable walking distance of public transportation.

(f) Each MHRS provider shall establish and adhere to a written evacuation plan to be used in fire, natural disaster, medical emergencies, bomb threats, terrorist attacks, violence in the workplace, or other disaster events for all service sites ("Disaster Evacuation Plan").

(g) The Disaster Evacuation Plan shall require the MHRS provider:

(1) To conduct periodic disaster evacuation drills;

(2) Ensure that all evacuation routes are clearly marked by lighted exit signs; and

(3) Ensure that all staff participate in annual training about the Disaster Evacuation Plan and disaster response procedures.

(h) Each MHRS provider shall obtain a written certificate of compliance from the District of Columbia Department of Fire and Emergency Medical Services indicating that all applicable fire and safety code requirements have been satisfied.

(i) Each MHRS provider shall provide physical facilities for all service site(s) that are structurally sound and meet all applicable Federal and District laws and regulations for construction, safety, sanitation, and health.

(j) Each MHRS provider shall establish and adhere to policies and procedures governing infection control ("Infection Control Policy"). The Infection Control Policy shall 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.

(k) Each MHRS provider shall establish and adhere to policies and procedures governing the purchase, receipt, storage, distribution, return, and destruction of medication that include accountability for and security of medications located at any of its service sites ("Medication Policy"). The Medication Policy shall comply with applicable Federal and District laws and regulations regarding the purchase, receipt, storage, distribution, dispensing, return, and destruction of medications and require the MHRS provider to maintain all medications and prescription blanks in a secured and locked area.

3413.30 Each MHRS provider shall have established by-laws or other legal documentation regulating the conduct of its internal financial affairs. This documentation shall clearly identify the individual(s) that are legally responsible for making financial decisions for the MHRS provider and the scope of such decision-making authority. Each MHRS provider shall:

(a) Maintain an accounting system that conforms to generally accepted accounting principles, provides for adequate internal controls, permits the development of an annual budget, an audit of all income received, and an audit of all expenditures disbursed by the MHRS provider in the provision of services;

(b) Have an internal process for the development of interim and annual financial statements that compares actual income and expenditures with budgeted amounts, accounts receivable, and accounts payable information; and

(c) Operate in accordance with an annual budget established by its governing authority.

3413.31 Each MHRS provider shall establish and adhere to policies and procedures governing the retention, maintenance, purging and destruction of its business records ("Records Retention Policy"). The Records Retention Policy shall:

(a) Comply with applicable Federal and District laws and regulations;

(b) Require the MHRS provider to maintain all business records pertaining to costs, payments received and made, and services provided to consumers for a period of ten (10) years or until all audits are completed, whichever is longer; and

(c) Require the MHRS provider to allow the Department, DHCF, the District's Inspector General, the United States Department of Health and Human Services, the Comptroller General of the United States, or any of their authorized representatives to review the MHRS provider's business records, including clinical and financial records.

3413.32 Each MHRS provider shall comply with the following requirements for maintaining certification, provider status, and contracts:

(a) Maintain proof of the Department certification;

(b) Maintain an active Medicaid provider status at all times;

(c) Maintain copies of contracts with the Department, vendors, suppliers, and independent contractors; and

(d) Require that its subcontractors continuously comply with the provisions of the MHRS provider's HCA with the Department.

3413.33 Each MHRS provider, at its expense, shall:

(a) Obtain at least the minimum insurance coverage required by its HCA; and

(b) Make evidence of its insurance coverage available to the Department upon request.

3413.34 Each MHRS provider shall establish and adhere to policies and procedures governing billing and payment for MHRS ("Billing and Payment Policy"). The Billing and Payment Policy shall require the MHRS provider to have the necessary operational capacity to submit claims, document information on services provided, and track payments received. This operational capacity shall include the ability to:

(a) Verify eligibility for Medicaid and other third-party payers;

(b) Document MHRS provided by MHRS provider staff and subcontractors;

(c) Submit claims and documentation of MHRS on a timely basis with applicable DBH and DHCF requirements; and

(d) Track payments for all provided MHRS.

3413.35 Each MHRS provider shall submit claims for MHRS provided to consumers described in § 3407.2 to the Department within ninety (90) calendar days of the date of service, or thirty (30) calendar days after a secondary or third-party payer has adjudicated a claim for this service. The Department shall not pay for a claim that is submitted more than one (1) year from the date of service, except when Federal law or regulations would require such payment to be made.

3413.36 Each MHRS provider shall have an established sliding fee schedule covering each of the MHRS it provides. For services provided to Medicaid-eligible consumers, no additional charge shall be imposed for services beyond that paid by Medicaid.

3413.37 Each MHRS provider shall utilize, and require its subcontractors to utilize, payments from other public or private sources, including Medicare. Payment of the Department and Federal funds to the MHRS provider shall be conditional upon the utilization of all benefits from other payment sources.

3413.38 Each MHRS provider shall operate according to all applicable Federal and District laws and regulations relating to fraud, waste, and abuse in health care, the provision of mental health services, and the Medicaid program. An MHRS provider's failure to report potential or suspected fraud, waste or abuse may result in sanctions, cancellation of contract, or exclusion from participation as an MHRS provider. Each MHRS provider shall:

(a) Cooperate and assist any District or Federal agency charged with the duty of identifying, investigating, or prosecuting suspected fraud, waste or abuse;

(b) Provide the Department with regular access to the provider's medical and billing records, including electronic medical records, within twenty-four (24) hours of a Departmental request, or, immediately in the case of emergency;

(c) Be responsible for promptly reporting suspected fraud, waste, or abuse to the Department, taking prompt corrective actions consistent with the terms of any contract or subcontract with the Department, and cooperating with DHCF or other governmental investigations; and

(d) Ensure that none of its practitioners have been excluded from participation as a Medicaid or Medicare provider. If a practitioner is determined to be excluded by the Center for Medicare and Medicaid Services ("CMS"), the provider shall notify the Department immediately.

3413.39 Each MHRS provider shall establish and adhere to a plan for ensuring compliance with applicable Federal and District laws and regulations ("Corporate Compliance Plan"), approved by the Department. Each MHRS provider shall submit any updates or modifications to its Corporate Compliance Plan to the Department for prior review and approval. Each MHRS provider's Corporate Compliance 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 that all officers, directors, managers, and employees sign a statement that they understand the Corporate Compliance Plan;

(c) Include procedures designed to prevent and detect potential or suspected fraud, waste, or abuse in the administration and delivery of MHRS;

(d) 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;

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

(f) Require that confirmed violations of the Corporate Compliance Plan be reported to the Department within twenty-four (24) hours of confirmation; and

(g) Require any confirmed or suspected fraud, waste, or abuse under state or Federal laws or regulations be reported to the Department.

3413.40 Each MHRS provider shall ensure that sufficient resources (*e.g.*, personnel, hardware, or software) are available to support the operations of computerized systems for collection, analysis, and reporting of information, along with claims submission.

3413.41 Each MHRS provider shall have the capability to submit accurate claims, encounter data, and other submissions as necessary directly to the Department.

3413.42 Claims for MHRS provided to consumers described in § 3407.2 shall be submitted using the format required by the Department.

3413.43 Each MHRS provider shall manage protected health information in compliance with the confidentiality requirements contained in applicable Federal and District laws and regulations, including Health Insurance Portability and Accountability Act (HIPAA) and the D.C. Mental Health Information Act. The provider shall develop and implement 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 HIE, unless exempted pursuant to § 3402.1. The program shall advise each consumer of the program's notice of privacy practices that authorizes the disclosure to other providers and shall afford the consumer the opportunity to opt-out of that disclosure in accord with the District of Columbia Mental Health Information Act, D.C. Official Code § 7-1203.01. The program shall document the individual's decision.

3413.44 Each MHRS provider shall establish and adhere to a plan that contains policies and procedures for maintaining the security of data and information ("Disaster Recovery Plan"). Each MHRS provider's Disaster Recovery 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.

3414 CORE SERVICES AGENCY REQUIREMENTS

3414.1 Each CSA shall comply with the certification standards described in § 3413, the service specific standards applicable to core services, and the certification standards set forth in this section, as well as the other certification standards in this chapter.

3414.2 Each CSA shall:

(a) Serve as the clinical home for the consumers it enrolls;

(b) Be responsible for ensuring that Plans of Care are developed and approved for its enrolled consumers; and

(c) Provide clinical management for its enrolled consumers.

3414.3 Each CSA shall satisfy the following minimum staffing requirements:

(a) A Chief Executive Officer with professional qualifications and experience who meets the requirements established by the MHRS provider's governing authority. The Chief Executive Officer shall be charged with responsibility for day-to-day management of the CSA, and shall be a full-time employee devoting at least twenty (20) hours a week to administrative and management functions of the CSA;

(b) A Medical Director who is a board-eligible psychiatrist, responsible for the quality of medical and psychiatric care provided by the MHRS provider. A child and youth-serving CSA may have a staff or consulting board-eligible child psychiatrist or a staff board-eligible psychiatrist with substantial child and adolescent experience as its Medical Director;

(c) A full-time Clinical Director who is an independently licensed qualified practitioner with an appropriate, relevant behavioral health advanced degree, with overall responsibility for oversight of the clinical program of the MHRS provider. The Clinical Director may also serve as the Medical Director if the Clinical Director is a board-eligible psychiatrist;

(d) A Controller, Chief Financial Officer, or designated individual responsible for executing or overseeing the financial operations of the MHRS provider. The designated financial officer shall have a Bachelors' Degree plus two (2) years of fiscal experience and may also oversee administrative operations and information services;

(e) A medical records administrator responsible for the following:

(1) Ongoing quality control of clinical documentation;

(2) Assuring that clinical records are maintained, completed, and preserved in accordance with the MHRS provider's Clinical Records Policy;

(3) Assuring that information on enrolled consumers is immediately retrievable; and

(4) Establishing a central records index for the MHRS provider.

3414.4 The CSA shall have an annual audit by an independent certified public accountant or a certified public accounting firm in accordance with generally accepted auditing standards. The resulting financial audit report shall be consistent with formats recommended by the American Institute of Public Accountants. The CSA shall

submit a copy of the financial audit report to the Department within one hundred and twenty (120) calendar days after the end of the provider's fiscal year.

3414.5 Each CSA shall comply with the following requirements regarding clinical operations:

(a) The CSA shall accommodate consumer preferences and needs with respect to primary staff and team representation.

(b) The consumer and the assigned CSA staff shall be responsible for the development and periodic review of the consumer's Plan of Care and for the coordination the delivery of all MHRS received by the consumer.

(c) The signing independently licensed qualified practitioner shall be primarily responsible for assuring that the Plan of Care assists the consumer in developing self-care skills and achieving recovery.

(d) Each CSA shall establish and adhere to policies and procedures governing its relationship with subcontractors ("Subcontractor Policy") in compliance with Federal and District laws and regulations. The Subcontractor Policy shall address, at a minimum, access to records, clinical responsibility and supervision, legal liability, and insurance and dispute resolution.

(e) Each CSA shall establish and adhere to policies and procedures governing the means by which family education and support will be offered and provided ("Consumer and Family Education Policy"). The Consumer and Family Education Policy shall require, at a minimum, the following:

(1) The CSA shall make family education and support available for all consumer families;

(2) Family education and support shall include general information about mental health and psychiatric illness;

(3) For adult consumers, a provider shall only disclose information about a consumer with the consent of the consumer. In the case of child, the provider shall only disclose information about a consumer with the consent of the parent or guardian in accordance with the CSA's Release of Consumer Information Policy;

(4) The availability of appointments for family members to meet with staff and availability of family support and education groups to be scheduled at times convenient for the family; and

(5) In written materials and face-to-face contacts provide information about available and needed services, as well as how the consumer

may access Crisis/Emergency Services. The materials shall be written at the 4th grade reading level and shall be printed in English and either Spanish or the secondary language conducive to facilitating communication with the majority of the CSA's target population.

3414.6 Each CSA shall comply with the following requirements regarding service accessibility:

(a) Each CSA shall operate an on-call system for its enrolled consumers twenty-four (24) hours per day, seven (7) days per week, to respond to urgent, emergency, and routine situations ("CSA On-Call System").

(b) Each CSA shall establish and adhere to policies and procedures governing the operation of its On-Call System ("On-Call System Policy"). The On-Call System Policy shall require the CSA to provide:

(1) Telephone access to an independently licensed qualified practitioner for consumers and their significant others to resolve problems telephonically, when possible;

(2) Timely access to an independently licensed qualified practitioner in order to provide any needed crisis support services, to include face-to-face interventions; and

(3) Linkage to Crisis/Emergency Services, including crisis stabilization services and "next day" appointments to assist the consumer to address urgent problems during the next business day.

(c) Each CSA shall, at a minimum, offer the core services as specified in § 3417.2. A CSA shall provide at least one (1) core service directly and may provide up to three (3) core services via contract with a sub-provider or subcontractor. A CSA may provide specialty services directly if certified by the Department as a specialty provider.

(d) Each CSA shall ensure that its business hours comply with the requirements of § 3413.21 and facilitate each enrolled consumer's ability to choose an MHRS provider.

(e) Each CSA shall provide a consumer presenting with an urgent need with an independently licensed qualified practitioner for an intervention which may include face-to-face contact on the same day that the consumer presents for service.

(f) Each potential consumer presenting with a routine need shall be provided an intake appointment by a CSA within seven (7) business days of presentation for service.

(g) Each CSA shall have policies and procedures for the provision of outreach services, including means by which these services and individuals will be targeted ("Outreach Policy"). The Outreach Policy shall include procedures for protecting the safety of staff who engage in outreach activities.

(h) Each CSA shall educate consumers on EBPs and document consumers' receipt of this information.

3414.7 Each CSA shall comply with the requirements for assessment and referral for Mental Health Supported Employment services and integration of Employment Specialists into the CSA's treatment team, in accordance with the requirements set forth in 22-A DCMR Chapter 37.

3414.8 Each CSA shall make a play area available for children in the waiting room area.

3414.9 Each CSA shall be responsible for submitting enrolled consumers' clinical information to the Department upon request to receive and maintain authorization for medically necessary services.

3414.10 The Department shall review and approve each CSA's Subcontractor Policy, Consumer and Family Education Policy, On-Call System Policy, Outreach Policy, Quality Improvement Policy, and Evidence-Based Practices Information Policy as part of the certification process.

3414.11 All MHRS providers certified for ACT, CPP-FV, Functional Family Therapy, Multisystemic Therapy, Community Based Intervention Level II and III, TF-CBT, and TST shall obtain the Department's approval to add teams supported through an HCA. Providers shall submit a written request which must include the staffing patterns, including supervisors, training plan and/or dates, staff-to-consumer ratio, and new capacity for the entire team including the new addition.

3415 SUB-PROVIDER AND SPECIALTY PROVIDER REQUIREMENTS

3415.1 Each sub-provider and specialty provider shall comply with the certification standards described in § 3413, the service specific standards applicable to the MHRS offered by the sub-provider or specialty provider, and the other certification standards in this chapter.

3415.2 Each sub-provider and specialty provider shall establish and adhere to policies and procedures ("CSA Referral Policy") governing its relationship with a CSA that address access to records, clinical responsibilities, legal liability, dispute resolution, and all other MHRS certification standards.

3415.3 Sub-providers shall provide one (1) or more of the core services only through a written agreement with a CSA. Sub-providers shall ensure consumers are enrolled with a CSA.

3415.4 Except for the provision of ACT, CBI, or Clubhouse services, specialty providers shall ensure consumers are enrolled with a CSA.

3415.5 Each specialty provider shall screen and assess consumers for EBP as appropriate and applicable, and shall refer them to services as necessary. Each specialty provider shall have an Evidence-Based Practices Information Policy, which includes how providers shall:

(a) Screen and document screening consumers for EBP;

(b) Describe the process of referring and linking consumers to another provider using a warm handoff, if the specialty provider does not render the appropriate EBP; and

(c) Collaborate with the CSA to ensure there are periodic assessments for the need for EBP.

3415.6 Each sub-provider and specialty provider shall satisfy the following minimum staffing requirements:

(a) A Chief Executive Officer or Program Director with professional qualifications and experience who shall meet requirements as established by the MHRS provider’s governing authority and is responsible for day-to-day management of the MHRS provider;

(b) A sub-provider or specialty provider who provides Rehabilitation Day services shall also have a Consulting Psychiatrist who is a board-eligible psychiatrist and advises the sub-provider or specialty provider on the quality of medical and psychiatric care provided;

(c) A Clinical Director who is an independently licensed qualified practitioner with overall responsibility for oversight of the clinical program of the sub-provider or specialty provider. If not full-time, the Clinical Director must dedicate sufficient time to execute the duties of the position;

(d) Each sub-provider who provides either Diagnostic Assessment or Medication/Somatic Treatment shall demonstrate adequate oversight of quality of medical and psychiatric care by employing or contracting with a Medical Director or arranging for the Medical Director of the consumer’s CSA to provide such oversight; and

(e) The required staff listed in this subsection shall be either employees of the sub-provider or specialty provider or under contract to the sub-provider or specialty provider for an amount of time sufficient to carry out the duties assigned.

3415.7 Each sub-provider and specialty provider shall establish and adhere to policies and procedures governing its collaboration with a referring CSA in the development, implementation, evaluation, and revision of each consumer's Plan of Care, that comply with the Department rules (Collaboration Policy). The Collaboration Policy shall:

(a) Be a part of each sub-provider and specialty provider's Treatment Planning Policy;

(b) Require sub-providers and specialty providers to incorporate CSA-developed Diagnostic Assessment material into the sub-provider and specialty provider's treatment planning process, including the use of EBP as an intervention; and

(c) Require sub-providers and specialty providers to coordinate the consumer's treatment with the consumer's CSA assigned staff.

3415.8 Each sub-provider shall offer core services in accordance with requirements in § 3413.21. At a minimum, the sub-provider shall offer services during these hours at its primary service site.

3415.9 At a minimum, each specialty provider shall offer access to specialty services in accordance with requirements in § 3413.22.

3415.10 Each sub-provider and specialty provider with total annual revenues at or exceeding three hundred thousand dollars ($300,000.00) shall have an annual audit by an independent certified public accountant or certified public accounting firm in accordance with generally accepted auditing standards. The resulting financial audit report shall be consistent with formats recommended by the American Institute of Public Accountants. Each sub-provider and specialty provider shall submit a copy of the financial audit report to the Department within one hundred and twenty (120) calendar days after the end of its fiscal year.

3415.11 Each sub-provider and specialty provider with total annual revenues less than three hundred thousand dollars ($300,000.00) shall submit financial statements reviewed by an independent certified public accountant or certified public accounting firm within one hundred twenty (120) calendar days after the end of its fiscal year.

3415.12 Each sub-provider and specialty provider shall only provide MHRS to consumers as specified in the consumers' Plans of Care as designated by the consumers' CSA.

3415.13 The Department shall review and approve the CSA Referral Policy, Collaboration Policy, and the Evidence-Based Programs Information Policy during the certification process.

3416 QUALIFIED PRACTITIONERS AND CREDENTIALED STAFF

3416.1 Qualified practitioners and credentialed staff are individuals permitted to provide MHRS, as identified in this section; the applicable service specific standards; and any other applicable standards in this chapter.

3416.2 Qualified practitioners are behavioral health clinicians appropriately licensed or registered in the District or jurisdiction where services are delivered, and who practice within the scope of their license or certification. Applicable laws and regulations dictate whether, and to what extent, a qualified practitioner:

(a) Is subject to supervision requirements when providing MHRS; and

(b) May supervise other qualified practitioners or credentialed staff in the provision of MHRS.

3416.3 Credentialed staff are non-licensed staff or staff who are not qualified practitioners who are permitted to provide MHRS or components of MHRS if under the supervision of an appropriate qualified practitioner in accordance with applicable laws and regulations.

3416.4 For the purposes of this chapter:

(a) A psychiatrist shall be a:

(1) Licensed physician who is at a minimum a board-eligible psychiatrist;

(2) Psychiatric resident providing care in an approved clinical rotation; or

(3) Moonlighting psychiatric resident.

(b) An APRN shall:

(1) Have psychiatry as a specialty area of practice;

(2) Work in a collaborative protocol with a psychiatrist; or

(3) Demonstrate proficiency in mental health, by having at least five (5) years of experience in psychiatric care delivery.

3416.5 A psychiatric resident is a medical school graduate from a program that meets the standards for medical education found in 17 DCMR § 4602, and who:

(a) Has completed at least one year of a psychiatric residency program that satisfies the requirements of 17 DCMR § 4611.4;

(b) Is supervised by a licensed psychiatrist who satisfies the requirements of 17 DCMR § 4611.4; and

(c) Complies with the standards of conduct for licensed physicians found in 17 DCMR § 4612.

3416.6 A moonlighting psychiatric resident is a medical school graduate who:

(a) Satisfies all of the requirements of § 3416.5; and

(b) Is working under the supervision of the Medical Director or Consulting Psychiatrist of a certified MHRS provider in accordance with protocols approved by the Department's Chief Clinical Officer.

3417 COVERED MHRS

3417.1 The service specific standards described in this section apply to the individual MHRS offered by each MHRS provider and reimbursed by the District in accordance with this chapter.

3417.2 Covered core services shall be Diagnostic Assessment, Medication/Somatic Treatment, Counseling, and Community Support.

3417.3 Covered specialty services shall be Crisis/Emergency Services, Rehabilitation Day Services, Intensive Day Treatment, CBI, ACT, Psychosocial Rehabilitation Clubhouse, CPP-FV, TF-CBT, TREM, and TST.

3418 DIAGNOSTIC ASSESSMENT

3418.1 A Diagnostic Assessment is an intensive clinical and functional evaluation of a consumer’s mental health condition that results in the issuance of a Diagnostic Assessment report, including a clinical formulation, with recommendations for service delivery that provides the basis for and includes the development of a Plan of Care. A psychiatrist shall supervise and coordinate all psychiatric and medical functions required by a consumer’s Diagnostic Assessment.

3418.2 A Diagnostic Assessment shall:

(a) Determine whether the consumer is appropriate for and can benefit from MHRS based upon the consumer's diagnosis, presenting problems, and recovery goals;

(b) Evaluate the consumer's level of readiness and motivation to engage in treatment;

(c) Include the development of a Plan of Care; and

(d) Screen and assess consumers for EBP and Mental Health Supported Employment services as appropriate and applicable.

3418.3 An initial Diagnostic Assessment shall be performed by an independently licensed qualified practitioner for each consumer being considered for enrollment with a CSA.

3418.4 The Diagnostic Assessment shall include the following elements:

(a) A chronological behavioral health history of the consumer's symptoms, treatment, treatment response, and attitudes about treatment and recovery, emphasizing factors that have contributed to or inhibited previous recovery efforts;

(b) For youth and adults, the chronological behavioral health history shall include both psychiatric history and substance use disorder history, treatment history for either or both diagnoses, and the consumer's perception of the outcome;

(c) Biological, psychological, familial, social, and environmental dimensions, and identified strengths and weaknesses in each area;

(d) A description of the presenting problem(s), including source of distress, precipitating events, associated problems or symptoms, and recent progression;

(e) Both a strengths summary and a problem summary, which address the following:

(1) Risk of harm;

(2) Functional status, including relevant emotional and behavioral conditions or complications, and self-control, self-care and interpersonal abilities, coping, and independent living skills;

(3) Co-morbidity, including biomedical conditions and complications;

(4) Recovery environment, including supports and stressors; and

(5) Treatment and recovery history, including relapse potential.

(f) Diagnoses in the DSM-5 or any subsequent version adopted by the Department pursuant to written notice published in the District of Columbia Register;

(g) A review of the consumer's substance use history and presenting problem(s), including an assessment of substances used and intensity of use, the likelihood and severity of withdrawal, and the medical and behavioral risks secondary to intoxication. This review shall identify or exclude substance use disorder as a co-occurring treatment need;

(h) Assessment of the need for psychiatric hospitalization for consumers referred to psychiatric inpatient services to assure that less restrictive alternatives are considered and used when appropriate; and

(i) Evidence of consumer participation and including families' or guardians' participation if appropriate.

3418.5 The Diagnostic Assessment may include psychological testing.

3418.6 Following the completion of the Diagnostic Assessment, an interpretative clinical summary of findings and recommendations for treatment shall be listed in a Diagnostic Assessment report. A Diagnostic Assessment report shall identify barriers to be addressed during treatment and recovery to reduce or eliminate identified deficits.

3418.7 The independently licensed qualified practitioner that performed the Diagnostic Assessment shall complete the Diagnostic Assessment report no later than ten (10) business days after completing the Diagnostic Assessment. The results of the Diagnostic Assessment shall be incorporated into the Plan of Care.

3418.8 A qualified practitioner shall convene the consumer, and the consumer's family and significant others, if appropriate, to review the Diagnostic Assessment report and develop the Plan of Care.

3418.9 One (1) Diagnostic Assessment shall be allowable every one hundred and eighty (180) calendar days. Additional units of Diagnostic Assessment shall be allowable with prior authorization by the Department when there is a significant change in the consumer's mental health status.

3418.10 Diagnostic Assessment shall not be billed on the same day as ACT.

3418.11 Diagnostic Assessment services shall be provided:

(a) At the MHRS provider's service site;

(b) In natural settings, including the consumer's home or community setting; or

(c) In a residential facility of sixteen (16) beds or less unless otherwise stated by the Department.

3418.12 Qualified practitioners of Diagnostic Assessment permitted to both diagnose and assess are:

(a) Psychiatrists;

(b) Psychologists;

(c) LICSWs; and

(d) APRNs working in a collaborative protocol with a psychiatrist.

3418.13 Individuals who may provide assessment and treatment planning services as part of a Diagnostic Assessment, but who may not diagnose, are:

(a) The following qualified practitioners:

(1) RNs;

(2) LISWs;

(3) LPCs; and

(b) Credentialed staff under the supervision of a qualified practitioner permitted to diagnose mental illness.

3419 MEDICATION/SOMATIC TREATMENT

3419.1 Medication/Somatic Treatment services are medical services and interventions, including physical examinations; prescription, supervision, or administration of mental-health related medications; monitoring and interpreting results of laboratory diagnostic procedures related to mental health-related medications; and medical interventions needed for effective mental health treatment provided as either an individual or group intervention.

3419.2 Medication/Somatic Treatment services include monitoring the side effects and interactions of a consumer's medications and the adverse reactions which a

consumer may experience, and providing education and direction for symptom and medication self-management.

3419.3 Group Medication/Somatic Treatment services shall be therapeutic, educational, and interactive with a strong emphasis on group member selection. These services shall facilitate therapeutic peer interaction and support as specified in the Plan of Care.

3419.4 Each Medication/Somatic Treatment provider shall offer:

(a) A comprehensive psycho-educational program for consumers and families, as appropriate, regarding the consumer's mental illness, emotional disturbance, or behavior disorder; treatment and recovery goals; potential benefits and risk of treatment; and self-monitoring aids; and

(b) Consumer/family groups for education, support, and enhancement of the therapeutic alliance between the consumer and the MHRS provider.

3419.5 Consumers receiving Medication/Somatic Treatment shall participate in a psychoeducational session to discuss medication side effects, adverse reactions to medications, and medication self-monitoring and management.

3419.6 Medication/Somatic Treatment shall be provided with no annual limits on services.

3419.7 Medication/Somatic Treatment shall not be billed on the same day as:

(a) ACT; or

(b) IDT.

3419.8 Medication/Somatic Treatment shall be provided:

(a) At the MHRS provider's service site;

(b) By telemedicine pursuant to 29 DCMR § 910;

(c) In natural settings, including the consumer's home or community setting; or

(d) A residential facility of sixteen (16) beds or less unless otherwise stated by the Department.

3419.9 Qualified practitioners of Medication/Somatic Treatment are:

(a) Psychiatrists;

(b) APRNs working in a collaborative protocol with a psychiatrist; and

(c) RNs.

3420 COUNSELING

3420.1 Counseling services are individual, group, or family face-to-face services for symptom and behavior management; development, restoration, or enhancement of adaptive behaviors and skills; and enhancement or maintenance of daily living skills. Adaptive behaviors and skills, and daily living skills include those skills necessary to access community resources and support systems, interpersonal skills, and restoration or enhancement of the family unit and/or support of the family. Mental health support and consultation services provided to consumer's families are reimbursable only when such services and supports are directed exclusively to the well-being and benefit of the consumer.

3420.2 Counseling services provided in excess of one hundred sixty (160) units within a twelve-month (12-month) period require prior authorization from the Department.

3420.3 Counseling shall not be billed:

(a) On the same day as:

(1) IDT;

(2) CBI;

(3) ACT;

(4) TF-CBT;

(5) TST; or

(b) During a Rehabilitation Day Services encounter.

3420.4 Counseling shall be provided:

(a) At the MHRS provider's service site;

(b) By telemedicine pursuant to 29 DCMR § 910;

(c) In natural settings, including the consumer's home or community setting; or

(d) A residential facility of sixteen (16) beds or less unless otherwise stated by the Department.

3420.5 Qualified practitioners of Counseling are:

(a) Psychiatrists;

(b) Psychologists;

(c) LICSWs;

(d) APRNs with psychiatry as a specialty area of practice;

(e) RNs;

(f) LPCs; and

(g) LISWs.

3420.6 LGSWs and credentialed staff who are behavioral health clinicians licensed by the jurisdiction where services are delivered and who practice within the scope of their license shall be permitted to provide Counseling under supervision of an independently licensed qualified practitioner.

3421 COMMUNITY SUPPORT

3421.1 Community Support services are rehabilitation and environmental supports considered essential to assist the consumer in achieving rehabilitation and recovery goals that focus on building and maintaining a therapeutic relationship with the consumer.

3421.2 Community Support services include but are not limited to:

(a) Participation in the development and implementation of a consumer's Plan of Care;

(b) Assistance and support for the consumer in stressor situations;

(c) Mental health education, support, and consultation to consumers' families and support systems directed exclusively to the well-being and benefit of the consumer;

(d) Individual mental health intervention for the development of interpersonal and community coping skills, including adapting to home, school, and work environments;

(e) Assistance to the consumer in symptom self-monitoring and self-management to identify and minimize the negative effects of psychiatric

symptoms, which interfere with the consumer's daily living, financial management, personal development, or school or work performance;

(f) Assistance to the consumer in increasing social support skills and networks that ameliorate life stresses resulting from the consumer's mental illness or emotional disturbance and which are necessary to enable and maintain the consumer's independent living;

(g) Development of strategies and supportive mental health intervention to avoid out-of-home placement for adults, children, and youth and to build stronger family support skills and knowledge of the adult's, child's, or youth's strengths and limitations;

(h) Development of mental health relapse prevention strategies and plans; and

(i) Assistance with coordination of any substance use disorders, co-occurring disorders, and primary care needs.

3421.3 Community Support services may be provided by a team of staff that is responsible for an assigned group of consumers, or by staff who are individually responsible for assigned consumers.

3421.4 The Community Support provider shall maintain a staff-to-consumer ratio of no less than one (1) staff person for every twenty (20) consumers for children and youth, and one (1) staff person for every forty (40) consumers for adults.

3421.5 Community Support services provided to children and youth shall include coordination with family and significant others and with other systems of care, such as education, managed health plans (including Medicaid managed care plans), juvenile justice, and children's protective services, when appropriate to treatment and recovery needs.

3421.6 Community Support services provided in excess of two hundred (200) units within one hundred and eighty (180) calendar days require prior authorization from the Department. Each subsequent authorization shall not exceed two hundred (200) units within a one hundred and eighty (180) calendar daytime period.

3421.7 Community Support shall not be billed on the same day as ACT.

3421.8 Individual Community Support shall not be billed during a Rehabilitation Day Services encounter.

3421.9 Group Community Support shall not be billed on the same day as Rehabilitation Day Services.

3421.10 Community Support services shall be provided:

(a) At the MHRS provider's service site;

(b) In natural settings, including the consumer's home or community settings; or

(c) In a residential facility of sixteen (16) beds or less unless otherwise stated by the Department.

3421.11 Subsections 3421.3 through 3421.9 shall not apply to Therapeutic Supported Employment services, as defined in 22-A DCMR Chapter 37, which are provided as Community Support services. Therapeutic Supported Employment services are reimbursed pursuant to any applicable authorization requirements and billing limitations set forth in 22-A DCMR Chapter 37.

3421.12 Qualified practitioners of Community Support are:

(a) Psychiatrists;

(b) Psychologists;

(c) LICSWs;

(d) APRNs with psychiatry as a specialty area of practice, working in a collaborative protocol with a psychiatrist, or demonstrated proficiency in mental health by having at least five (5) years of experience in psychiatric care delivery;

(e) RNs;

(f) LPCs; and

(g) LISWs.

3421.13 Credentialed staff shall be permitted to provide Community Support under the supervision of an independently licensed qualified practitioner.

3422 CRISIS/EMERGENCY SERVICES

3422.1 A Crisis/Emergency Service is an immediate response face-to-face or via telephone to an emergency situation involving a consumer with mental illness or emotional disturbance that is available twenty-four (24) hours per day, seven (7) days per week.

3422.2 Crisis/Emergency Services are provided to consumers involved in an active mental health crisis and consist of immediate response to evaluate and screen the

presenting situation, assist in immediate crisis stabilization and resolution, and ensure the consumer's access to care at the appropriate level.

3422.3 The Crisis/Emergency Services provider shall adjust its staffing to meet the requirements for immediate response.

3422.4 Each Crisis/Emergency Services provider shall:

(a) Consult with other service providers, locate other MHRS and resources, and provide written and oral information to assist the consumer in obtaining follow-up MHRS;

(b) Be a certified MHRS provider of Diagnostic Assessment or have an agreement with a CSA as a sub-provider or specialty provider to provide hospital pre-admission screenings; and

(c) Demonstrate the capacity to assure continuity of care for consumers by facilitating follow-up mental health appointments and providing telephonic support until outpatient services occur.

3422.5 Each Crisis/Emergency Services provider shall have waiting, assessment, and treatment areas for children, youth, and families that are separate from the areas for adults.

3422.6 Each Crisis/Emergency Services provider shall establish and adhere to policies, procedures, and staffing sufficient to ensure that all individuals seeking and in need of Crisis/Emergency Services receive face-to-face services within one (1) hour of request or referral ("Crisis/Emergency Staffing Policy"). The Crisis/Emergency Staffing Policy shall:

(a) Require independently licensed qualified practitioners to be available twenty-four (24) hours per day, seven (7) days per week for telephone, face-to-face and mobile interventions for individuals needing crisis services;

(b) Delineate the criteria upon which appropriate venue for service delivery is determined;

(c) Require that backup support for staff who need assistance during an intervention is always available;

(d) Require that all staff receive current training in persuasion, engagement, and de-escalation techniques for disruptive or aggressive acts, consumers, and situations; and

(e) Require all staff to hold current certification in cardiopulmonary resuscitation and first aid.

3422.7 Crisis/Emergency Services shall be provided with no annual limits on services.

3422.8 ACT providers shall not bill Crisis/Emergency Services when provided to one of their current consumers.

3422.9 Crisis/Emergency Services shall be provided:

(a) At the MHRS provider's service site;

(b) By telemedicine pursuant to 29 DCMR § 910; or

(c) In natural settings, including the consumer's home or community settings.

3422.10 Qualified practitioners of Crisis/Emergency Services are:

(a) Psychiatrists;

(b) Psychologists;

(c) LICSWs;

(d) APRNs with psychiatry as a specialty area of practice, working in a collaborative protocol with a psychiatrist, or demonstrated proficiency in mental health by having at least five (5) years of experience in psychiatric care delivery;

(e) LISWs;

(f) LPCs; and

(g) RNs.

3422.11 Credentialed staff shall be permitted to provide Crisis/Emergency Services under the supervision of an independently licensed qualified practitioner.

3423 REHABILITATION DAY SERVICES

3423.1 Rehabilitation Day Services is a structured, clinical program intended to develop skills and foster social role integration through a range of social, psycho-educational, behavioral, and cognitive mental health interventions. Rehabilitation Day Services:

(a) Are curriculum-driven and psycho-educational and assist the consumer in the retention or restoration of independent and community living, socialization, and adaptive skills;

(b) Include cognitive-behavioral interventions and diagnostic, psychiatric, rehabilitative, psychosocial, counseling, and adjunctive treatment; and

(c) Are offered most often in group settings, but may be provided individually.

3423.2 Rehabilitation Day Services shall:

(a) Be founded on the principles of consumer choice and the active involvement of each consumer in their mental health recovery;

(b) Provide both formal and informal structures through which consumers can influence and shape service development;

(c) Facilitate the development of a consumer's independent living and social skills, including the ability to make decisions regarding self-care, management of illness, life, work, and community participation;

(d) Promote the use of resources to integrate the consumer into the community; and

(e) Include education on self-management of symptoms, medications and side effects, the identification of rehabilitation preferences, the setting of rehabilitation goals, and skills teaching and development.

3423.3 Each consumer shall have a person-centered plan that addresses the consumer's needs and progress toward achievement of Rehabilitation Day Services treatment goals.

3423.4 Each Rehabilitation Day Services provider shall provide adequate space, equipment, and supplies to ensure that services can be provided effectively. Rehabilitation Day Services program space and furnishings shall be separate and distinct from other services offered within the same service site(s).

3423.5 Each Rehabilitation Day Services provider shall have policies and procedures included in its Service Specific Policies addressing the provision of Rehabilitation Day Services ("Rehabilitation Day Services Organizational Plan") which includes:

(a) A description of the particular rehabilitation models utilized, types of intervention practiced, and typical daily curriculum and schedule; and

(b) A description of the staffing pattern, including a staffing plan to ensure that the required staff-to-consumer ratios are maintained, and a plan for coverage during unplanned staff absences.

3423.6 Each Rehabilitation Day Services provider shall have a minimum of one (1) full-time equivalent staff for every ten (10) consumers based on average daily attendance.

3423.7 At least one (1) independently licensed qualified practitioner shall be present on site at all times.

3423.8 Each Rehabilitation Day Services provider shall have a clinical supervisor or director who is an independently licensed qualified practitioner on site at least thirty (30) hours per week.

3423.9 Each consumer shall participate in at least three (3) hours of Rehabilitation Day Services per day, excluding adequate time for breaks and administrative functions, for the services to be reimbursable.

3423.10 Rehabilitation Day Services in excess of ninety (90) units within a twelve-month (12-month) period shall require prior authorization from the Department. Each subsequent authorization shall not exceed ninety (90) units within a twelve-month (12-month) period.

3423.11 Rehabilitation Day Services shall not be billed:

(a) On the same day as:

(1) Group Community Support;

(2) ACT;

(3) IDT;

(4) TF-CBT;

(5) TREM;

(6) TST;

(7) Psychosocial Rehabilitation Clubhouse; or

(b) During:

(1) A Counseling encounter; or

(2) An Individual Community Support encounter.

3423.12 Rehabilitation Day Services shall only be provided at an MHRS provider's service site.

3423.13 Qualified practitioners of Rehabilitation Day Services are:

(a) Psychiatrists;

(b) Psychologists;

(c) LICSWs;

(d) APRNs with psychiatry as a specialty area of practice, working in a collaborative protocol with a psychiatrist, or demonstrated proficiency in mental health by having at least five (5) years of experience in psychiatric care delivery;

(e) RNs;

(f) LPCs; and

(g) LISWs.

3423.14 Credentialed staff shall be permitted to provide Rehabilitation Day Services under the supervision of an independently licensed qualified practitioner.

3424 INTENSIVE DAY TREATMENT

3424.1 IDT is a facility-based, structured, intensive, and coordinated acute treatment program which serves as an alternative to acute inpatient treatment or as a step-down service from inpatient care, and is rendered by an interdisciplinary team to provide stabilization of psychiatric impairments.

3424.2 Daily physician and nursing services are essential components of IDT services.

3424.3 IDT shall:

(a) Be time-limited and provided in an ambulatory setting to consumers who are not in danger of self-harm or harming others, but who have behavioral health issues that are incapacitating and interfering with their ability to carry out daily activities;

(b) Be provided within a structured program of care which offers individualized, strengths-based, active and timely treatment directed toward alleviating the impairment which caused the admission to IDT;

(c) Be an active treatment program that consists of documented mental health interventions that address the individualized needs of the consumer as identified in the Plan of Care;

(d) Consist of structured individual and group activities and therapies that are planned and goal-oriented, and provided under active psychiatric supervision;

(e) Offer short-term day-programming consisting of therapeutically intensive, acute, and active treatment;

(f) Be comprised of services that closely resemble the intensity and comprehensiveness of inpatient services; and

(g) Include psychiatric, other medical, nursing, social work, occupational therapy, medication/somatic treatment, care coordination, and psychology services focusing on timely crisis intervention and psychiatric stabilization so that consumers can return to their normal daily lives.

3424.4 Each consumer shall participate in at least five (5) hours of IDT services per day, excluding time for adequate breaks and administrative functions, for the services to be reimbursable.

3424.5 Each consumer shall be directly evaluated by an independently licensed qualified practitioner as part of the admissions process.

3424.6 Each consumer’s care shall be supervised by an independently licensed qualified practitioner who assumes primary responsibility for the consumer's assessment, treatment planning, and treatment services.

3424.7 Each consumer shall be assigned to a full-time staff member who assists the consumer and the consumer’s family to assess the consumer’s needs and progress toward achieving the treatment goals.

3424.8 An interdisciplinary treatment team shall meet within one (1) business day of the consumer’s admission to develop an initial IDT Plan of Care.

3424.9 Each IDT Plan of Care shall be updated every three (3) business days and shall be reviewed by the interdisciplinary treatment team on a weekly basis and upon termination of treatment.

3424.10 At least one (1) independently licensed qualified practitioner shall be present on site at all times.

3424.11 Each IDT provider shall have policies and procedures included in its Service Specific Policies addressing the provision of IDT (Intensive Day Treatment Organizational Plan) which includes the following:

(a) A description of the particular treatment models utilized, types of intervention practiced, and typical daily curriculum and schedule;

(b) A description of the staffing pattern including a staffing plan to ensure that the required staff-to-consumer ratios are maintained, and a plan for coverage for unplanned staff absences; and

(c) A description of how the IDT Plan of Care is modified or adjusted to meet the needs specified in each consumer's Plan of Care.

3424.12 The IDT provider shall maintain a minimum staff-to-consumer ratio of one (1) staff for every eight (8) consumers. The IDT provider shall maintain a minimum staffing pattern sufficient to address consumer needs, including adequate physician, nursing, social work, therapy, and psychology services to assure the availability of intensive services.

3424.13 Prior authorization by the Department shall be required for IDT services. Initial and any subsequent authorizations shall not exceed seven (7) units at a time.

3424.14 IDT shall not be billed on the same day as:

(a) Medication/Somatic Treatment;

(b) Counseling;

(c) Rehabilitation Day Services;

(d) ACT;

(e) TF-CBT;

(f) TREM;

(g) TST;

(h) Psychosocial Rehabilitation Clubhouse; or

(i) Supported Employment services subject to the Supported Employment program standards set forth in 22-A DCMR Chapter 37.

3424.15 IDT shall only be provided at an MHRS provider's service site.

3424.16 Qualified practitioners of IDT are:

(a) Psychiatrists;

(b) Psychologists;

(c) LICSWs;

(d) APRNs with psychiatry as a specialty area of practice, working in a collaborative protocol with a psychiatrist, or demonstrated proficiency in mental health by having at least five (5) years of experience in psychiatric care delivery;

(e) RNs;

(f) LPCs; and

(g) LISWs.

3424.17 Credentialed staff shall be permitted to provide IDT under the supervision of an independently licensed qualified practitioner.

3425 COMMUNITY BASED INTERVENTION

3425.1 CBI services are time-limited, intensive, mental health services delivered to children and youth. CBI services are intended to prevent the utilization of an out-of-home therapeutic resource or a detention of the consumer. CBI services may be provided at the time a child or youth is identified for a service, particularly to meet an urgent or emergent need during their course of treatment.

3425.2 In order to be eligible for CBI services, a consumer shall have:

(a) Insufficient or severely limited individual or family resources or skills to cope with an immediate crisis; and

(b) Either individual or family issues, or a combination of individual and family issues, that are unmanageable and require intensive coordinated clinical and positive behavioral interventions.

3425.3 There shall be four (4) levels of CBI services available to children and youth. A provider may be certified to offer one (1) or more level(s) of CBI services. The four (4) levels of CBI services are:

(a) CBI Level I, delivered using the Multisystemic Therapy ("MST") treatment model adopted by the Department;

(b) CBI Level II, delivered using the Intensive Home and Community-Based Services ("IHCBS") model adopted by the Department;

(c) CBI Level III, delivered using the IHCBS model adopted by the Department; and

(d) CBI Level IV, delivered using the Functional Family Therapy (“FFT”) model adopted by the Department.

3425.4 The CBI provider shall be responsible for coordinating the treatment planning process for all consumers authorized to receive CBI for the duration of CBI services. CBI services shall be delivered primarily in natural settings and shall include in-home services.

3425.5 The basic goals of all levels of CBI services are to:

(a) Defuse the consumer’s current situation to reduce the likelihood of a recurrence, which if not addressed, could result in the use of more intensive therapeutic interventions;

(b) Coordinate access to covered mental health services and other covered Medicaid services;

(c) Provide mental health services and support interventions for consumers that develop and improve consumer and family interaction and improve the ability of parents, legal guardians, or caregivers to care for the consumer; and

(d) Assess the needs of the consumer, and transition the consumer to an appropriate level of care following the end of CBI treatment services.

3425.6 All levels of CBI services shall include the following services, as medically necessary and clinically appropriate for the consumer:

(a) Immediate crisis response for enrolled consumers;

(b) Stabilization and behavioral support services to:

(1) Reduce family conflict;

(2) Stabilize the family unit;

(3) Maintain the consumer in the home environment;

(4) Increase family support; and

(5) Monitor the consumer’s medication compliance with prescribed psychiatric medications;

(c) Environmental assessment to:

(1) Identify risk factors that may endanger either the consumer or the consumer's family; and

(2) Assess the strengths of the consumer and the consumer's family;

(d) Individual and family support interventions that develop and improve the ability of parents, legal guardians, or significant others to care for the consumer's behavioral and emotional disturbance(s);

(e) Skills training related to:

(1) Consumer self-help;

(2) Parenting techniques to help the consumer's family develop skills for managing the consumer's emotional disturbance;

(3) Problem solving;

(4) Behavior management;

(5) Communication techniques, including the facilitation of communication and consistency of communication for both the consumer and the consumer's family; and

(6) Medication management, monitoring, and follow-up for family members and other caregivers; and

(f) Coordination and linkage with other covered MHRS and supports and other covered Medicaid services to prevent the utilization of more restrictive residential treatment, including one (1) or more of the following activities:

(1) Referral of consumers to other MHRS providers;

(2) Assisting consumers in transition to less intensive or more intensive MHRS;

(3) Referral of consumers to providers of other Medicaid covered services; or

(4) Supporting and consulting with the consumer's family or support system directed exclusively to the well-being and benefit of the consumer.

3425.7 CBI Level I services are intended for children and youth ages twelve (12) through seventeen (17) who are experiencing serious emotional disturbance with either of the following:

(a) A documented behavioral concern with externalizing (aggressive or violent) behaviors; or

(b) A history of chronic juvenile offenses that has resulted or may result in involvement with the juvenile justice system.

3425.8 CBI Level I services shall not be authorized for:

(a) Children or youth who require the safety of a hospital or other secure setting;

(b) Children or youth in independent living programs; or

(c) Children or youth without a long-term placement option.

3425.9 Eligible consumers of CBI Level I services shall have a permanent caregiver who is willing to participate with service providers for the duration of CBI Level I treatment services and be:

(a) At imminent risk for out-of-home placement within thirty (30) calendar days; or

(b) Currently in out-of-home placement due to the consumer's disruptive behavior, with permanent placement expected to occur within thirty (30) calendar days.

3425.10 CBI Level I services shall require prior authorization from the Department. Authorizations shall not exceed one hundred eight (180) calendar days.

3425.11 Re-admission to CBI Level I services, after the one hundred eighty (180) calendar day time period may be considered for prior authorization by the Department in accordance with medical necessity requirements specified by the Department.

3425.12 CBI Level II is intended for consumers ages birth through twenty-one (21) who shall meet at least one (1) of the following criteria:

(a) A history of involvement with the Child and Family Services Agency ("CFSA") or the Department of Youth Rehabilitation Services ("DYRS");

(b) A history of negative involvement with schools for behavioral-related issues; or

(c) A history of either chronic or recurrent episodes of negative behavior that has resulted or may result in out-of-home placement.

3425.13 CBI Level II services shall not be authorized for children or youth who require the safety of a hospital or other secure setting.

3425.14 CBI Level II services shall require prior authorization from the Department. Authorizations shall not exceed one hundred eight (180) calendar days.

3425.15 Re-admission to CBI Level II services, after the one hundred eighty (180) calendar day time period may be considered for prior authorization by the Department in accordance with medical necessity requirements specified by the Department.

3425.16 CBI Level III is intended for consumers ages birth through twenty-one (21) who shall meet at least one (1) of the following criteria:

(a) Has situational behavioral problems that require short-term, intensive treatment;

(b) Is currently dealing with stressor situations such as trauma or violence and requires development of coping and management skills;

(c) Recently experienced out-of-home placement and requires development of communication and coping skills to manage the placement change;

(d) Is undergoing transition from adolescence to adulthood and requires skills and supports to successfully manage the transition; or

(e) Was recently discharged or is being discharged within the next thirty (30) calendar days from an inpatient setting such as a hospital or psychiatric residential treatment facility.

3425.17 CBI Level III services shall not be authorized for children or youth who require the safety of a hospital or other secure setting.

3425.18 CBI Level III services shall require prior authorization from the Department. Authorizations shall not exceed ninety (90) calendar days.

3425.19 Re-admission to CBI Level III services, after the ninety (90) calendar day period may be considered for prior authorization by the Department in accordance with medical necessity requirements specified by the Department.

3425.20 CBI Level IV is intended for consumers ages eleven (11) through eighteen (18), who shall meet the following two (2) criteria:

(a) First (1st) criteria:

(1) Have a documented history of moderate to serious behavioral problems which impair functioning in at least one (1) area (for example school or home);

(2) Exhibit significant externalizing behavior which impairs functioning in at least one (1) area (for example school or home); or

(3) Be at risk of a disruption in placement; and

(b) Second (2nd) criteria:

(1) Be willing to participate with service providers for the duration of CBI Level IV treatment services; and

(2) Be involved with a caregiver who is willing to participate with service providers for the duration of CBI Level IV treatment services.

3425.21 CBI Level IV services shall not be authorized for:

(a) Children or youth who require the safety of a hospital or other secure setting;

(b) Children or youth in congregate living programs; or

(c) Children or youth in an emergency or respite placement.

3425.22 CBI Level IV Service providers shall obtain prior authorization of CBI Level IV services from the Department for a period not to exceed one hundred and eighty (180) calendar days.

3425.23 Re-admission to CBI Level IV services after the one hundred and eighty (180) calendar day time period may be considered for prior authorization by the Department in accordance with medical necessity requirements specified by the Department.

3425.24 A maximum of twenty-four (24) additional units of CBI Level IV services may be delivered at the discretion of the provider, in consultation with the consumer and the consumer's caregiver without an additional authorization, within twelve (12) months of the close of the initial one hundred and eighty (180) calendar day authorization period.

3425.25 Discharge from all levels of CBI services shall occur when the consumer has achieved the goals for CBI outlined in the Plan of Care, or the consumer no longer

benefits from CBI services. Discharge decisions shall be based on one (1) or a combination of the following:

(a) The consumer is performing reasonably well in relation to goals contained in the Plan of Care and discharge to a lower level of care is indicated (for example, the consumer is not exhibiting risky behaviors or family functioning has improved);

(b) The consumer or the consumer's family or caregiver has developed the skills and resources needed to step down to a less intensive service;

(c) The consumer is not making progress or is regressing and all realistic CBI treatment options have been exhausted;

(d) A family member or caregiver requests discharge and the consumer is not imminently dangerous to self or others;

(e) The consumer requires a higher level of care (for example, inpatient hospitalization or psychiatric residential treatment facility); or

(f) The consumer does not reside in the District and:

(1) Is not eligible to participate in the District's Medicaid program;

(2) Is not within the physical or legal custody of the CFSA; or

(3) Is not within the physical or legal custody of the DYRS.

3425.26 Eligible providers of CBI Level I services shall:

(a) Be licensed MST providers in good standing;

(b) Be either a Network Partner that is providing the MST services and receiving MST consultation services from another MST Network Partner, or a non-Network Partner that is receiving MST consultant services from a MST Network Partner or MST Services;

(c) Have the capacity to provide or arrange for the non-Medicaid reimbursed wraparound services required by eligible consumers;

(d) Meet CBI Level I training requirements specified by the Department;

(e) Have the capacity to deliver CBI Level I services to four (4) to six (6) consumers for each full-time team member; and

(f) Be available to consumers twenty-four (24) hours per day, seven (7) days per week.

3425.27 Eligible providers of CBI Level II services shall:

(a) Meet CBI Level II training requirements specified by the Department;

(b) Have the capacity to provide or arrange for the non-Medicaid reimbursed wraparound services required by eligible consumers;

(c) Have the capacity to deliver CBI Level II services to at least four (4) to six (6) consumers for each full-time team member; and

(d) Be available to consumers twenty-four (24) hours per day, seven (7) days per week.

3425.28 Eligible providers of CBI Level III services shall:

(a) Meet CBI Level III training requirements specified by the Department;

(b) Have the capacity to provide or arrange for the non-Medicaid reimbursed wraparound services required by eligible consumers;

(c) Have the capacity to deliver CBI Level III services to at least four (4) to six (6) consumers for each full-time team member; and

(d) Be available to consumers twenty-four (24) hours per day, seven (7) days per week.

3425.29 Eligible providers of CBI Level IV services shall:

(a) Be certified by FFT LLC as an FFT provider;

(b) Comply with the CBI Level IV training and site certification requirements specified by the Department;

(c) Have the capacity to deliver CBI Level IV services to at least ten (10) to twelve (12) consumers for each therapist; and

(d) Be available to work a flexible schedule based on the needs of the consumer and the family or caregiver.

3425.30 Providers of all levels of CBI services shall:

(a) Individually design CBI services for each consumer and family to minimize intrusion and maximize independence;

(b) Provide more intensive services at the beginning of treatment and decrease the intensity of treatment over time as the strengths and coping skills of the consumer and family develop;

(c) Provide services utilizing a team approach;

(d) Maintain appropriate back-up coverage for team member absences and facilitate substitution of team members, as necessary;

(e) Conduct face-to-face transition planning with consumers and families no later than thirty (30) calendar days prior to the anticipated discharge date, including meetings with providers of more intensive or less intensive services;

(f) Conduct continuity of care planning with consumers and families prior to discharge from any level of CBI services, including facilitating follow-up mental health appointments and providing telephonic support until follow-up mental health services occur;

(g) Provide all of the components of treatment specified in § 3425.6, as appropriate, based on each consumer's needs;

(h) Provide CBI services with a family-focus;

(i) Assist the consumer and his or her family with the development of mental health relapse prevention strategies and plans, if none exist;

(j) Assist the consumer and his or her family with the development of a safety plan to address risk factors identified during the environmental assessment;

(k) Have policies and procedures included in its Service Specific Policies that address the provision of CBI ("CBI Organizational Plan") which include the following:

(1) A description of the particular treatment models utilized, types of intervention practiced, and typical daily curriculum and schedule;

(2) A description of the staffing pattern and how staff is deployed to ensure that the required staff-to-consumer ratios are maintained, including a plan for unplanned staff absences;

(3) A requirement to directly conduct or arrange for Diagnostic Assessment services within thirty (30) calendar days before or after the initiation of CBI services. The Department may approve alternative sources to serve as the diagnostic assessment instrument

if similar assessments have been conducted within the past twelve (12) months of an individual's referral to CBI services; and

(4) A requirement to collect and submit clinical outcome data and any other requested information using the process, timeline, and tools specified or approved by the Department.

3425.31 Each CBI Level I team shall include:

(a) A full-time CBI Level I clinical supervisor; and

(b) Two (2) to four (4) full-time CBI Level I clinicians.

3425.32 The CBI Level I team clinical supervisor shall be an independently licensed qualified practitioner experienced in providing individual, group, marital or family counseling or psychotherapy, with a minimum of two (2) years of post-graduate experience working with behaviorally challenged youth and their families in community-based settings.

3425.33 The CBI Level I team clinicians shall be qualified practitioners.

3425.34 Each CBI Level II team shall include:

(a) A full-time clinical supervisor dedicated at a minimum fifty percent (50%) to IHCBS; and

(b) At a minimum, two (2) full-time clinicians dedicated to IHCBS.

3425.35 The CBI Level II team clinical supervisor shall be a Master's level independently licensed qualified practitioner experienced in providing individual, group, marital or family counseling or psychotherapy, with a minimum of two (2) years of post-graduate experience working with behaviorally challenged youth and their families in community-based settings.

3425.36 The CBI Level II team clinicians shall be qualified practitioners and have a minimum of one (1) year of experience working with behaviorally challenged youth and their families in community-based settings.

3425.37 Each CBI Level III team shall include:

(a) A full-time clinical supervisor dedicated at a minimum fifty percent (50%) to IHCBS; and

(b) At a minimum, two (2) full-time clinicians dedicated to IHCBS.

3425.38 The CBI Level III team clinical supervisor shall be a Master's level independently licensed qualified practitioner experienced in providing individual, group, marital or family counseling or psychotherapy, with a minimum of two (2) years post-graduate experience working with behaviorally challenged youth and their families in community-based settings.

3425.39 The CBI Level III team clinicians shall be qualified practitioners and have a minimum of one (1) year of experience working with behaviorally challenged youth and their families in community-based settings.

3425.40 Each CBI Level IV team shall include:

(a) An FFT-trained supervisor who provides the clinical and administrative supervision of the FFT Team and has the capacity to carry up to five (5) cases; and

(b) Three (3) to eight (8) FFT clinicians who have satisfied the FFT requirements for a therapist.

3425.41 The CBI Level IV supervisor shall be a Master's level independently licensed qualified practitioner experienced in providing individual, group, marital or family counseling or psychotherapy, with a minimum of two (2) years of post-graduate experience working with behaviorally challenged youth and their families in community-based settings who has satisfied the FFT requirements for a clinical supervisor.

3425.42 The CBI Level IV clinicians shall be qualified practitioners and have a minimum of one (1) year of experience working with behaviorally challenged youth and their families in community-based settings, and shall have satisfied the FFT requirements for FFT therapists.

3425.43 Providers of all levels of CBI services shall ensure referral to and coordination with any medically necessary substance use disorder treatment and recovery support services and any services to facilitate consumers' transition from adolescence to adulthood.

3425.44 CBI shall not be billed on the same day as:

(a) Counseling;

(b) ACT; or

(c) TF-CBT.

3425.45 CBI Level II and CBI Level III shall not be billed on the same day as TREM.

3425.46 CBI Level IV shall not be billed on the same day as TST.

3425.47 CBI shall be provided:

(a) At the MHRS provider's service site; or

(b) In natural settings, including the consumer's home or community settings.

3425.48 Qualified practitioners of CBI:

(a) Psychiatrists;

(b) Psychologists;

(c) LICSWs;

(d) APRNs with psychiatry as a specialty area of practice;

(e) LPCs;

(f) RNs; and

(g) LISWs.

3425.49 Credentialed staff who may provide this service working under appropriate supervision are the following:

(a) LGSWs; and

(b) LGPCs.

3425.50 CBI services shall not exceed thirty-two (32) units in a twenty-four (24) hour period, without prior authorization from the Department. The Department may conduct clinical record reviews to verify the medical necessity of services provided.

3425.51 CBI providers shall comply with training requirements:

(a) For CBI Level I through nationally recognized body;

(b) For CBI Level II and CBI Level III in accordance with the Department CBI Policy;

(c) For CBI IV through FFT LLC; and

(d) All other trainings provided through the Department's Training Institute during the calendar year as requested by the Department.

3426 ASSERTIVE COMMUNITY TREATMENT

3426.1 ACT is an intensive, integrated, rehabilitative, crisis, treatment, and mental health community support service provided by an interdisciplinary team to individuals eighteen (18) and over with serious and persistent mental illness with dedicated staff time and specific staff-to-consumer ratios.

3426.2 Service coverage by the ACT team is required twenty-four (24) hours per day, seven (7) days per week.

3426.3 The consumer's ACT team shall complete a comprehensive or supplemental assessment and develop a self-care-oriented Plan of Care (if a current and effective one does not already exist).

3426.4 Services offered by the ACT team shall include:

(a) Medication prescription, administration, and monitoring;

(b) Crisis assessment and intervention;

(c) Symptom assessment, management, and individual supportive therapy;

(d) Substance use disorder treatment for consumers with a co-occurring substance use disorder;

(e) Psychosocial rehabilitation and skill development;

(f) Interpersonal, social, and interpersonal skill training;

(g) Education, support, and consultation to consumers' families and their support system which is directed exclusively to the well-being and benefit of the consumer;

(h) Finding safe and affordable supportive housing;

(i) Money management and benefits counseling and acquisition; and

(j) Coordination of medical and psychosocial services.

3426.5 ACT services shall include a comprehensive and integrated set of medical and psychosocial services for the treatment of the consumer's mental health condition that is provided in non-office settings by the consumer's ACT team.

3426.6 The ACT team provides community support services that are interwoven with treatment and rehabilitative services and regularly scheduled team meetings. ACT team meetings shall be held a minimum of four (4) times a week.

3426.7 ACT services and interventions shall be highly individualized and tailored to the needs and preferences of the consumer, with the goal of maximizing independence and supporting recovery.

3426.8 Each ACT provider shall have policies and procedures included in its Service Specific Policies that address the provisions of ACT ("ACT Organizational Plan") which include the following:

(a) A description of the particular treatment models utilized, types of intervention practiced, and typical daily curriculum and schedule; and

(b) A description of the staffing pattern and how staff are deployed to ensure that the required staff-to-consumer ratios are maintained, including how unplanned staff absences and illnesses are accommodated.

3426.9 At a minimum, the ACT team shall include the following members:

(a) A full-time team leader or supervisor who is the clinical and administrative supervisor of the ACT team and who is at minimum an independently licensed Master's level qualified practitioner or a Master's level RN;

(b) A psychiatrist or a psychiatric prescriber working on a full-time or part-time basis for a minimum of four (4) hours per week per twenty (20) consumers, who provides clinical and crisis services to all consumers served by the ACT team, works with the ACT team leader to monitor each consumer's clinical status and response to treatment, and directs psychopharmacologic and medical treatment;

(c) An RN working on a full-time basis, who provides nursing services for all ACT team consumers. The RN works with the ACT team to monitor each consumer's clinical status and response to treatment, and who functions as a primary practitioner on the ACT team for a caseload of consumers;

(d) A certified addiction counselor who is working on a full-time basis and providing or accessing substance use disorder services for ACT team consumers, and who functions as a primary practitioner on the ACT team for a caseload of consumers;

(e) A clinically trained and licensed generalist practitioner working on a full-time basis and providing individual and group supportive therapy to ACT team consumers, and who functions as a primary practitioner on the ACT team for a caseload of consumers and is a qualified practitioner;

(f) A certified recovery coach or certified peer specialist carrying out rehabilitation and support functions who may be a consumer in recovery that has been specially credentialed based on their psychiatric and life experiences. Certified recovery coaches and certified peer specialists are fully integrated ACT team members who provide consultation to the ACT team and highly individualized services in the community, and who promote consumer self-determination and decision making; and

(g) A vocational specialist with at least one year of training or experience who has knowledge of supported employment, vocational assessment, job exploration and marketing to recipient's interest and strengths and securing and maintain employment.

3426.10 The ACT team shall maintain a minimum consumer-to-staff ratio of no more than ten (10) consumers per staff person, and such ratio shall take into consideration evening and weekend hours, needs of special populations, and geographical areas to be covered.

3426.11 Eligible providers of ACT services shall:

(a) Utilize the ACT model adopted by the Department;

(b) Meet ACT training requirements specified by the Department; and

(c) Have culturally and linguistically competent staff.

3426.12 ACT shall require prior authorization from the Department. Initial and subsequent authorizations shall not exceed one hundred eighty (180) calendar days and five hundred (500) units.

3426.13 ACT consumers shall receive vocational and supported employment services through their ACT team. ACT consumers shall not be eligible for Supported Employment services that are subject to the Supported Employment program standards set forth in 22-A DCMR Chapter 37.

3426.14 ACT shall not be billed on the same day as:

(a) Diagnostic Assessment;

(b) Medication/Somatic Treatment;

(c) Counseling;

(d) Community Support;

(e) Rehabilitation Day Services;

(f) IDT;

(g) CBI;

(h) TF-CBT;

(i) TREM; or

(j) TST.

3426.15 ACT providers shall not bill Crisis/Emergency Services when provided to one of their current consumers.

3426.16 ACT shall be provided:

(a) At the MHRS provider's service site; or

(b) In natural settings, including the consumer's home or community settings.

3426.17 Qualified practitioners of ACT are:

(a) Psychiatrists; and

(b) RNs.

3426.18 Credentialed staff shall be permitted to provide ACT services under the supervision of an independently licensed qualified practitioner or a Master's level RN.

3427 CHILD-PARENT PSYCHOTHERAPY FOR FAMILY VIOLENCE

3427.1 Child-Parent Psychotherapy for Family Violence ("CPP-FV") is a relationship-based treatment intervention for young children with a history of trauma exposure or maltreatment, and their parents or caregivers. CPP-FV helps restore developmental functioning and reduce trauma symptoms in the wake of trauma by focusing on restoring the attachment relationship that was negatively affected. Young children, birth through six (6) years of age, who have experienced traumatic stress often have difficulty regulating their behaviors and emotions during distress. They may exhibit fearfulness of new situations, be easily frightened, difficult to console, aggressive, or impulsive. These children may also have difficulty sleeping, lose recently acquired developmental skills, and show regression in functioning and behavior. Under CPP-FV, clinicians assess and provide information on how parents' or caregivers' past experiences, including past insecure or abusive relationships, affect their relationships with their children. Sessions focus on parent/caregiver-child interactions and clinicians provide support

on healthy coping, affect regulation, and increased appropriate reciprocity between parent/caregiver and child, resulting in a stronger relationship between a child and his or her parent or caregiver, and improvement in the child's symptoms. On average CPP-FV sessions are sixty (60) to ninety (90) minutes, one (1) time per week, for a period up to fifty-two (52) weeks. CPP-FV sessions are longer in the first six months of treatment (*i.e.*, ninety (90) minutes) and decrease over time (to sixty (60) minutes) as the child improves his or her coping skills.

(a) The goals of CPP-FV are to:

(1) Reduce post-traumatic stress reactions and symptoms in children;

(2) Improve both parent/caregiver and child functioning, as well as improve the parent/caregiver-child attachment relationship;

(3) Establish a sense of safety and trust within the parent/caregiver-child relationship;

(4) Return a child to a normal developmental trajectory; and

(5) Restore parental/caregiver sensitivity and responsiveness, in order to strengthen the child-parent/caregiver relationship.

(b) CPP-FV is available to children ages birth through six (6) years with a mental health diagnosis, who have experienced at least one traumatic event including maltreatment, the sudden or traumatic death of a caregiver, a serious accident, medical traumas, sexual abuse, physical abuse, neglect, or exposure to domestic violence, and, as a result, are experiencing behavioral, attachment, and/or mental health problems, including post-traumatic stress symptoms.

(c) CPP-FV shall only be provided with the participation of the parent or caregiver.

(d) Providers of CPP-FV services shall meet and maintain certification as a CPP-FV provider from the Department-approved training entity.

(e) All CPP-FV clinicians shall complete the Department-approved CPP-FV clinical training.

(f) Each CPP-FV Team shall include one (1) clinical supervisor and no more than six (6) clinicians who have successfully completed the CPP-FV training requirements. The clinical supervisor shall be an independently licensed qualified practitioner.

(g) CPP-FV clinicians shall be qualified practitioners who hold a Master's degree in psychology, social work, therapy, or other related field;

(h) Credentialed staff shall receive supervision from a qualified practitioner trained in CCP-FV in accordance with the CPP-FV fidelity standards; and

(i) Providers of CCP-FV shall maintain an acceptable rating on an annual CPP-FV fidelity audit.

3427.2 CPP-FV may be provided without prior authorization from the Department.

3427.3 CPP-FV shall not be billed on the same day as:

(a) TF-CBT; or

(b) TST.

3427.4 CPP-FV shall be provided:

(a) At the MHRS provider's service site;

(b) In natural settings, including the consumer's home or community settings; or

(c) In a residential facility of sixteen (16) beds or less unless otherwise stated by the Department.

3427.5 Qualified practitioners of CPP-FV are:

(a) Psychiatrists;

(b) Psychologists;

(c) LICSWs;

(d) APRNs with psychiatry as a specialty area of practice;

(e) LPCs;

(f) RNs.

3427.6 Credentialed staff who may provide this service working under appropriate supervision are the following:

(a) LGSWs;

(b) LGPCs;

(c) LISWs; and

(d) Psychology Associates.

3428 TRAUMA-FOCUSED COGNITIVE BEHAVIORAL THERAPY

3428.1 Trauma-Focused Cognitive Behavioral Therapy ("TF-CBT") is a psychotherapeutic intervention designed to help children, working with their parent or caregivers, overcome the negative effects of traumatic life events. The treatment focuses on parent-child interactions, parenting skills, therapeutic treatment, skills development (such as stress management, cognitive processing, communication, problem solving, and safety), and parental support. A parent/caregiver treatment component is an integral part of this treatment model. It parallels the interventions used with the child so that parent or caregivers are aware of the content covered with the child and are prepared to reinforce or discuss this material with the child between treatment sessions and after treatment has ended. A typical course of TF-CBT treatment requires children to participate in sixty (60) to ninety (90) minute individual and conjoint child parent or caregiver sessions, at a minimum one (1) time per week, over an average period of twelve (12) to sixteen (16) weeks in accordance with the evidence-based practice requirements.

(a) The goals of TF-CBT are to:

(1) Target symptoms of post-traumatic stress disorder that are often co-occurring with depression and behavior problems;

(2) Address issues commonly experienced by traumatized children, such as poor self-esteem, difficulty trusting others, mood instability, and self- injurious behavior, including substance use disorder;

(3) Increase stress management skills of youth and parent/caregiver;

(4) Improve youth's self-esteem, problem-solving and safety skills and decrease self-injurious and aggressive behaviors; and

(5) Decrease caregiver trauma-related distress.

(b) TF-CBT is available to children ages four (4) through eighteen (18) years of age with a diagnosed serious emotional disorder, who have experienced or witnessed one or more traumatic events and who are experiencing behavioral, or mental health problems, including post-traumatic stress symptoms as a result of the event.

(c) TF-CBT is recommended to be provided with an active parent/caregiver willing to participate for the anticipated treatment period.

(d) Providers of TF-CBT services shall maintain fidelity to the TF-CBT model adopted by the Department.

(e) All TF-CBT Clinical team members shall complete the Department-approved TF-CBT clinical training.

(f) Each TF-CBT Team shall include at least one (1) clinical supervisor, and no more than ten (10) clinicians who have successfully completed the TF-CBT training requirements. The clinical supervisor shall be an independently licensed qualified practitioner experienced in providing individual, group, marital, or family counseling or psychotherapy.

(g) TF-CBT clinicians shall be qualified practitioners who hold a Master's degree in psychology, social work, therapy, or other related field.

(h) Services provided by credentialed staff shall be supervised by a qualified practitioner trained in TF-CBT as required by the TF-CBT requirements and documented in the TF-CBT Practice Session Checklist.

3428.2 TF-CBT may be provided without prior authorization from the Department.

3428.3 TF-CBT shall not be billed the same day as:

(a) Counseling;

(b) Rehabilitation Day Services;

(c) IDT;

(d) CBI;

(e) ACT;

(f) CPP-FV; or

(g) TST.

3428.4 TF-CBT shall be provided:

(a) At the MHRS provider's service site;

(b) In natural settings, including the consumer's home or community settings; or

(c) In a residential facility of sixteen (16) beds or less unless otherwise stated by the Department.

3428.5 Qualified practitioners of TF-CBT are:

(a) Psychiatrists;

(b) Psychologists;

(c) LICSWs;

(d) APRNs with psychiatry as a specialty area of practice;

(e) RNs; and

(f) LPCs.

3428.6 Credentialed staff who may provide this service working under appropriate supervision are the following:

(a) LGSWs;

(b) LGPCs;

(c) LISWs; and

(d) Psychology Associates.

3429 TRAUMA RECOVERY AND EMPOWERMENT MODEL

3429.1 TREM is a structured group therapy intervention designed for individuals who have survived trauma and have substance use disorders and/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. A curriculum for each model outlines the topic of discussion, a rationale, a set of goals, and a series of questions to be posed to the group in addition to an experiential exercise for each session.

The components are:

(a) Therapy sessions focused on empowerment, self-comfort, and accurate self-monitoring, as well as ways to establish safe physical and emotional boundaries;

(b) Therapy sessions focused on the trauma experience and its consequences; and

(c) Therapy sessions focused on skills building, including emphases on communication style, decision-making, regulating overwhelming feelings, and establishing safer, more reciprocal relationships.

3429.2 Each TREM group is population specific and on average consists of eighteen (18) to twenty-four (24) sessions, with each session at least seventy-five (75) minutes in duration. Population-specific groups include:

(a) TREM for women;

(b) TREM for men;

(c) TREM for girls twelve (12) to seventeen (17) years of age;

(d) TREM for boys twelve (12) to seventeen (17) years of age; and

(e) TREM for individuals who are lesbian, gay, bisexual, transgender, questioning, intersex, or asexual (groups for either individuals under eighteen (18) or individuals eighteen (18) and over.

3429.3 Due to the sensitive nature of the discussions, TREM requires at least two (2) facilitators to be assigned to every group to ensure the safety and continuity of the group. At least one (1) facilitator shall be an independently licensed qualified practitioner. A team approach is required to: address situations that may arise within the group; decrease burnout; provide continuity if one facilitator is absent; and to lend additional therapeutic support to the group. Qualified practitioners staff working as facilitators shall have completed Department-approved, population-specific TREM training.

3429.4 TREM may be provided without prior authorization from the Department.

3429.5 TREM shall not be billed on the same day as:

(a) Rehabilitation Day Services;

(b) Intensive Day Treatment;

(c) CBI Level II and III; or

(d) ACT.

3429.6 TREM shall be provided:

(a) At the MHRS provider's service site; or

(b) In a residential facility of sixteen (16) beds or less unless otherwise stated by the Department.

3429.7 Qualified Practitioners of TREM are:

(a) Psychiatrists;

(b) Psychologists;

(c) LICSWs;

(d) APRNs with psychiatry as a specialty area of practice;

(e) LMFTs;

(f) LPCs;

(g) LISWs;

(h) LGSWs;

(i) LGPCs; and

(j) Psychology Associates.

3429.8 Certified Recovery Coaches, Certified Peer Specialists, and Certified Addiction Counselors I and II who have successfully completed a TREM group and Department-approved TREM training shall be authorized to support TREM services under the supervision of the two (2) group facilitators.

3430 TRAUMA SYSTEMS THERAPY

3430.1 TST is 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 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 traumatic stress. TST focuses on the interaction between the child's difficulties regulating their emotions and the deficits within the child's social environment. The three phases of the model are Safety-Focused, Regulation-Focused, and Beyond Trauma.

3430.2 On average, individual TST sessions are one (1) to three (3) sessions per week, depending on the phase of treatment. Sessions are on average forty-five (45) to sixty (60) minutes in duration.

3430.3 TST is intended for children and youth six (6) through eighteen (18) years of age, who have:

(a) Been exposed to trauma;

(b) Plausible trauma histories;

(c) Difficulty regulating emotional and behavioral states;

(d) Dysregulation that is plausibly related to the trauma history; and

(e) Stable housing or a plan to achieve stable housing in the community.

3430.4 At a minimum, the TST team shall include:

(a) A TST-trained supervisor who provides the clinical and administrative supervision of the TST team. The supervisor shall be an independently licensed qualified practitioner experienced in providing individual, group, marital, or family counseling or psychotherapy;

(b) Access to a psychiatrist to monitor each youth's clinical status and response to treatment, and to direct psychopharmacologic treatment or consult with the consumer's psychopharmacologic treatment team. The psychiatrist shall be knowledgeable in TST ("be TST-informed");

(c) TST-trained therapists who provide individual therapy. Therapists shall hold a Master's degree in psychology, social work, counseling, or other related field and shall be appropriately licensed by the jurisdiction where services are delivered and practice within the scope of their license.

(d) TST-trained individuals who are qualified practitioners of Community-Based Intervention or who are credentialed to provide Community Support to provide crisis support, care coordination, skills building, and TST treatment plan support; and

(e) Individuals who provide Legal Advocacy Support and who are knowledgeable in TST ("are TST-informed").

3430.5 All TST supervisors and therapists shall have completed DBH-approved TST training.

3430.6 Providers of TST services shall maintain certification as a TST provider from a DBH-approved training entity.

3430.7 TST may be provided without prior authorization from the Department.

3430.8 TST shall not be billed on the same day as:

(a) Counseling;

(b) Rehabilitation Day Services;

(c) IDT;

(d) CBI Level IV;

(e) ACT;

(f) CPP-FV; or

(g) TF-CBT.

3430.9 TST shall be provided:

(a) At the MHRS provider's service site; or

(b) In natural settings, including the consumer's home or community settings;

3430.10 Qualified Practitioners of TST are:

(a) Psychiatrists;

(b) Psychologists;

(c) LICSWs;

(d) APRNs with psychiatry as a specialty area of practice;

(e) LMFTs;

(f) LPCs;

(g) LGSWs;

(h) LGPCs;

(i) LISWs; and

(j) Psychology Associates.

3430.11 Services provided by qualified practitioners who are subject to supervision requirements, per applicable licensing and registration laws and regulations, shall be supervised by a qualified practitioner who is:

(a) Licensed to practice independently, and

(b) Trained in TST, as required by this chapter's TST requirements.

3431 REIMBURSABLE SERVICES

3431.1 Reimbursement for the provision of MHRS shall be on a per unit basis as indicated in § 3431.4.

3431.2 Each covered service shall have a unique billing code as established by the Department.

3431.3 The actual start and stop time of the service shall be used to calculate the duration of the service rounded to the nearest fifteen-minute unit.

3431.4 Reimbursement shall be limited as follows:

MHRS	LIMITATIONS AND SERVICE SETTING	BILLABLE UNIT OF SERVICE
Diagnostic Assessment	• One (1) every one hundred and eighty (180) calendar days • Additional units allowable when there is a significant change in the consumer's mental health status • Shall not be billed the same day as ACT • Provided only in an MHRS provider's service site, home or community setting, or residential facility of sixteen (16) beds or less unless otherwise stated by the Department	An assessment, which is at least three (3) hours in duration
Medication/ Somatic Treatment	• No annual limits • Shall not be billed the same day as ACT or IDT • Provided only in an MHRS provider's service site, home or community setting, via telemedicine, or in residential facility of sixteen (16) beds or less unless otherwise stated by the Department	Fifteen (15) Minutes

MHRS	LIMITATIONS AND SERVICE SETTING	BILLABLE UNIT OF SERVICE
Counseling	• One hundred sixty (160) units per twelve (12) month period • Additional units allowable with prior authorization • Shall not be billed the same day as IDT, CBI, ACT, TF-CBT, or TST. Shall not be billed during a Rehabilitation Day Services encounter • Shall be rendered face-to-face, when consumer is present, unless there is adequate documentation to justify why the consumer was not present during the session • May be provided in individual on-site, individual off-site or group • Provided only in an MHRS provider's service site, home or community setting, via telemedicine, or in a residential facility of sixteen (16) beds or less unless otherwise stated by the Department	Fifteen (15) minutes
Community Support	• Two hundred (200) units per one hundred and eighty (180) calendar days • Additional units allowable with prior authorization; each authorization cannot exceed (200) units per one hundred and eighty (180) calendar days • Shall not be billed on the same day as ACT. Individual Community Support shall not be billed during a Rehabilitation Day Services encounter and Group Community Support shall not be billed on the same day as Rehabilitation Day Services • Provided only in an MHRS provider's service site, home, community setting, or residential facility of sixteen (16) beds or less unless otherwise stated by the Department • Limitations applicable to Therapeutic Supported Employment services provided as Community Support services are described in 22-A DCMR Chapter 37	Fifteen (15) minutes

MHRS	LIMITATIONS AND SERVICE SETTING	BILLABLE UNIT OF SERVICE
Crisis/ Emergency Services	• No annual limits • ACT providers shall not bill Crisis/Emergency Services when provided to one of their current consumers. • Provided only in an MHRS provider's service site, home or community setting, or via telemedicine	Fifteen (15) minutes
Rehabilitation Day Services	• Ninety (90) units within a twelve (12) month period • Additional units allowable with prior authorization; each authorization cannot exceed ninety (90) units per twelve (12) month period • Shall not be billed on the same day as Group Community Support, ACT, IDT, TF-CBT, TREM, TST, or Clubhouse. Shall not be billed during a Counseling or Individual Community Support encounter • Provided only in an MHRS provider's service site	One (1) day (which shall consist of at least three (3) hours) of service, excluding appropriate time for breaks and administrative functions)
Intensive Day Treatment ("IDT")	• Prior authorization required. Initial and subsequent authorizations shall not exceed seven (7) days at a time • Shall not be billed on the same day as Medication/Somatic Treatment, Counseling, Rehabilitation Day Services, ACT, TF-CBT, TREM, TST, Clubhouse, or Supported Employment • Provided only in an MHRS provider's service site	One (1) day [which shall consist of at least five (5) hours of IDT services, excluding appropriate time for breaks and administrative functions]
Community Based Intervention ("CBI")	• Prior authorization required for enrollment and continued stay (see §3425 for details) • Shall not be billed on the same day as Counseling, ACT, or TF-CBT. CBI Level II and III shall not be billed on the same day as TREM and CBI Level IV shall not be billed on the same day as TST • Provided only in an MHRS provider's service site, or home or community setting	Fifteen (15) minutes

MHRS	LIMITATIONS AND SERVICE SETTING	BILLABLE UNIT OF SERVICE
Assertive Community Treatment (“ACT”)	• Prior authorization required. Initial and subsequent authorizations shall not exceed one hundred eighty (180) calendar days and five (500) hundred units • Shall not be billed on the same day as Diagnostic Assessment, Medication/Somatic Treatment, Counseling, Community Support, Rehabilitation Day Services, IDT, CBI, TF-CBT, TREM, or TST. ACT providers shall not bill Crisis/Emergency Services if provided to one of their current consumers • Provided only in an MHRS provider’s service site, or home or community setting	Fifteen (15) minutes
Child-Parent Psychotherapy for Family Violence (“CPP-FV”)	• May be provided without prior authorization • Shall not be billed on the same day as TF-CBT or TST • Provided only in an MHRS provider’s service site, home or community setting, or residential facility of sixteen (16) beds or less. unless otherwise stated by the Department	Fifteen (15) minutes up to ninety (90) minutes once (1) per week
Trauma-Focused Cognitive Behavioral Therapy (“TF-CBT’)	• May be provided without prior authorization • Shall not be billed the same day as Counseling, Rehabilitation Day Services, IDT, CBI, ACT, CPP-FV, or TST • Provided only in an MHRS provider’s service site, home or community setting, or residential facility of sixteen (16) beds or less unless otherwise stated by the Department	Fifteen (15) minutes up to ninety (90) minutes once (1) per week
Trauma Recovery and Empowerment Model (“TREM”)	• May be provided without prior authorization • TREM shall not be billed on the same day as Rehabilitation Day Services, IDT, CBI Level II and III, or ACT • Provided only in an MHRS provider’s service site, or residential facility of sixteen (16) beds or less unless otherwise stated by the Department	Fifteen (15) minutes

MHRS	LIMITATIONS AND SERVICE SETTING	BILLABLE UNIT OF SERVICE
Trauma Systems Therapy ("TST")	• May be provided without prior authorization • TST shall not be billed on the same day as Counseling, Rehabilitation Day Services, IDT, CBI Level IV, ACT, CPP-FV, or TF-CBT	Fifteen (15) minutes

3432 NON-REIMBURSABLE SERVICES

3432.1 Services not covered as MHRS include, but are not limited to:

(a) Room and board residential costs;

(b) Inpatient hospital services, including hospital, nursing facility, intermediate care facility for individuals with intellectual disabilities, and institutions for mental diseases;

(c) Transportation services;

(d) Educational, vocational, and job training services;

(e) Services rendered by parents or other family members;

(f) Social or recreational services;

(g) Screening and prevention services (other than those provided under Early and Periodic Screening, Diagnosis, and Treatment requirements);

(h) Services that are not medically necessary;

(i) Services that are not provided and documented in accordance with these certification standards;

(j) Services that are not behavioral health services as described in these rules; and

(k) Services furnished to persons other than the consumer, when those services are not directed primarily to the well-being and benefit of the consumer.

3499 DEFINITIONS

3499.1 The following terms in this chapter have the meaning ascribed in this section:

Advanced Practice Registered Nurse (“APRN”) – A person licensed as an advanced practice registered nurse in accordance with applicable laws and regulations of the District or jurisdiction where services are delivered.

Assertive Community Treatment team (“ACT team”) – A mobile inter-disciplinary team of qualified practitioners and other staff involved in providing ACT to a consumer.

Authorized - MHRS services that are prior authorized or reauthorized by the Department, in accordance with these standards.

Behavioral Concern – A behavioral and emotional reaction of childhood and adolescence that can range from normal to severe responses and can be categorized as troubling, disruptive, or threatening. Behavioral concerns can have varying ranges of manifestations by children that include but are not limited to poor concentration, changes in social interactions, sadness, poor academic performance, high levels of irritability, acting out aggressively, expressing anger inappropriately, and engaging in a variety of antisocial and destructive acts, including violence towards people and animals, destruction of property, lying, stealing, truancy, and running away from home.

Certified Addiction Counselor (“CAC”) – A person certified as a Certified Addiction Counselor I or II in accordance with applicable laws and regulations of the District or jurisdiction where services are delivered.

Certification – The written authorization from the Department rendering an entity eligible to provide MHRS. The Department grants certification to community-based organizations that submit an approved certification application and satisfy the certification standards.

Certification Application – The application and supporting materials prepared and submitted to the Department by a community-based organization requesting a new certification or renewal of an existing certification to provide MHRS.

Certification Standards – The minimum requirements established by the Department in this chapter that a provider shall satisfy to obtain and maintain certification to provide MHRS and receive reimbursement from the District for MHRS.

Certified Peer Specialist – An individual who has completed the Peer Specialists Certification Program requirements and is approved to deliver Peer Support Services within the District’s public behavioral health network.

Certified Recovery Coach – An individual with any DBH-approved recovery coach certification.

Child and Family Services Agency ("CFSA") – The District agency responsible for the coordination of foster care, adoption, and child welfare services and services to protect children against abuse or neglect.

Child-Parent Psychotherapy for Family Violence or CPP-FV Fidelity Audit – A process by which the implementation of CPP-FV, in accordance with the established standards and guiding principles, are annually evaluated.

Community Based Intervention Team ("CBI team") – The interdisciplinary team of qualified practitioners and other staff involved in providing CBI to a consumer.

Consumer – A person eligible to receive MHRS as set forth in this chapter.

Core Services – The following five categories of MHRS: Diagnostic Assessment, Medication/Somatic Treatment, Counseling, and Community Support.

Core Services Agency ("CSA") – A Department-certified community-based MHRS provider that has entered into a Human Care Agreement with the Department to provide specified MHRS.

Corrective Action Plan ("CAP") – A written plan prepared by either an applicant for certification or the certified MHRS provider describing the actions that the provider intends to take to correct or abate the violations described in an SOD issued by the Department.

CPP-FV Fidelity Standards – The six established interconnected standards of fidelity, as set forth by the developers of CCP-FV.

Credentialed Staff – Non-licensed staff or staff who are not qualified practitioners that are credentialed by the MHRS provider to perform certain MHRS or components of MHRS under the clinical supervision of an appropriate qualified practitioner.

Crisis Support Services – Mental health services that support the consumer through a crisis, such as meeting with the consumer in the community or an emergency department to help calm the consumer; implementing the crisis plan developed for the consumer; assisting the consumer to reach an emergency department; and providing pertinent mental health information about a consumer to an emergency department to assist in addressing a crisis.

Cultural and Linguistic Competence – The ability of an MHRS provider to deliver mental health services and mental health supports in a manner that

effectively responds to the languages, values, and practices present in the various cultures of the MHRS provider's consumers.

Department ("DBH") – The Department of Behavioral Health, the successor in interest to the Department of Mental Health and the Addiction and Prevention Recovery Administration.

Department of Health Care Finance ("DHCF") – The District's Medicaid authority.

Department of Youth Rehabilitation Services ("DYRS") – The District agency responsible for providing security, supervision, and residential and community support services for committed and detained juvenile offenders and juvenile persons in need of supervision.

Diagnostic Assessment Report – The report prepared by an independently licensed qualified practitioner that summarizes the results of the Diagnostic Assessment service and includes recommendations for service delivery. The Diagnostic Assessment report is used to initiate the Plan of Care.

Director – The Director of the Department of Behavioral Health.

District of Columbia ("District") – The government of the District of Columbia.

Economic Security Administration ("ESA") – The unit within the District of Columbia Department of Human Services that determines eligibility for medical assistance programs for District residents.

Enrollment – Process by which the Department adds a consumer to the MHRS system of care and assigns them to a provider after ascertaining their eligibility.

Evidence-Based Practice – A process that brings together the best available research, professional expertise, and input from consumers to identify and deliver services that have been demonstrated to achieve positive outcomes for individuals. Evidence-based programs and practices (EBPPs) are specific techniques and intervention models that have shown to have positive effects on outcomes through rigorous evaluations.

Governing Authority – The designated individuals or governing body legally responsible for conducting the affairs of the MHRS provider.

Grievance – A description by any individual of his or her dissatisfaction with an MHRS provider, including the denial or abuse of any consumer right or protection provided by applicable Federal and District laws and regulations.

Human Care Agreement ("HCA") – A written agreement entered into by the certified MHRS provider and the Department which establishes a contractual relationship between the parties.

ICD-10 – The 10th Revision of the International Classification of Diseases and Related Health Problems.

Independent Living Program – A residential program licensed by the District in accordance with Title 29 DCMR Chapter 63, Licensing of Independent Living Programs for Adolescents and Young Adults.

Intensive Home and Community-Based Services or IHCBS – An intensive model of treatment adopted by the Department to prevent the utilization of out-of-home treatment resources by emotionally disturbed children and youth. IHCBS is the modality adopted for CBI Levels II and III.

Licensed Independent Clinical Social Worker ("LICSW") – A person licensed as an independent clinical social worker in accordance with applicable laws and regulations of the District or jurisdiction where services are delivered.

Licensed Independent Social Worker ("LISW") – A person licensed as a licensed independent social worker in accordance with applicable laws and regulations of the District or jurisdiction where services are delivered.

Licensed Marriage and Family Therapist ("LMFT") – A person licensed as a licensed marriage and family therapist under laws and regulations of the District or jurisdiction where services are delivered.

Licensed Graduate Professional Counselor ("LGPC") – A person licensed as a licensed graduate professional counselor in accordance with applicable laws and regulations of the District or jurisdiction where services are delivered.

Licensed Graduate Social Worker ("LGSW") – A person licensed as a licensed graduate social worker in accordance with applicable laws and regulations of the District or jurisdiction where services are delivered.

Licensed Professional Counselor ("LPC") – A person licensed as a licensed professional counselor in accordance with applicable laws and regulations of the District or jurisdiction where services are delivered.

Long-Term Placement Option – A permanent caregiver or permanent home. A group home or other residential placement is not a long-term placement option.

Medicaid – The medical assistance program approved by federal Centers for Medicare and Medicaid Services and administered by the Department of

Health Care Finance, which enables the District to receive Federal financial assistance for its medical assistance program and other purposes as permitted by law.

Medical Necessity (or medically necessary) – Health care services or products that a prudent provider would provide to a client for the purpose of preventing, diagnosing, or treating an illness, injury, disease, or its symptoms in a manner that is: (a) in accordance with generally accepted standards of health care practice; (b) clinically appropriate in terms of type, frequency, extent, site, and duration; and (c) not primarily for the economic benefit of the health plans and purchasers or for the convenience of the client or treating provider.

Member – A consumer who has joined a Psychosocial Rehabilitation Clubhouse.

Mental Health Rehabilitation Services ("MHRS") – Mental health rehabilitative services provided by a certified MHRS provider to consumers in accordance with the District of Columbia State Medicaid Plan, the Department Memorandum of Understanding with the Department of Health Care Finance and this chapter.

Mental Illness – A substantial disorder of thought, mood, perception, orientation, or memory that grossly impairs judgment, behavior, capacity to recognize reality, or ability to meet the ordinary demands of life.

MHRS Provider – An organization certified by the Department to provide MHRS. MHRS provider are CSAs, sub-providers, and specialty providers.

Mobile Crisis Response Team – A team of mental health clinicians who provide face-to-face and telephone support to children and families in crisis.

Multisystemic Therapy ("MST") – An intensive model of treatment based on empirical data and evidence-based interventions that target specific behaviors with individualized behavioral interventions.

Natural Settings – The consumer's home; the consumer's residence, school, or workplace; or other locations in the community the consumer frequents, such as community centers, homeless shelters, street locations, or other public facilities. Natural settings do not include inpatient hospitals.

Organizational Onboarding – The mechanism through which new employees acquire the necessary knowledge, skills, and behaviors to become effective performers. It begins with recruitment and includes a series of events, one of which is employee orientation, which helps new employees understand performance expectations and contribute to the success of the organization.

Out-of-home therapeutic resource – A psychiatric hospital or psychiatric residential treatment facility.

Permanent Caregiver – A natural or adoptive family or foster home that has cared for the consumer for at least six (6) consecutive months within the twelve (12) month period immediately preceding the referral for CBI. A group home or other residential placement is not a permanent caregiver.

Physician Assistant – A person licensed as a physician assistant in accordance with applicable laws and regulations of the District or jurisdiction where services are delivered.

Plan of Care (formerly called the Individual Plan of Care / Individual Recovery Plan) – The Plan of Care refers to what the DBH formerly called the IPC/IRP, and encompasses the provision of services to all consumers regardless of age.

Prior Authorization – Approval by the Department in advance for the initiation of an MHRS to a consumer.

Psychiatric residential treatment facility – Shall have the meaning ascribed in 42 CFR Subpart G, Section 483.352.

Psychiatrist – A person who is: 1) licensed as a physician in accordance with applicable laws and regulations of the District or jurisdiction where services are delivered; 2) a psychiatric resident providing care in an approved clinical rotation; or 3) a moonlighting psychiatric resident.

Psychologist – A person licensed as a psychology in accordance with applicable laws and regulations of the District or jurisdiction where services are delivered.

Psychology Associate – A person registered as a psychology associate in accordance with applicable laws and regulations of the District or jurisdiction where services are delivered.

Psychosocial Rehabilitation Clubhouse ("Clubhouse") – MHRS specialty service that assists individuals with behavioral health diagnoses to develop social networking, independent living, budgeting, self-care, and other skills that will assist them to live in the community and to prepare for securing and retaining employment. A Clubhouse shall operate in accordance with established standards coordinated by Clubhouse International and the standards set forth in 22-A DCMR Chapter 39.

Qualified Practitioner – A Qualified Practitioner is a behavioral health clinician appropriately licensed or registered in the District or by the jurisdiction where services are delivered. Pursuant to service specific MHRS standards

a qualified practitioner may practice MHRS within the scope of their license or registration, and any applicable supervision requirements.

Referral – A recommendation to seek or request services or evaluation between a CSA and a sub-provider or specialty provider in order to assess or meet the needs of consumers.

Registered Nurse ("RN") – A person licensed as a registered nurse in accordance with applicable laws and regulations of the District or jurisdiction where services are delivered.

Residential Placement – A psychiatric residential treatment center, group home, independent living program, or other residence where children or youth are temporarily receiving services. A permanent home is not a residential placement.

Service specific standards – The certification standards described in §§ 3418 through 3430, which set forth the specific requirements applicable to each MHRS.

Specialty Provider – An MHRS provider certified by the Department to provide specialty services either directly or through contract.

Specialty Services – Assertive Community Treatment, Child-Parent Psychotherapy for Family Violence, Community Based Interventions, Psychosocial Rehabilitation Clubhouse, Crisis Emergency Services, Intensive Day Treatment, Rehabilitation Day Services, Trauma-Focused Cognitive-Behavioral Therapy, Trauma Recovery and Empowerment Model, and Trauma Systems Therapy.

Statement of Deficiencies ("SOD") – A written statement of non-compliance issued by the Department, which describes the areas in which an applicant for certification or the certified provider fails to comply with the certification standards.

Subcontractor – A licensed independent practitioner qualified to provide mental health services in the District or in the jurisdiction in services are provided. A subcontractor may provide one (1) or more core service(s) under contract with a CSA. A subcontractor may also provide specialty service(s) under contract with a specialty provider.

Sub-provider – A community-based organization certified by the Department to provide one (1) or more core services.

Supported Employment Services – Evidence-based Mental Health Supported Employment program designed for MHRS consumers for whom

competitive employment has been interrupted or is intermittent as a result of a severe mental illness. Services assist consumers in obtaining and maintaining permanent part-time or full-time employment in a competitive setting. Mental Health Supported Employment service providers shall be certified and deliver services to eligible consumers according to standards set forth in 22-A DCMR Chapter 37.

TF-CBT Practice Session Checklist – An instrument used to track whether supervisors and therapists are implementing TF-CBT in accordance with the established model.

Triaging – Prioritizing the level of crisis services required by a consumer, based upon the assessed needs of the consumer.

Urgent need – A situation where, due to a mental illness, there is no immediate risk to life, health, or property, but if the situation is not addressed promptly may turn into an emergency situation. An emergency situation is where a consumer is an immediate risk to life, health, or property due to a mental illness.

Chapter 35, DEPARTMENT OF MENTAL HEALTH (DMH) INFRACTIONS, of Title 16 DCMR, CONSUMERS, COMMERCIAL PRACTICES, AND CIVIL INFRACTIONS, is amended as follows:

Section 3502, MENTAL HEALTH PROVIDER CERTIFICATION INFRACTIONS, is repealed in its entirety.

Chapter 25, HEALTH HOME CERTIFICATION STANDARDS, of Title 22-A DCMR, MENTAL HEALTH, is amended as follows:

Section 2512, COMPREHENSIVE CARE PLAN, is amended by amending § 2512.4 to read as follows:

2512.4 The CCP shall be developed in coordination with the consumer's healthcare providers. If the Health Home team develops the CCP, the MHRS Plan of Care, developed in accordance with Section 3411 of Chapter 34 of this title, shall be incorporated into the CCP. If the MHRS team develops the care plan the Health Home team will collaborate and participate in the care planning process to ensure the care plan is comprehensive.

Chapter 39, PSYCHOSOCIAL REHABILITATION CLUBHOUSE CERTIFICATION STANDARDS, of Title 22-A DCMR, MENTAL HEALTH, is amended as follows:

Section 3900, PSYCHOSOCIAL REHABILITATION CLUBHOUSE CERTIFICATION STANDARDS, is amended by amending:

§ 3900.5(c) to read as follows:

3900.5

…

(c) In compliance with the qualification standards described in § 3413 of this subtitle and the certification standards as required by this chapter, except an affiliation agreement with a CSA is not necessary for the provision of Clubhouse services; and

§ 3900.7(b) to read as follows:

3900.7

…

(b) Require Clubhouse specialty providers to incorporate CSA-developed Diagnostic Assessment material into the Clubhouse specialty provider's Plan of Care process; and

§ 3900.8 to read as follows:

3900.8 Each Clubhouse specialty provider shall offer access or referrals to core and other specialty services, as clinically indicated.

§ 3900.9 to read as follows:

3900.9 Each Clubhouse specialty provider with total annual revenues at or exceeding three hundred thousand dollars ($300,000.00) shall have an annual audit by an independent certified public accountant or certified public accounting firm in accordance with generally accepted auditing standards. The resulting financial audit report shall be consistent with formats recommended by the American Institute of Public Accountants. Each Clubhouse specialty provider shall submit a copy of the financial audit report to the Department within one hundred and twenty (120) calendar days after the end of its fiscal year.

§ 3900.10 to read as follows:

3900.10 Each Clubhouse specialty provider with total annual revenues less than three hundred thousand dollars ($300,000.00) shall submit financial statements reviewed by an independent certified public accountant or certified public accounting firm within one hundred twenty (120) calendar days after the end of its fiscal year.

§ 3900.11 to read as follows:

3900.11 Each Clubhouse specialty provider shall have the capability to submit accurate claims, encounter data, and other submissions as necessary directly to the Department.

Section 3902, CERTIFICATION REQUIREMENTS, is amended as follows:

3902.1 A Clubhouse providing services to members shall comply with all of the requirements set forth in Chapter 34 of this subtitle except for the requirements set forth in §§ 3411, 3412, 3413.7, 3413.12-3413.16, 3413.19, 3413.26, 3413.29(c), 3414, 3415, and 3418-3430.

Section 3906, DISTRICT REIMBURSEMENT LIMITATIONS, is amended by amending § 3906.6 to read as follows:

3906.6 In accordance with § 3432 of this subtitle, certain services may not be reimbursed through Medicaid.

Section 3907, DOCUMENTATION REQUIREMENTS, is amended by amending § 3907.2(c) to read as follows:

3907.2

…

(c) Current Plan of Care prepared by the Clubhouse and if applicable, the Plan of Care prepared by the CSA in accordance with §§ 3411-3412 of this subtitle that includes a recommendation for Clubhouse services;

Section 3908, CLUBHOUSE REFERRALS, is amended by amending:

§ 3908.4 to read as follows:

3908.4 A person enrolled with a CSA must have a Diagnostic Assessment and a Plan of Care that includes Clubhouse services in order to participate in the Clubhouse.

§ 3908.5 is deleted.

Section 3909, PLAN OF CARE DEVELOPMENT PROCESS, is amended by amending:

The title of § 3909 to read as follows:

3909 CLUBHOUSE PLAN OF CARE DEVELOPMENT PROCESS

§ 3909.1 to read as follows:

3901.1 The Clubhouse Plan of Care development process for members shall, at a

minimum, include:

(a) The completion of a Diagnostic Assessment service and required components as described in § 3418 of this subtitle, unless the referral comes from a CSA, in which case the CSA may provide the Diagnostic/Assessment report;

(b) Development of a Clubhouse Plan of Care as described in § 3910 of this chapter;

(c) Consideration of the member's beliefs, values, and cultural norms in how, what, and by whom Clubhouse services are to be provided; and

(d) Consideration, screening, and assessment of the member for treatment via other appropriate evidence-based practices (EBP) offered through DBH MHRS providers.

§ 3909.3 to read as follows:

3909.3 The Clubhouse Plan of Care shall be developed by the Clubhouse in accordance with the member's existing MHRS Plan of Care for those members enrolled in a CSA and in cooperation with other specialty providers if applicable

Section 3910, PLAN OF CARE DEVELOPMENT, is amended by amending:

The title of § 3910 to read as follows:

3910 CLUBHOUSE PLAN OF CARE DEVELOPMENT

§ 3910.1 to read as follows:

3910.1 Each Clubhouse Plan of Care shall:

(a) Be person-centered:

(b) Include the member's self-identified recovery goals; and

(c) Provide for the delivery of services in the most normative, least restrictive environment that is appropriate for the member.

Section 3911, PLAN OF CARE IMPLEMENTATION, is amended by amending the title of § 3911 to read as follows:

3911 CLUBHOUSE PLAN OF CARE IMPLEMENTATION

Section 3999, DEFINITIONS, Subsection 3999.1, is amended by amending:

The definition of "Rehabilitation Plan" to read as follows, and moved to be in alphabetical order:

Clubhouse Plan of Care – the plan developed to provide services to Clubhouse members in accordance with ICCD standards.

The definition of "Specialty services" to read as follows:

Specialty services – ACT, CBI, Crisis/Emergency Services, Intensive Day Treatment, Psychosocial Rehabilitative Clubhouse, Rehabilitation Day Services, TF-CBT, TREM, and TST.

Chapter 73, DEPARTMENT OF BEHAVIORAL HEALTH PEER SPECIALIST CERTIFICATION, of Title 22-A DCMR, MENTAL HEALTH, is amended to read as follows:

Section 7300, PURPOSE AND APPLICATION, is amended by amending § 7300.5 to read as follows:

7300.5 Certified Peer Specialists, certified in accordance with this chapter, must also meet all MHRS non-licensed staff requirements as specified in Sections 3413 and 3416 in Chapter 34 of this subtitle in order to be employed as a Certified Peer Specialist by a Department-certified mental health provider.

Section 7303, CORE COMPETENCIES, is amended by amending § 7303.1(d) to read as follows:

7303.1

…

(d) Ability to document services provided including preparation of encounter notes required by Subsection 3413.19 of Chapter 34 of this subtitle;

Section 7308, FIELD PRACTICUM SUPERVISION AND ACTIVITIES, is amended by amending § 7308.5(b) to read as follows:

7308.5

…

(b) Ensure that peer support services delivered by the candidate during the field practicum are consistent with the Plan of Care for the consumer receiving the services; and

Section 7314, CERTIFIED PEER SPECIALIST SUPERVISION, is amended by amending § 7314.7 to read as follows:

7314.7 The Peer Specialist Supervisor shall:

(a) Ensure that when Peer Support Services are identified as part of a consumer's Plan of Care, the Plan of Care:

(1) Specifies individualized goals and objectives pertinent to the consumer's recovery and community integration in language that is outcome oriented and measurable;

(2) Identifies interventions directed to achieving the individualized goals and objectives;

(3) Specifies the Certified Peer Specialist's role in relating to the consumer and involved others; and

(4) Identifies both the specific components of MHRS that will be provided by the Certified Peer Specialist, and the frequency of delivery;

(b) Ensure that the Certified Peer Specialist participates in treatment planning activities for consumers whose Plans of Care include or are expected to include Peer Support Services;

(c) Ensure that delivery of services is consistent with the requirements of the Plan of Care; and

(d) Ensure that Peer Support Services delivered by the Certified Peer Specialist are coordinated with the other mental health services provided to the consumer.

Section 7399, DEFINITIONS, is amended by amending 7399.1 as follows:

Replace definitions of "Individualized Plan of Care" and "Individualized Recovery Plan" with the following:

Plan of Care – developed in accordance with the requirements of Chapter 34 of this subtitle. The Plan of Care includes the consumer's treatment goals, strengths, challenges, objectives, and interventions.