# The Department of Medical Assistance Services

# Community Psychiatric Support and Treatment (CPST) – Home/Community Setting

## 1. Definitions

Refer to Appendix A and the Telehealth Supplement for definition of terms used in this Appendix. The following definitions are specific to Community Psychiatric Support Teams (CPST).

**Affiliated** means any entity or property in which a DMAS enrolled provider has a direct or indirect ownership interest of 5 percent or more, or any management, partnership or control of an entity.

**Comprehensive Assessment of Needs and Strengths (CANS Lifetime)**: CANS Lifetime is a multi-purpose tool developed to support care planning and level of care decision-making, to facilitate quality improvement initiatives, and to allow for the monitoring of outcomes of services for both adults and youth. The CANS Lifetime was developed from a communication perspective to facilitate the linkage between the assessment process and the design of individualized service plans including the application of evidence-based practices.

**Early Serious Mental Illness (Adults)** means the initial onset of a diagnosable mental, behavioral, or emotional disorder that significantly impacts an individual's functioning, potentially hindering their ability to achieve expected levels of interpersonal, academic or occupational success.

**Face-to-face** means the service component may be delivered via telemedicine if clinically appropriate. Refer to the Telehealth Services Supplement for the definition of telemedicine and requirements for service delivery through telemedicine.

**In-Person** means physically in the presence of the individual/caregiver.

**Licensed Mental Health Professional** or **LMHP** means the same as defined in 12VAC35-105-20. LMHPs shall be a physician, licensed clinical psychologist, licensed professional counselor, licensed clinical social worker, licensed substance abuse treatment practitioner, licensed marriage and family therapist, certified psychiatric clinical nurse specialist, licensed behavior analyst, or licensed psychiatric/mental health nurse practitioner. LMHPs are fully licensed to practice independently.

**Licensed Mental Health Professional-type or LMHP-type** means A LMHP-Resident in Counseling (LMHP-R), LMHP-Resident in Psychology (LMHP-RP) or LMHP-Supervisee in Social Work (LMHP-S). LMHP residents/supervisees shall only perform activities where indicated as allowed by a LMHP-R, LMHP-RP or LMHP-S.

**Natural, community-based settings** are defined as everyday environments where people typically participate, including but not limited to the individual's home, workplace, educational institutions, libraries, parks, recreational facilities, places of worship, community centers, and other integrated community locations. These settings provide opportunities for interaction with other community members, reflect the individual's cultural and linguistic preferences, and support full participation in community life.

**Part-time employment (PTE)** means any staff person that averages 29 hours or less of work per week.

**Serious Mental Illness (Adults)** means an individual over the age of 18, having within the past year, a diagnosable mental, behavioral, or emotional disorder that substantially interferes with the individual's life and ability to function.

**Serious Emotional Disturbance (Youth)** means someone under the age of 18 having (within the past year) a diagnosable mental, behavioral, or emotional disorder that resulted in functional impairment that substantially interferes with or limits the child's role or functioning in family, school or community activities.

**DMAS Mental Health Services Supervision** is relationship-based education and training that is work-focused and which manages, supports, develops and evaluates the work of a staff person. It is a structured professional relationship where a more experienced mental health professional (the supervisor) oversees the work of a less experienced or newer professional or paraprofessional (the supervisee), with the primary goal of fostering growth and learning. Supervision encompasses multiple roles where the supervisors are a teacher, coach, consultant, mentor, evaluator, and administrator; the supervisor provides support, encouragement, and education to staff while addressing an array of psychological, interpersonal, physical, and spiritual needs of the individual participating in services.

The process involves regular meetings between supervisor and supervisee to discuss individual cases, treatment strategies, ethical considerations, professional development needs, and service decision-making. Supervision makes sure that the care provided meets the standards in terms of safety and effectiveness, and that any concerns related to the individual participating in services are addressed.

**Core Functions of DMAS Mental Health Services Supervision**

For the purposes of the CPST service, supervision serves three primary functions. This does not include administrative supervision functions which are not required to be provided by the clinical supervisor for the purpose of this service. If agencies have a separate compliance/quality assurance role that meets the regulatory/compliance function of supervision for CPST, the clinical supervisor does not have to directly carry out those tasks so long as there is evidence that those tasks are completed by agency staff. The three primary functions and the activities that may be considered supervision time are:

**Educational/Clinical Function:** Supervisors are responsible for imparting knowledge, refining skills, and promoting professional development. The supervisor teaches therapeutic skills and helps the staff and collaborative behavioral health team develop self-awareness to better the therapeutic interactions with individuals participating in services.

**Regulatory Compliance Function:** Objectives of the agency/organization's policy and public accountability are transformed into practice standards. This ensures compliance with regulations, documentation requirements, and organizational protocols, including ensuring supervisees maintain required licenses, certifications, and continuing education.

**Supportive Function:** Daily work with individuals experiencing symptoms of a mental illness can be inherently distressing, so a key aspect of supervision is often helping staff to learn to manage the emotional demands of the work. Supervision has been found to increase provider competence and decrease stress.

**Supervision-Related Activities include:**

**Individual supervision sessions** - One-on-one meetings between supervisor and supervisee to review cases, discuss treatment approaches, and address professional development needs

**Group supervision** - Sessions facilitated by the supervisor with multiple supervisees to discuss cases, share learning, and develop skills collectively

**Case consultation** - Reviewing specific client cases, treatment plans, diagnoses, and interventions to ensure appropriate care and competency

**Clinical documentation review** - Examining and providing feedback on progress notes, treatment plans, assessments, and other required clinical records

**Clinical case oversight for collaborative behavioral health services** means education, two-way communication, collaborative treatment planning and collaborative monitoring of outcomes between a team member who provides the assessment, treatment planning, and psychotherapy components of CPST and team members who provides rehabilitative skill building, care coordination, crisis support, and/or rehabilitative skills practice components of CPST.

**Rehabilitative skills practice planning** means education, two-way communication, and collaborative treatment activity planning between a team member who provides the restorative life skill training, care coordination and crisis support components of CPST with a team member who provides the rehabilitative skills practice components of CPST.

**Direct observation** - Watching supervisees conduct sessions (live, recorded, or through one-way mirrors) to assess skills and provide feedback

**Co-treatment sessions** - Supervisor and supervisee working together with clients to model interventions and provide real-time guidance

**Performance evaluation** - Formal assessment of supervisee competencies, skills, and professional development progress

**Training and education** - Providing instruction on techniques, ethical standards, legal requirements, and evidence-based practices

**Crisis intervention oversight** - Being available for consultation during emergencies and reviewing crisis response procedures

**Ethical and legal guidance** - Discussing ethical dilemmas, legal obligations, confidentiality, and professional boundaries

**Professional development planning** - Setting goals and creating pathways for supervisees' career advancement and skill enhancement

## 2. Service Definition/Critical Features

Community Psychiatric Support and Treatment (CPST) is a multi-component, team-based service for adults and youth that recognizes the widespread impact of trauma and prioritizes safety, trustworthiness, and collaboration. CPST consists of assessment, counseling, therapeutic interventions, care coordination, crisis and functional supports, all delivered through a trauma-informed lens in natural, community-based settings where individuals live, work, learn, and socialize.

In partnership with the individual, CPST services concentrate on strengths-based, goal-directed supports and solution-focused interventions, which focus on restoring functional skills of daily living, building natural supports, and achieving identified person-centered goals and objectives as identified in the Individual Service Plan (ISP). These individualized, trauma-informed interventions are grounded in principles of safety, choice, collaboration, and cultural humility. The interventions are designed to assist the individual in achieving stability and functional improvement in daily living, family/caregiver and interpersonal relationships, and personal recovery and resilience within the natural contexts of their daily routines and community activities.

CPST services prioritize the individual's inherent strengths and ability to succeed in the community while recognizing that trauma responses are normal adaptations to abnormal circumstances. **Providing services in natural, community-based settings is essential to CPST's effectiveness**, as it allows individuals to develop and practice skills in the actual environments where they will use them, promotes genuine community integration, reduces stigma, and supports the development of natural supports and relationships that enhance long-term recovery and independence. Services support individuals in identifying and accessing needed resources, demonstrating improvement in school, work, and family/caregiver and interpersonal relationships and enhancing the family/caregiver's capacity to provide supportive environments that promote healing and successful community integration.

CPST is delivered by two or more members of a team consisting of professional and paraprofessional staff, offering a combination of medically necessary community-based interventions that emphasize physical and emotional safety and shared decision-making. Services are provided through a team-based approach under collaborative behavioral health services (as defined in § 54.1-3500). A licensed mental health professional

completes trauma-informed assessments that account for trauma history and current safety needs, develops individual service plans, and oversees direct services provided by qualified team members as described in the ISP, ensuring that all interventions are delivered in settings that promote normalization, community participation, and the individual's full inclusion in community life.

### 2.1 CPST Teams

CPST is delivered by two or more members of a team consisting of professional and paraprofessional staff. The team includes the providers interacting directly with the individual/family as well as the licensed clinical supervisor who is overseeing the case. It is important that agencies ensure that in meeting the supervision, case oversight, and documentation requirements of CPST that all members of a team serving an individual/family are in communication and working together.

CPST tier one shall include a LMHP and may also include an additional LMHP or LMHP-R, LMHP-RP, LMHP-S, QMHP or QMHP-T. Section 5 of this appendix provides information about the qualifications required for each service component. Individuals will interact with one or two team members face-to-face regularly.

CPST tier two shall include the same requirements as CPST tier one teams. In addition, a CPST tier two team may include a Behavioral Health Technician (BHT) to provide rehabilitation skills practice only. Individuals will interact with two team members face to face regularly and may interact with three team members face to face regularly.

### 2.2 Service Goals for Adults:

CPST services are expected to achieve the following goals and outcomes:

1. Reduce the disabling symptoms of mental illness and assist in the recovery and resiliency of the individual;
2. Assist individuals in the stabilization of acute symptoms of a mental illness;
3. Assist individuals in coping with chronic symptoms of a mental illness;
4. Reduce the impact of illness-related factors that interfere with an individual’s ability to live independently;
5. Reduce or prevent psychiatric hospitalizations;
6. Identify and develop strengths;
7. Focus on recovery;
8. Require minimal ongoing professional intervention and achieve optimal community integration;
9. The individual’s natural supports such as family/caregiver, friends and other collateral contacts may also be engaged in services. Adults participating in this service choose natural supports who are involved in their care.

### 2.3 Service Goals for Youth

The goal of CPST services for youth is restoration to a youth’s best level of functioning by restoring the youth to their best developmental trajectory. This includes consideration of key developmental needs and protective factors such as:

1. Restoration of positive family/caregiver relationships;
2. Prosocial peer relationships;
3. Community connectedness/social belonging;
4. Reduce or prevent psychiatric hospitalizations;
5. Identify and develop strengths;
6. Reduce the disabling symptoms of mental illness and assist in the recovery and resiliency of the individual; and
7. The ability to function in a developmentally appropriate manner within home, school, vocational and other community settings such as libraries, grocery stores, parks, and other public settings.

Youth shall be served within the context of the family/caregiver relationships to assure that family/caregiver dynamics are addressed and are a primary part of the ISP and approach. The plan for family/caregiver

involvement in treatment shall be included in the ISP and documented in progress notes. When services are delivered to younger children, the services shall be delivered with a caregiver or legally authorized representative participating with the youth as the services are delivered. The most developmentally appropriate, clinically effective service shall be delivered with the full engagement and participation of the family/caregiver as described in the admission criteria.

## 3. Required Evidence-Based Practices (EBP)

Use of trauma-informed and evidence-based principles, practices, and protocols are required for all agencies providing CPST tier one and tier two. All providers shall incorporate appropriate research-based programming for both treatment planning and service delivery. Evidence based *protocols* are detailed procedural specifications of indicated treatments.

1. Evidence based *principles* are modular alternatives to evidence-based protocols that are drawn from supported protocols, but flexibly and dynamically applied.
2. Evidence based *practices* are general practices that have been shown to increase quality of care across behavioral health conditions and approaches, including routine outcome monitoring, feedback, supervision, and quality improvement.
3. Evidence based *policies* include mandates, differential reimbursement, or development of core competencies.

The provider's policies and standard operating procedures shall clearly demonstrate what EBP protocols, principles, practices, and/or policies they are incorporating and how staff are trained on those elements.

### 3.1 Measurement Based Care

#### 3.1.1 CANS Lifetime and Treatment Planning

The CANS Lifetime assessment serves as the primary assessment for Level of Need (LON) placement and longer-term treatment planning and monitoring. The CANS Lifetime supports treatment planning, level of need identification and updates, monitoring outcomes, and facilitates team communication and linkages between the assessment process and the design of the ISP including the application of evidence-based practices.

#### 3.1.2 Other Clinical Assessments to Support Measurement Based Care

To better inform treatment approaches and the monitoring of progress, in addition to the CANS Lifetime assessment, providers are strongly encouraged to utilize ongoing clinical assessments and symptom checklists to monitor service progress and inform treatment modifications.

For adults, the following assessments are recommended:

1. Ask Suicide-Screening Questions (ASQ)
2. Columbia Suicide Severity Rating Scale (C-SSRS)
3. Daily Living Activities-20 (DLA-20)
4. Patient Health Questionnaire (PHQ-9)
5. Post-Traumatic Stress Disorder (PTSD) Scale
6. World Health Organization Disability Assessment Schedule (WHODAS)

For youth, the following assessments are recommended:

1. Ages and Stages Questionnaire (ASQ: SE-2)
2. Alabama Parenting Questionnaire (APQ-SR and corporal punishment module)
3. Ask Suicide-Screening Questions (ASQ)
4. Brief Child Abuse Potential Inventory (BCAP)
5. Child PTSD Symptom Scale for DSM5 (CPSS-5)
6. Client Satisfaction Questionnaire (CSQ-8)
7. Clinical Global Impression Scale (CGI)

8. Columbia Suicide Severity Rating Scale (C-SSRS)
9. Conflict Tactics Scale (CTS)
10. Family Environment Scale (FES)
11. Individual Goal Achievement Rating Scale (IGAR)
12. Parenting Stress Index Short Form (PSI-36)
13. Pediatric Symptom Checklist (PSC)
14. Revised Child Anxiety and Depression Scale (RCADS)
15. Screening, Brief Intervention, and Referral to Treatment (SBIRT)
16. Strengths and Difficulties Questionnaire (SDQ)
17. World Health Organization Disability Assessment Schedule (WHODAS)

### 3.2 Referral to Standalone EBPs

The Virginia Medicaid behavioral health benefit includes several specific evidence-based practices as stand-alone services. As a matter of best practice, individuals who meet criteria for these services shall be referred to these services as a first-choice treatment option.
Individuals shall be referred to and their needs assessed for any clinically appropriate standalone EBPs of which they may meet admission criteria, prior to the authorization of CPST services, regardless of whether the agency completing the CANS Lifetime offers the EBP. Services that individuals and families shall be referred to and offered, if they meet admission criteria, prior to the authorization of CPST include:

1. Applied Behavior Analysis with a primary diagnosis of Autism Spectrum Disorder.
2. Assertive Community Treatment
3. Coordinated Specialty Care
4. Functional Family Therapy
5. Multisystemic Therapy

### 3.3 Service Delivery for CPST Populations

#### 3.3.1 Service Delivery- Specific to Youth

For CPST service delivery, all youth serving agencies shall meet state requirements for training and certification in Managing and Adapting Practice (MAP). MAP is a modular, flexible approach to guide treatment planning and leverage evidence-based principles for a range of common presenting problems. Training requirements by professional type for CPST-Youth serving agencies are as follows:

1. Each agency shall have at least one LMHP who meets the criteria of a MAP Credentialed Therapist.
2. All LMHP-Types who provide services to youth shall complete the CPST LMHP MAP curriculum.
3. All QMHPs and QMHP-Ts who provide services to youth shall complete the CPST QMHP MAP curriculum.
4. All BHTs who provide services to youth shall complete the CPST BHT MAP curriculum.

The statewide training includes mandatory modules for all professional types on the following topics:

1. Anxious Behaviors and Exposure Based Treatments
2. Cognitive Behavioral Approaches to Address Depressive and Withdrawn Behaviors
3. Contingency Management, Community Reinforcement for Co-Occurring Substance Use Disorders
4. Parent Management Training, Managing Hyperactive and Disruptive Behaviors
5. Teacher Training, Managing Hyperactive and Disruptive Behaviors
6. Treating Traumatic Stress in Youth

The statewide requirement for training and application of Managing and Adapting Practice (MAP) does not limit professional staff from providing other clinically appropriate, evidence-based protocols in which they are trained to meet the needs of CPST clients, particularly as part of the psychotherapy component of CPST. For example, evidence-based protocols such as Trauma-Focused Cognitive Behavioral Therapy (TF-CBT), Brief Strategic Family Therapy (BFST) and Family Centered Treatment (FCT) would represent an appropriate protocol-based

approach that ties together the MAP recommendations for traumatic stress which would include parent training, psychoeducation, cognitive processing, and exposure, all of which are the key components of the TF-CBT protocol.

Clinical best practice guidelines should be maintained and regularly updated in agency policy, particularly for the most common presenting problems to include, Neurodevelopmental Disorders, Anxiety Disorders, Trauma- and Stressor-Related Disorders, Depressive Disorders, Disruptive, Impulse-Control and Conduct Disorders and any other disorders commonly treated by the provider. For youth presenting with a mental health disorder, that aligns with an evidence-based treatment approach, that cannot be provided directly through the CPST service structure, CPST providers shall ensure that the EBP options are coordinated through the care coordination component of the service. Application and education on clinical best practice guidelines and evidence-based approaches shall be a priority focus in supervision and other reflective and professional development opportunities offered by the agency to support staff.

All professional types shall complete the Foundational Skills Curriculum-Youth Track trainings. The statewide training includes mandatory modules for all professional types on the following topics:

1. Crisis skills
2. Fundamentals of SED and youth behaviors/functioning
3. Listening and engagement skills
4. Motivational Interviewing
5. Person centered planning
6. Professional ethics for providing services to youth and families

### 3.3.2 Service Delivery specific to Adults

For CPST service delivery, all adult serving agencies shall meet state requirements for training in Foundational Skills Curriculum-Adult Track trainings.

All professional types shall complete the Foundational Skills Curriculum-Adult Track trainings. The statewide training includes mandatory modules for all professional types on the following topics:

1. Crisis skills
2. Fundamentals of psychiatric rehabilitation to include Permanent Supportive Housing
3. Fundamentals of Serious Mental Illness to include Severe and Persistent Mood Disorders
4. Listening and engagement skills
5. Motivational Interviewing
6. Person-centered planning
7. Professional ethics
8. Recovery principles

In addition to the required statewide training, LMHPs providing supervision or the assessment and counseling components of CPST shall seek training (requirements to be defined by CEP-VA, DBHDS, and DMAS) in at least one of the following approaches based on the needs of the population served:

1. Cognitive Behavioral Therapy for Anxiety
2. Cognitive Behavioral Therapy for Mood
3. Cognitive Behavioral Therapy for Personality Disorders
4. Cognitive Behavioral Therapy for Psychosis (CBT-p)
5. Cognitive Behavioral Therapy for Trauma

Other relevant and suggested EBPs are as follows:

1. Acceptance and Commitment Therapy
2. Brief Solution Focused Therapy
3. Collaborative Assessment and Management of Suicidality

4. Cognitive Processing Therapy
5. Dialectical Behavioral Therapy
6. Eye Movement Desensitization and Reprocessing
7. Exposure and Response Prevention
8. Family Focused Therapy
9. Interpersonal Social Rhythm Therapy
10. Mindfulness Based Cognitive Therapy
11. Prolonged Exposure
12. Rational Emotive Behavioral Therapy
13. Seeking Safety

#### 3.3.3 Service Delivery - Transition Age Youth

Providers of CPST services for transition age youth are required to complete all trainings for adults and youth as indicated above.

### 3.4 Required Documentation

Annually, providers shall submit documentation to the Center for Evidence-Based Partnerships (CEP-VA) at Virginia Commonwealth University (VCU) demonstrating compliance with statewide training requirements and clinical best practice policies outlined in this section.

## 4. Required Service Oversight and Supervision

### 4.1 LMHP and Service Oversight Requirements

1. CPST providers shall have a full-time LMHP who holds a current, active and unrestricted, Virginia license from the Department of Health Professions who has oversight over the CPST program for the agency. This position is referred to as the "CPST Clinical Director."
2. The CPST Clinical Director shall have the ability to provide in-person services and support to agency staff when needed.
3. All LMHPs, including the CPST Clinical Director and LMHP Clinical Supervisors, shall hold current, active and unrestricted Virginia licenses from the Virginia Department of Health Professions that qualifies them as a LMHP
4. All LMHPs shall have the ability to provide in-person services.
5. All CPST services shall be recommended, overseen, and supervised by the CPST Clinical Director or a LMHP Clinical Supervisor (Clinical Director may act as the LMHP Clinical Supervisor).
6. All CPST providers are required to have policies and procedures regarding LMHP oversight and crisis consultation for all CPST agency staff.
    - CPST agency policies and procedures shall include an experienced LMHP with a current, active and unrestricted license from the Department of Health Professions that is available to provide on-call crisis consultation to all CPST staff 24 hours a day, 7 days a week. It is not required that the experienced LMHP be consulted on each case, rather, policies shall ensure that ultimately an experienced LMHP is available on-call for crisis consultation if needed.
        - An experienced LMHP shall be trained in working with individuals with SMI and SED and have at least two years experience working with individuals with a Serious Mental Illness (SMI) or Serious Emotional Disturbance (SED).
7. The LMHP, LMHP-R, LMHP-S, or LMHP-RP providing the assessment, treatment planning and psychotherapy components of CPST shall provide face-to-face services to the individual as clinically indicated and no less than every 90 calendar days.
8. A LMHP may choose to have a QMHP or QMHP-T assist with gathering information/documentation for assessment and treatment planning activities, however, the LMHP is ultimately responsible for the

monitoring, quality, completeness, and accuracy for all assessment activities, the diagnosis and ISP. The LMHP is ultimately responsible for the service goals and outcomes defined in the ISP.

### 4.2 Collaborative Behavioral Health Services, Supervision of Individual Staff, and Supervision of Cases

1. It is the responsibility of the CPST Clinical Director and all LMHP Clinical Supervisors to ensure that all non-licensed staff practice within the scope of their education, training, and expertise and are not providing any services that require licensure.
2. Agencies shall have a formal schedule of weekly face-to-face meetings between groups of staff members working under the direction of a LMHP to meet the supervision and oversight requirements of CPST.
    a. The weekly meetings shall ensure the following:
        i. Each individual staff member receives supervision.
        ii. Each individual case receives clinical case oversight within the model of collaborative behavioral health services and, if relevant, rehabilitative skills planning.
        iii. The planned interventions are provided;
        iv. Staff discuss the status of all individuals receiving services;
        v. Staff problem-solve emerging challenges; and
        vi. Staff plan approaches to intervene and prevent crises.
        vii. This may be coordinated or integrated into group supervision hours. Additional supervision or support may be provided as a group or with individual team members to address specific concerns or challenges during staff supervision.
        viii. Meetings shall be arranged to ensure that each individual's care is discussed by all team members involved in the care and the LMHP directing the service at least monthly.

#### 4.2.1 Supervision of Individual Staff, Time Spent in Supervision and Supervision Related Activities

1. Supervision shall be provided at least weekly for non-licensed staff (BHTs, QMHPs, QMHP-Ts, LMHP-R, LMHP-S, and LMHP-RPs) and at least monthly for LMHPs.
2. Documentation of staff supervision shall be maintained in the staff employment records held by the DBHDS licensed CPST agency.
    a. The provider shall provide ongoing supervision of staff consistent with the requirements of 12VAC35-105 in addition to as outlined here.
3. LMHPs shall receive at least one hour per calendar month of supervision by the CPST Clinical Director. If an agency employs only a single LMHP who serves as the Clinical Director, this is not required.
4. LMHP-Rs, LMHP-RPs and LMHP-Ss shall receive regularly scheduled supervision in accordance with requirements established by the practitioner's professional licensing board.
    a. Official documentation from the Department of Health Professions of the board approved supervision and supervisor shall be maintained in the staff employment record.
    b. Official documentation of the board approved supervision sessions shall be maintained in the staff employment record.
    c. Supervision to meet the requirements established by the practitioner's professional licensing board only meets the supervision requirements of CPST if provided by a LMHP employed by the CPST agency.
5. Full-time LMHP-Rs, LMHP-RPs, LMHP-Ss, QMHPs, QMHP-Ts, BHTs, all part-time LMHP-Rs, LMHP-RPs, LMHP-Ss, QMHPs, QMHP-Ts, and BHTs with caseloads 10 or greater:
    a. Shall receive a minimum of two hours of supervision with a LMHP Clinical Supervisor per calendar month.
    b. Shall spend a minimum of four hours per calendar month in all supervision-related activities (see Section 1 for details related to supervision-related activities).
6. Part-time LMHP-Rs, LMHP-RPs, LMHP-Ss, QMHPs, QMHP-Ts, and BHTs with caseloads less than 10 shall receive a minimum of one hour of supervision per calendar month and shall spend a minimum of

two hours in supervision-related activities per calendar month (e.g., providing/receiving clinical case oversight).

### 4.3 Staff Caseloads

1. Appropriate caseloads will vary based on team composition and Level of Need and shall be monitored by a LMHP Clinical Supervisor or CPST Clinical Director.
2. CPST agencies shall have policies and procedures regarding caseloads that take into account the experience level of staff members, coverage of cases between staff during staff leave, and when staff leave the agency. Policies shall clearly articulate how staff at the agency shall be protected from high caseloads, even if there is staff turnover.
3. In general, blended caseloads of CPST tier one and CPST tier two services are recommended. Caseloads are calculated as follows and the caseload limit for non-licensed staff shall not exceed 20.
    a. Caseload = (# Tier Two Clients * 2.5) + (# Tier One Clients)
4. The CPST provider shall keep an ongoing formal log of each staff's caseload. An average, per month, over a six-month period shall be used to demonstrate compliance with caseload limits.
5. All CPST agencies shall require all employees to disclose outside employment that includes the provision of Medicaid-billed services. If an employee discloses outside employment providing Medicaid-billed services, the CPST agency shall document the outside employment and provide this information upon any CPST audit.
6. Individual non-licensed staff caseloads shall be managed in a way to prevent individual staff from providing any more than 600 CPST units in a calendar month across all agencies in which they are employed. Individual non-licensed staff are prohibited from billing more than 600 CPST units in a calendar month.
7. A single LMHP is prohibited from providing supervision/oversight of more than 120 cases in a calendar month. The total number of cases a single LMHP provides oversight to, shall take into consideration the other staff involved in the care of cases, for example, if supervising a number of LMHP-types who are completing the assessment, treatment planning, and psychotherapy components of CPST, 100 cases may be appropriate. If the LMHP is supervising primarily paraprofessionals and providing the assessment and treatment planning components of the service directly, oversight of 120 cases would not be appropriate.

## 5. Required Service Components

Covered service components provided in the provider's DBHDS licensed office location shall not exceed two hours a week (Sunday-Saturday) per individual and shall be for the benefit of the individual.

The LMHP, LMHP-R, LMHP-S, or LMHP-RP providing the assessment, treatment planning and psychotherapy components of CPST shall provide at least one face-to-face service component to the individual as clinically indicated in the assessment and ISP and no less than every 90 calendar days.

### 5.1 Standardized Comprehensive Assessment of Needs and Strengths (CANS Lifetime)

Assessment means the in-person interaction in which the provider obtains information from the individual and family/caregivers, as appropriate, about the individual's current mental health status and symptoms as well as the history of the severity, intensity and duration of symptoms associated with a mental illness and behavioral and emotional issues and diagnosis of mental health conditions. Assessment includes assisting the individual and family/ caregivers, as appropriate with identifying strengths and needs, resources and natural supports used in developing individualized goals and objectives to address functional deficits associated with their mental illness.

1. No more than 30 days prior to starting services, a CANS Lifetime shall be completed to include a comprehensive assessment of the individual's treatment needs and strengths, identification of a Level of

Need, differential service identification, that the individual meets the admission criteria for the recommended service (s) and to support a service authorization for CPST Tier One or Tier Two Services.

2. The assessment shall be conducted by a LMHP, LMHP-R, LMHP-RP or LMHP-S in person with the individual in the individual's home or another location of the individual's/family/caregiver's choice. Assessments completed by a LMHP-R, LMHP-RP or LMHP-S require a LMHP review and co-signature.
3. The LMHP, LMHP-R, LMHP-RP or LMHP-S completing the assessment shall be trained and certified to administer the CANS Lifetime.
    - QMHP and QMHP-Ts assisting the LMHP or LMHP-Type with assessment activities shall be trained and certified to administer the CANS Lifetime.
4. The CANS Lifetime shall be provided on an individual basis with the LMHP or LMHP-type providing services with one individual.
5. Assessments inclusive of the CANS Lifetime, shall be performed at a minimum of once every 365 days until discharge.

### 5.2 Treatment Planning

Treatment Planning means the development of a person-centered ISP that is specific to the individual's unique treatment needs, developed with the individual, in consultation with the individual's natural supports, as appropriate.

1. Treatment planning shall be provided by a LMHP, LMHP-R, LMHP-RP or LMHP-S.
2. CPST services shall be incorporated into a person-centered ISP documenting activities and trauma-informed, evidence-based interventions to prevent, correct, or ameliorate conditions identified during the initial CANS Lifetime, with clinical documentation supporting the appropriateness of the selected intervention.
3. The ISP is what directs collaborative behavioral health treatment. The ISP shall be actively utilized with the individual/family/caregiver during each encounter.
4. The ISP is required during the entire duration of services and shall be current. (see Chapter IV for requirements).
5. The ISP shall be developed in collaboration with the individual and natural supports through a team approach under collaborative behavioral health services.
6. Treatment planning shall be provided on an individual basis with staff providing services with one individual and their natural supports.
7. The ISP shall be authorized and overseen by an LMHP.
8. At a minimum, the ISP shall be signed by:
    a. The individual and the individual's legally authorized representative.
    b. The CPST team members working with the individual; and
    c. The LMHP Clinical Supervisor overseeing the services.
9. Youth shall be served within the context of the family/caregiver relationships to assure that family/caregiver dynamics are addressed and are a primary part of the ISP and treatment approach.
10. Needs identified in the CANS Lifetime shall be associated with identified goals and objectives as set forth in the ISP. Subsequent assessments and needs shall be reflected in updated ISPs with updated goals and objectives.
11. ISP Reviews and Updates:
    a. ISPs shall be formally reviewed at a minimum of every 90 calendar days or more frequently depending on the individual's needs. The ISP review shall be completed face-to-face and include the LMHP Clinical Supervisor, CPST team and the individual/family/caregiver. Refer to Chapter IV for additional guidance and documentation requirements for the 90-calendar day review as well as additional quarterly review requirements.
    b. Assessing the individual's level of progress and improved functioning may be assessed utilizing a variety of methods including: ratings on standardized assessment tools, checklists, direct observation, role-play, self-report, improved grades, improved attendance at school or work, improved medication adherence, feedback from the individual, family/caregiver, teacher, and

other natural supports, and reduced psychiatric hospitalizations, emergency room, and/or residential treatment services utilization.

c. When it is determined that an individual is making limited to no progress or is not engaged, the LMHP Clinical Supervisor, in collaboration with the CPST team, the individual and the individual's natural supports, shall review and update the ISP to increase the possibility that the individual will make progress achieving the identified goals and objectives. If the individual continues to make limited to no progress (remains at the same Level of Need for 18 months), the LMHP Clinical Supervisor shall consider if a referral to a different service may improve progress.
d. Following initial authorization, if a youth is not progressing and the family/caregiver is not engaged or participating in treatment, the ISP shall be updated to assure individual/family/caregiver involvement before reauthorization of services is considered.

12. The service location shall be determined based on the individual's ISP, the service delivered, and the participants involved. The service location shall be documented on the individual's ISP and shall be associated with a specific goal or objective. Services shall be provided in locations that meet the treatment needs of the individual to include developing and applying skills in natural settings.

### 5.3 Crisis Support

Crisis Support means an intervention to assist the individual and their natural supports in developing the capacity to prevent a crisis episode or reduce the severity of a crisis episode. Crisis support includes crisis planning, crisis avoidance and crisis intervention. Crisis support assists the individual with effectively responding to or avoiding identified precursors or triggers that would risk their remaining in a natural community location. Crisis support also includes the development and ongoing review and update of a crisis management plan to assist the individual and their natural supports with identifying a potential behavioral health crisis and steps to manage the crisis and restore stability and functioning after distress or crisis. CPST providers shall prioritize the utilization of internal crisis support resources and preventative interventions as the primary response to behavioral health crises.

1. Crisis support shall be provided by a LMHP, LMHP-R, LMHP-RP, LMHP-S, QMHP or QMHP-T.
2. Crisis Support shall be available 24 hours per day, seven days per week, 365 days per year, to provide immediate assistance to the individual experiencing acute behavioral health problems that require immediate intervention to stabilize and prevent harm and higher level of acuity.
3. Crisis Supports shall be provided on an individual basis with staff providing services with one individual and their natural supports.
4. In-person crisis support shall be offered and available 24 hours per day, seven days per week, 365 days per year. The individual's needs, preferences and specific crisis mitigation plan shall be the determining factor regarding whether crisis supports are provided in-person, face-to-face (telemedicine), or audio-only.
5. In-person crisis support shall be provided by the CPST provider prior to any referral to a Comprehensive Crisis and Transition Services (Mental Health Services Manual, Appendix G) unless the referral to Comprehensive Crisis and Transition Services or other emergency service is due to an acute crisis situation with safety concerns. If a referral to another type of service to assist with the acute crisis situation (911, 988, Emergency Room, CSB Emergency Services, 23-Hour Crisis Stabilization, Residential Crisis Stabilization Unit) is made by the CPST provider, the CPST provider shall remain engaged in the situation and with other service providers that are involved.
6. The CPST Provider agency may utilize triage and coordination policies and procedures across other service areas provided by the same provider (e.g., a single provider after-hours number) if they have policies and procedures in place to ensure that crisis mitigation plans are available in real-time to the individual answering the after-hours call.
7. Any use of telemedicine shall be for the clinical benefit of the individual.
8. Providers are required to collaborate with the individual and their natural supports to develop a crisis mitigation plan.
9. The use of Comprehensive Crisis and Transition Services will be monitored by the individual's MCO.

### 5.3.10 Crisis Mitigation Plan and a Tiered Crisis Response Approach

A **crisis mitigation plan** is a dynamic, individualized plan developed collaboratively with an individual and their natural supports to assist the individual and their natural supports in developing the capacity to prevent a crisis episode or reduce the severity of a crisis episode and how to manage behavioral health crises if they occur. The crisis mitigation plan shall emphasize proactive crisis prevention strategies and provider-delivered crisis support services before considering external crisis resources. The crisis mitigations plan shall include how the individual and their natural supports will manage the full continuum of behavioral health crises from less intensive to acute situations. The crisis mitigation plan shall:

1. Be completed and signed by all team members and the individual or legal representative no more than 30 calendar days after admission.
2. Be reviewed and updated on an ongoing basis to reflect the individual's current needs and circumstances.

The plan shall include:

3. **Preventative and Recovery Strategies:** The crisis mitigation plan shall incorporate multiple preventative interventions, including:
    a. Identify potential precursors and triggers that could lead to a behavioral health crisis.
    b. Outline specific steps to prevent or avoid crisis episodes.
    c. Detail intervention strategies to manage crises when they occur.
    d. Early identification and monitoring of precursors and triggers
    e. Proactive skill-building and coping strategies
    f. Regular review and reinforcement of crisis prevention techniques
    g. Enhanced support during high-risk periods
    h. Coordination with natural supports for early intervention
    i. Assist natural supports in recognizing and responding to crisis warning signs.
    j. Support the individual in maintaining stability in community settings.
    k. Guide the restoration of functioning after distress or crisis.
4. **External Crisis Resources:** Referrals to Mobile Crisis Response, 988 Suicide and Crisis Lifeline, Comprehensive Crisis and Transition Services, or other emergency services shall be reserved for situations where:
    a. Internal crisis support interventions have been attempted and proven insufficient to stabilize the individual
    b. The acute nature and severity of the crisis requires immediate specialized intervention beyond the scope of CPST crisis support
    c. Safety concerns necessitate immediate emergency response
5. **Provider Accountability:** When external crisis resources are utilized, the CPST provider shall remain actively engaged with the individual and coordinate with all responding service providers to ensure continuity of care and seamless transition back to community-based support.

This approach ensures that individuals receive crisis support within the context of their established therapeutic relationship while reserving external crisis resources for situations requiring specialized or emergency intervention.

## 5.4 Restorative Life Skills Training

Restorative Life Skills Training means evidence-based therapeutic interventions, designed to decrease symptoms of the mental health diagnosis, restore functional skills of daily living, build natural supports, and achieve identified person-centered goals and objectives as set forth in the ISP. Restorative Life Skills Training shall be focused on the individual's ability to succeed in the community; and to show improvement in community and home functioning. Encounters occur in community locations, where the person lives, works, attends school or socializes.

CPST may include employment/instructional supports if the activities being provided are focused on management of symptoms of mental illness and recovery. CPST team members work with individuals at the worksite or instructional setting to implement appropriate interventions to support an individual's employment or instructional goals as described in the ISP. Interventions include helping an individual develop skills to address symptoms associated with a mental illness that interfere with seeking, obtaining, or maintaining employment or successfully completing training necessary for employment.

1. Restorative life skills training shall be provided by a LMHP, LMHP-R, LMHP-RP, LMHP-S, QMHP or QMHP-T.
2. Restorative life skills training shall be provided in accordance with the frequency identified in the ISP.
3. At least half of the Restorative life skills units shall be provided in-person.
4. Restorative life skills training may be provided via telemedicine if deemed clinically appropriate and in consultation with the LMHP Clinical Supervisor and individual.
5. Restorative life skills training may be provided in a group if deemed clinically appropriate and in consultation with the LMHP Clinical Supervisor.
    a. The individual to team member ratio shall not exceed:
        i. One LMHP, LMHP-R, LMHP-RP, LMHP-S, QMHP or QMHP-T to six youth
        ii. One LMHP, LMHP-R, LMHP-RP, LMHP-S, QMHP or QMHP-T to ten adults
6. At least half of the Restorative life skills units shall be provided individually with one team member per individual receiving the service. The remaining units may be provided in a group as described in #5.
7. Restorative life skills training may be provided via telemedicine if deemed clinically appropriate and in consultation with the LMHP Clinical Supervisor.

### 5.5 Care Coordination

Care Coordination means consultation, collaboration, and coordination among health providers and others involved in the individual's treatment including collateral contacts to improve the restorative care, identify and access needed activities and supports and align service plans. Activities may include scheduling appointments and meetings to improve care; planning and implementing individualized behavior modification plans; and monitoring treatment and progress with ISP goals. The provider will be asked to explain what care coordination has taken place during treatment as well as in preparation for discharge and step down to lower levels of care for all service authorization requests.

1. Care coordination shall be provided by a LMHP, LMHP-R, LMHP-RP, LMHP-S, QMHP or QMHP-T.
2. Providers shall follow all requirements for care coordination (See Care Coordination Requirements of Mental Health Providers section of Chapter IV).
3. Care Coordination shall be provided on an individual basis with team member(s) providing services with or for one individual.
4. Care Coordination shall include the following but is not limited to:
    a. Consistent and regular communication with the individual's MCO Care Coordinator.
    b. Requested communication by a MCO Utilization Management Reviewer.
    c. If the CANS Lifetime is completed and the results indicate a fit for a standalone EBP, the provider shall notify the individual's MCO, and all entities shall engage in care coordination to assure a warm hand off to a standalone EBP provider.
    d. All efforts to refer the individual to the standalone EBP shall be documented if the EBP is not available due to extenuating circumstances such as MCO network availability, geographic location, extended wait lists, or does not take allowable forms of insurance.
    e. In the case of extended waitlist, prior to referral to CPST, the provider must document coordination with the MCO to address barriers to accessing the service more timely.
    f. If an individual is not making progress in CPST as evidence by 18 calendar months remaining in the same Level of Need and is not assessed to be at a lower Level of Need, the individual shall be referred to an appropriate EBP.

### 5.6 Rehabilitation skills practice (Tier Two Only)

Rehabilitation skills practice means practice of skills through the collaborative behavioral health model as identified in the ISP. Activities include rehabilitation interventions and individualized, collaborative, hands-on training to build developmentally appropriate skills. The intent is to promote personal independence and autonomy through the restoration of skills in self-management, symptom management, interpersonal relationships, communication, and problem solving.

1. Rehabilitation skills practice shall be provided for all individuals receiving Tier Two CPST services.
2. All Rehabilitation skills practice shall be provided in-person and cannot be provided via telehealth.
3. Rehabilitation skills practice shall be provided by a LMHP, LMHP-R, LMHP-RP, LMHP-S, QMHP, QMHP-T or BHT.
4. Rehabilitation skills practice shall be provided in accordance with the frequency identified in the ISP.
5. Rehabilitation skills practice shall be provided on an individual basis with a team member providing services with one individual. Rehabilitation skills practice shall not be provided in groups of individuals.

## 6. Additional covered service components

### 6.1 Psychotherapy

Psychotherapy means the application of principles, standards, and methods of the LMHP profession in (i) conducting assessments and diagnoses for the purpose of establishing treatment goals and objectives and (ii) planning, implementing, and evaluating treatment plans using treatment interventions to facilitate human development and to identify and assist in the recovery from mental, emotional, or behavioral disorders and associated distresses that interfere with mental health. Psychotherapy helps individuals find relief from emotional distress, seek solutions to problems in their lives, and modify ways of thinking and acting that are preventing the individual from working productively and enjoying personal relationships.

1. Psychotherapy shall be provided by a LMHP, LMHP-S, LMHP-R or LMHP-RP acting within their scope of practice.
2. Psychotherapy shall be provided in accordance with the frequency identified in the ISP.
3. Psychotherapy may be provided in a group if deemed clinically appropriate and in consultation with the LMHP Clinical Supervisor and the individual. The LMHP, LMHP-S, LMHP-R or LMHP-RP to individual ratio shall not exceed:
    a. One LMHP, LMHP-S, LMHP-R or LMHP-RP to six youth
    b. One LMHP, LMHP-S, LMHP-R or LMHP-RP to ten adults
4. Psychotherapy may be provided via telemedicine if deemed clinically appropriate and in consultation with the LMHP Clinical Supervisor and individual.

## 7. Provider Qualification Requirements

CPST providers shall follow all general Medicaid provider requirements specified in Chapter II of this manual.

### 7.1 Department of Behavioral Health and Developmental Services (DBHDS) Licensing Requirements

Prior to rendering CPST and/or claiming reimbursement providers are required to be:

1. Licensed by DBHDS as a provider of: (To be determined). The DBHDS license shall be active and in good standing (conditional or triennial).

### 7.2 DMAS Provider Enrollment (provider type and specialty type)

Prior to rendering CPST and/or claiming reimbursement providers are required to be:

1. Enrolled with DMAS with provider type 156 or 456 and provider specialty (to be determined).

2. Providers shall submit with their DMAS enrollment application evidence of their initiation of accreditation process or their formal accreditation.

### 7.3 Provider Accreditation

Providers are required to be accredited 18 months from July 1, 2026 or within 18 months of establishment as a new agency by the Council on Accreditation (COA), Commission on Accreditation of Rehabilitation Facilities (CARF), or The Joint Commission (TJC). Providers shall submit with their DMAS enrollment application evidence of their initiation of accreditation process or their formal accreditation.

## 8. CPST Medical Necessity Criteria

### 8.1 Tier One CPST Admission Criteria

**All** the following shall be met:

1. **Standardized Comprehensive Assessment of Needs and Strengths (CANS Lifetime) Requirements (See MHS Chapter IV for requirements related to completing the CANS Lifetime assessment)**
    a. Individuals shall be assessed using the CANS Lifetime assessment within 30 days prior to admission.
    b. The Level of Need for the individual shall be assessed at a Level of Need two or three on the CANS Lifetime. CANS Lifetime scoring algorithm is To Be Determined (TBD).
    c. The assessment shall document specific functional deficits requiring Community Psychiatric Support and Treatment.
    d. An adult with longstanding deficits (12 calendar months or greater) who previously met the CANS Lifetime criteria but now scores at Level of Need one may continue to receive medically necessary CPST services for stabilization and maintenance at a lower intensity, provided there are no acute changes in their status and the services are deemed medically necessary.
2. **Diagnostic Criteria: shall meet criteria a or b**
    a. The individual's current symptoms meet criteria for a primary ICD diagnosis that correlates to a DSM diagnosis and are not solely attributable to an Neurodevelopmental Disorder or to a Substance Use Disorder, with the exception of Attention-Deficit/Hyperactivity Disorder (F90.0, F90.1, F90.2, F90.8, or F90.9).
    b. For a period not to exceed 90 calendar days, individuals may have a provisional diagnosis developed by an LMHP, when no definitive diagnosis has been made.
        i. In instances where mental health needs have been identified but a diagnosis is not yet known and/or not specified, providers may use an unspecified ICD-10 diagnosis code, such as R69 (illness, unspecified), F99 (mental disorder, not otherwise specified), or an appropriate Z-code.
    c. Individuals may also have a co-occurring diagnosis of a substance use disorder or neurodevelopmental disorder.
3. **Functional Impairment Criteria: shall meet a and at least one (level of need two) or two (level of need three) additional criteria (b- d)**
    The individual is unable to maintain an adequate level of functioning without CPST due to a mental illness as evidenced by moderate impairment in functioning.
    a. Symptom Management – Documentation submitted by the provider shall indicate that the individual exhibits moderate impairment in the ability to manage symptoms of mental illness. Examples of moderate impairment include, but are not limited to:

i. Mental health symptoms often make it harder to do everyday activities and responsibilities
ii. Has some understanding of their symptoms but is still learning ways to manage them effectively
iii. Symptoms cause noticeable stress and make some areas of life more challenging
iv. Has some coping skills but they do not always work well or are not used consistently
v. Uses some healthy coping strategies but sometimes relies on less helpful ways of managing stress
vi. Has difficulty when daily routines change or when in new or unfamiliar situations

**In addition to meeting impairment in symptom management (a) above, level of need two requires that the individual meet at least one of the following (b-d).**

**In addition to meeting impairment in symptom management (a) above, level of need three requires that the individual meet at least two of the following (b-d).**

b. Social Relationships and Community Integration. To meet this domain, documentation submitted by the provider shall indicate that the individual exhibits moderate impairment in social relationships and community integration. Examples of moderate impairment include, but are not limited to:
   i. Experiences tension or stress in relationships with family members or caregivers
   ii. Struggles with attachment and maintaining long-term relationships
   iii. Difficulty with appropriate boundaries in relationships
   iv. Has limited involvement in community activities, groups, or events
   v. Mental health symptoms sometimes make it hard to maintain friendships
   vi. Participates in community activities only with significant support
   vii. Social connections are primarily with family or treatment providers
c. Personal Care and Daily Living Skills. To meet this domain, documentation submitted by the provider shall indicate that the individual exhibits moderate impairment in personal care and daily living skills. Examples of moderate impairment include, but are not limited to:
   i. Inconsistent personal care and hygiene routines
   ii. Limited cooking skills or inconsistent eating habits that affect nutrition
   iii. Needs significant help managing household tasks and chores
   iv. Sometimes forgets to take medications or does not take them consistently
   v. Needs prompting and assistance with daily routines
   vi. Attendance at school or work is sometimes affected by mental health symptoms
   vii. Needs assistance with complex decision-making
   viii. Difficulty managing finances independently
   ix. Has difficulty finding and using community resources and services on their own
d. Personal Safety and Self-Regulation. To meet this domain, documentation submitted by the provider shall indicate that the individual exhibits moderate impairment in personal safety and self-regulation. Examples of moderate impairment include, but are not limited to:
   i. Sometimes has thoughts about not wanting to be alive or has hurt themselves in the past
   ii. Difficulty developing skills to recognize and avoid potentially unsafe situations
   iii. Has difficulty managing strong emotions and needs support learning healthy coping strategies
   iv. Sometimes becomes very angry or upset and may say or do things they later regret
   v. Sometimes engages in risky behaviors

4. **Intensity of Service Criteria: shall meet all criteria a though c**
The interventions necessary to stabilize the individual's behaviors, symptoms, and ability to function require the frequency, intensity, and duration of contact provided by a CPST tier one provider. Clinical

documentation shall support the medical necessity for weekly intervention averaging 2-3 hours per week and demonstrate the need for:

a. Direct observation and assessment of the individual's functioning in multiple settings to identify environmental triggers and protective factors;
b. Individualized skill-building interventions that require repetition, modeling, and hands-on practice across sessions to achieve skill acquisition and generalization; and
c. Active engagement strategies for individuals who may require modified approaches delivered in their natural environment.

### 8.2 Additional Tier One CPST criteria for youth

1. There shall be an identified caregiver or legally authorized representative available and willing to participate.
2. The caregiver shall be a responsible adult(s) who lives in the same household as the youth and is responsible for engaging in family/caregiver psychotherapy and service-related activities to benefit the youth.
3. The family/caregiver shall commit to participating in ≥ 30 minutes of CPST covered service components a week.

### 8.3 CPST Tier Two Admission Criteria

1. **Standardized Comprehensive Assessment of Needs and Strengths (CANS Lifetime) Requirements**
   a. Individuals shall be assessed using the CANS Lifetime assessment within 30 days prior to admission.
   b. The level of need for the individual shall be assessed at a level of need four or greater on the CANS Lifetime. CANS Lifetime scoring algorithm is TBD.
   c. The assessment shall document specific functional deficits requiring Community Psychiatric Support and Treatment.
2. **Diagnostic Criteria: shall meet criteria a and b**
   a. The individual meets criteria for a primary ICD diagnosis that correlates to a mental health disorder DSM diagnosis and
   b. Individual meets criteria for an Early Serious Mental Illness, Serious Mental Illness or Serious Emotional Disturbance.
   c. Individuals may also have a co-occurring diagnosis of a substance use disorder or neurodevelopmental disability.
3. **Functional Impairment Criteria: shall meet criteria a and at least one (level of need four) or two (level of need five) or three (level of need 6) additional criteria (b-d).**
   The individual is unable to maintain an adequate level of functioning without CPST due to a mental illness as evidenced by significant impairment in functioning.
   a. Symptom Management – Documentation submitted by the provider shall indicate that the individual exhibits significant impairment in the ability to manage symptoms of mental illness. Examples of significant impairment include, but are not limited to:
      i. Mental health symptoms significantly interfere with everyday activities and responsibilities
      ii. Has limited understanding of their symptoms and struggles to develop effective management strategies
      iii. Regularly experiences mental health crises requiring intervention
      iv. Symptoms cause significant distress and impair multiple areas of life functioning
      v. Has limited coping skills that are inconsistently effective or not regularly utilized
      vi. Infrequently uses healthy coping strategies and often relies on unhelpful or potentially harmful ways of managing stress

vii. Has great difficulty functioning when daily routines change and becomes very distressed in new or unfamiliar situations

**In addition to meeting impairment in symptom management (a) above, level of need four requires that the individual meet at least one of the following (b-d).**

**In addition to meeting impairment in symptom management (a) above, level of need five requires that the individual meet at least two of the following (b-d).**

**In addition to meeting impairment in symptom management (a) above, level of need six requires that the individual meet all three of the following (b-d).**

b. Social Relationships and Community Integration: To meet this domain, documentation submitted by the provider shall indicate that the individual exhibits significant impairment in social relationships and community integration. Examples of significant impairment include, but are not limited to:
    i. Experiences regular conflict or significant strain in relationships with family members or caregivers
    ii. Significant attachment difficulties with great difficulty forming or maintaining long-term relationships
    iii. Considerable problems with appropriate boundaries in relationships
    iv. Very limited involvement in community activities, groups, or events
    v. Mental health symptoms regularly interfere with the ability to maintain friendships
    vi. Rarely participates in community activities and requires extensive support when participating
    vii. Social connections are very limited, primarily with family or treatment providers
c. Personal Care and Daily Living Skills: To meet this domain, documentation submitted by the provider shall indicate that the individual exhibits significant impairment in personal safety and self-regulation. Examples of significant impairment include, but are not limited to:
    i. Frequently neglected personal care and hygiene routines
    ii. Limited cooking skills with poor eating habits that negatively impact nutrition
    iii. Requires extensive help and supervision with household tasks and chores
    iv. Often forgets medications or takes them inconsistently, sometimes creating concerns
    v. Requires frequent prompting and assistance with most daily routines
    vi. Regular absences from school or work due to mental health symptoms
    vii. Requires significant assistance with complex decision-making
    viii. Requires substantial help or supervision managing finances
    ix. Has great difficulty finding and accessing community resources and services independently
d. Personal Safety and Self-Regulation: To meet this domain, documentation submitted by the provider shall indicate that the individual exhibits significant impairment in personal safety and self-regulation. Examples of significant impairment include, but are not limited to:
    i. Regular thoughts about not wanting to be alive or has history of self-harm behaviors
    ii. Often has difficulty recognizing unsafe situations and sometimes places self at risk
    iii. Significant difficulty managing strong emotions with episodes requiring intervention
    iv. Sometimes becomes very aggressive or destructive during emotional episodes
    v. Regularly engages in risky behaviors that raise safety concerns

**4. Intensive Service Criteria: shall meet all criteria a through d**

The interventions necessary to stabilize the individual's behaviors, symptoms, and ability to function require the frequency, intensity, and duration of contact provided by a CPST tier one provider. Clinical documentation must support the medical necessity for weekly intervention averaging 5-8 hours per week and demonstrate the need for:

a. Supporting the need for weekly intervention that requires an average of 20 and 32 hours per calendar month with a focus on skill building, community integration and crisis support; and
b. Demonstrating that CPST Tier One is or was insufficient for stabilization and
c. Supporting the need for behavioral interventions requiring:
    i. Real-time crisis coaching and de-escalation
    ii. Environmental modifications and crisis mitigations plans
    iii. Intensive behavioral modeling and scaffolding
    iv. Skills training that shall occur in natural settings (home, school, community) and
d. Supporting the need for care coordination with multiple service providers (psychiatry, case management, crisis services)

### 8.4 Additional Tier Two CPST criteria for youth

1. There shall be an identified caregiver or legally authorized representative available and willing to participate.
    a. The caregiver shall be a responsible adult who lives in the same household as the youth and is responsible for engaging in family/caregiver psychotherapy and service-related activities to benefit the youth.
    b. The family/caregiver(s) shall commit to participating in ≥ two hours of CPST covered service components a week.
    c. The family/caregiver(s) shall attend treatment planning meetings quarterly.
    d. The family/caregiver(s) shall be available for crisis consultation within two hours during business days.

### 8.5 Additional criteria for workplace or instructional setting assistance

Documentation shall support the need for workforce or instructional setting assistance due to psychiatric symptoms interfering with achieving the individual's identified employment goals. The individual's assessment and ISP shall document the individual's employment goals and barriers due to psychiatric symptoms that are impeding an individual's employment success.

### 8.6 Continued Stay Criteria

CPST is a recovery-oriented intervention. If the individual is not making significant progress after 180 calendar days, then the provider and MCO shall develop an alternative Individual Service Plan.

To meet continued stay criteria, all the following shall be met:

1. The individual continues to meet admission criteria.
2. Recovery requires a continuation of these services.
3. The individual and family/caregiver (as included in the ISP) are making progress toward goals and actively participating in the interventions. In the instance of limited or no progress, there shall be documented evidence of changes in the ISP, efforts to engage the individual and natural supports including family/caregiver for youth, or some other action to address the lack of progress.
4. There is a reasonable likelihood of continued substantial benefit as a result of active continuation of the services, as demonstrated by objective behavioral/functional measurements of improvement.
    a. Individuals shall be expected to improve at this current level of service, and
    b. The individual has not yet achieved the maximum benefit at the requested service

### 8.7 Discharge Criteria

Discharge is expected once the individual has met one of the following criteria:

1. The individual no longer meets admission criteria.
2. The individual has successfully met the specific goals outlined in the individual service plan for discharge.

3. Individual is not making progress on established service goals, nor is there expectation of any progress with continued provision of services.
4. The individual is no longer engaged in the service, despite multiple attempts on the part of the provider to apply reasonable engagement strategies.
5. The individual and/or family/caregiver(s) no longer need this service as they are obtaining a similar benefit through other services and resources.

## 9. Exclusions and Service Limitations

In addition to the "Non-Reimbursable Activities for all Mental Health Services" section in Chapter IV, the following service limitations apply:

1. The following are not reimbursable:
    a. Services not in compliance with the Mental Health Services Manual may not be billed to Medicaid.
    b. The provider shall ensure that treatment is the active delivery of an intervention identified on an individual's treatment plan. Passive observation of an individual without an intervention is not a billable activity.
    c. Phone contacts including attempts to reach the individual by telephone to schedule, confirm, or cancel appointments are not reimbursable.
    d. Completion of paperwork/documentation is not reimbursable.
    e. Requiring the individual to be present to complete documentation in order to bill for services is not permitted or reimbursable.
    f. Team meetings and collaboration exclusively with staff employed or contracted by the provider where the individual and/or their family/caregiver are not present.
    g. Team member research on behalf of the individual;
    h. Providers may not set up summer camps, after school programs or any other group-based programs and bill the time as a mental health rehabilitation service;
2. Admission and Concurrent Services Limitations:
    a. Individuals with a sole diagnosis of a Neurocognitive Disorder or Substance Use Disorder without a co-occurring mental health disorder are not eligible for this service
    b. Comprehensive Crisis and Transition Services:
        i. The CPST provider or any affiliated provider or business of the CPST provider shall not provide Mobile Crisis Response, 23-Hour Crisis Stabilization or Residential Crisis Stabilization to any individual receiving CPST.
    c. Individuals that meet the admission criteria for Applied Behavior Analysis with a primary diagnosis of Autism Spectrum Disorder, Assertive Community Treatment, Coordinated Specialty Care, Functional Family Therapy, or Multisystemic Therapy, are not eligible to receive CPST, except when the EBP services have failed to address the individual's treatment goals adequately.
        i. Early Periodic Screening Diagnostic and Treatment policies apply as well as exceptions if the MCO/FFS service authorization contractor determine CPST is the appropriate service.
    d. Individuals receiving CPST may not be simultaneously serviced authorized to receive the following services:
        i. Applied Behavior Analysis with a primary diagnosis of Autism Spectrum Disorder,
        ii. Assertive Community Treatment,
        iii. Coordinated Specialty Care,
        iv. Community Stabilization,
        v. Functional Family Therapy,
        vi. Mental Health Intensive Outpatient,
        vii. Multisystemic Therapy,
        viii. Psychiatric Residential Treatment Facility (PRTF) or
        ix. Therapeutic Group Home (TGH) services.

e. Short-term service authorization overlaps are allowable as approved by the FFS service authorization contractor or MCO during transitions from one service to another for care coordination and continuity of care.
f. The authorization of additional behavioral health services, not included in the list above is determined by the CANS Lifetime assessment/identified level of need in collaboration with the individual and their Managed Care Organization or FFS contractor.

3. Other Limitations:
   a. Group size is limited to a staff to individual ratio of one to six for youth and one to ten for adults.
   b. Covered service components provided in the provider's DBHDS licensed office location shall not exceed two hours a week (Sunday-Saturday) per individual and shall be for the benefit of the individual.
   c. The following employment supports are not allowable in the CPST Program:
      i. Skills training related to a specific job (how to operate equipment, use computer programs, fill customer orders, etc.).
      ii. Team member presence in the workplace to assist with supervision or teaching of routine work duties.
      iii. Approaching potential employers to "job develop" without the beneficiary present or without a specific beneficiary for the position.
      iv. Presentations to the business community to seek partnerships in hiring.
   d. As identified in the ISP, services may occur with a family or caregiver without the individual present when it is for the clinical benefit of the individual with the exception of Rehabilitative Skills Practice, which can only be provided in-person with the individual present.
   e. Services are not provided in segregated, disability-specific, or institutional settings unless temporarily necessary to address acute safety concerns.

# 10. Service Authorization (SA)

## 10.1 General requirements

a. Service authorization is required.

b. Providers shall submit service authorization requests within one business day of admission for preservice authorization requests and by the requested start date for concurrent service authorization requests. If submitted after the required time frame, the start date of the authorization will be based on the date of receipt.

c. The LMHP in collaboration with the individual, family/caregiver, and CPST team members, shall request services based on each individual's CANS Lifetime assessment/reassessment, treatment history, individual service plan, progress toward accomplishing goals/objectives, level of individual/family/caregiver engagement, individual choice/preference and level of need. The intensity, frequency, and duration for any requested service shall be individualized.

d. All service authorization requests will initially start with the standard 6 calendar month timeframe and the corresponding units required in the chart below.

e. If an individual remains at the same Level of Need or higher for 18 calendar months, the service authorization timeframe will decrease to 3 calendar months.

f. If a provider is requesting and providing services within the permissible amount based on the assessment and individuals are recovering, the MCO may waive the service authorization requirement.

g. Interventions recommended shall not be limited to the services delivered by the provider or provider agency conducting the assessment and submitting the authorization request.

h. The individual's MCO/FFS service authorization contractor conducting the service authorization review may approve the requested service(s) or may recommend a more clinically appropriate service based on their review.

Additional information on service authorization is located in Appendix C of the manual. Service authorization forms and information on Medicaid MCOs processes is located at www.dmas.virginia.gov/for-providers/behavioral-health/training-and-resources/. Information regarding our FFS service authorization contractor can be found here: Service Authorizations Home (Acentra Health/DMAS) | MES

### 10.2 Level of Need and CPST Service Authorization Requests:

All service authorizations require a standardized timeframe of 6 calendar months period, with some changes to authorization timeframes if individuals are in a single Level of Need for 18 calendar months or more. The identified Level of Need shall correspond to a standardized amount of units. The Level of Need Model and corresponding standardized amount of units is still under development by DMAS.

### 10.3 Preservice Authorization

The following information shall be submitted with the preservice authorization request:

1. Complete service authorization request form
2. Initial Assessment including the completed CANS Lifetime
3. Initial ISP
    a. Shall specify evidence-based practice used in treatment.
    b. Shall include plan for telemedicine as described in the ISP section of Chapter IV, if applicable.

### 10.4 Concurrent Authorization

The following information shall be submitted with the concurrent authorization request

1. Completed service authorization request form
2. Current addendum to the initial assessment (can be a progress note) that describes any new information impacting care, progress and interventions to date, a description of the rationale for continued service delivery, and evidence the individual meets medical necessity criteria.
3. Updated ISP:
    a. Shall include plan for telemedicine as described in the ISP section of Chapter IV, if applicable.
    b. Youth: Following initial authorization, if an individual is not progressing and the family/caregiver is not engaged or participating in treatment, the ISP shall be updated to assure family/caregiver involvement before reauthorization is considered.
    c. Adults: Following initial authorization, if an individual is not progressing and/or engaged, the ISP shall be updated to assure engagement and progress before reauthorization is considered.

## 11. Additional Documentation Requirements and Utilization Review

1. The progress note shall clearly document that the services provided are related to the individual's goals, objectives and interventions in the treatment plan, and are medically necessary and clinically appropriate.
2. Each service/progress note shall document the specific interventions delivered including a description of what materials were used when teaching a skill.
3. Service/progress notes shall include:
    a. Each individual's response to the intervention, noting if progress is or is not being made.
    b. Observed behaviors if applicable and a plan for the next scheduled contact with the individual.
    c. Sufficient detail to support the length of the contact.
    d. The content shall be specific enough so a third party will understand the purpose of the contact and supports the service and claims data.
    e. The only team member who may complete a progress note is the team member who delivered the service. It is not permissible for one team member to deliver the service and another team member to document and/or sign the progress notes.

4. An LMHP shall review documentation of non-licensed team members at least every 30 calendar days as evidenced by a progress note in the individual's chart written by the LMHP or a co-signature on the non-licensed team member's progress notes. Non-licensed team members include LMHP-Rs, LMHP-RPs, LMHP-Ss, QMHPs, QMHP-Ts and BHTs.
5. Justification for more than one staff person billing simultaneously shall be documented in the progress note for that specific session.

Refer to Chapter VI of this manual for additional documentation and utilization review requirements.

## 12. CPST Billing Requirements

Services shall be billed with the modifier based on the staff level required for the service component:

| Service Component | Team Member Type | Rate Unit | CPST Adult Community Procedure Code and Modifier Combination | CPST Youth Community Procedure Code and Modifier Combination |
|---|---|---|---|---|
| Standardized Comprehensive Assessment of Needs and Strengths (CANS Lifetime) | LMHP, LMHP-R, LMHP-S, LMHP-RP,<br><br>see section 5 for QMHP assessment participation requirements. | 1 unit per member per 365 calendar days | H0031 | H0031 |
| Assessment | LMHP, LMHP-R, LMHP-S, LMHP-RP | Per 15 minutes | H0036, HO **and** HB | H0036, HO **and** HA |
| Treatment Planning | LMHP, LMHP-R, LMHP-S, LMHP-RP | Per 15 minutes | H0036, HO **and** HB | H0036, HO **and** HA |
| Treatment Planning, if assisting the LMHP | QMHP, QMHP-T | Per 15 minutes | H0036, HN **and** HB | H0036, HN **and** HA |
| Psychotherapy | LMHP, LMHP-R, LMHP-S, LMHP-RP | Per 15 minutes | H0036, HO **and** HB (individual) | H0036, HO **and** HA (individual) |
| | | | H0036, HO **and** HQ (group) | H0036, HO **and** HK (group) |
| Care Coordination | LMHP, LMHP-R, LMHP-S, LMHP-RP | Per 15 minutes | H0036, HO **and** HB | H0036, HO **and** HA |
| Care Coordination | QMHP, QMHP-T | Per 15 minutes | H0036, HN **and** HB | H0036, HN **and** HA |
| Crisis Support | LMHP, LMHP-R, LMHP-S, LMHP-RP | Per 15 minutes | H0036, HO **and** HB | H0036, HO **and** HA |
| Crisis Support | QMHP, QMHP-T | Per 15 minutes | H0036, HN **and** HB | H0036, HN **and** HA |
| Restorative Life Skills Training | LMHP, LMHP-R, LMHP-S, LMHP-RP, QMHP, QMHP-T<br><br>All professional levels of staff shall bill with these procedure code and modifier combination. | Per 15 minutes | H0036, HN **and** HB (individual) **or** | H0036, HN **and** HA(individual) **or** |
| | | | H0036, no modifier (group) | H0036, HN **and** HQ (group) |

| Service Component | Team Member Type | Rate Unit | CPST Adult Community Procedure Code and Modifier Combination | CPST Youth Community Procedure Code and Modifier Combination |
|---|---|---|---|---|
| Rehabilitative Skills Practice | LMHP, LMHP-R, LMHP-S, LMHP-RP, QMHP, QMHP-T or BHT<br><br>All professional levels of staff shall bill with these procedure code and modifier combination. | Per 15 minutes | H0036, HM **and** HB | H0036, HM **and** HA |

1. A QMHP may provide BHT level services and shall bill using the procedure code/Modifier combination associated with BHTs.
2. An LMHP, LMHP-S, LMHP-R, or LMHP-RP may provide any component of CPST and shall bill using the procedure code and modifier combination associated with the service component.
3. Non-licensed staff (LMHP-S, LMHP-R, LMHP-RP, QMHP, QMHP-T or BHT) shall not bill more than 600 CPST units in any calendar month (across all agencies in which they are employed).
4. Assessment and treatment planning service components allow for more than one staff person billing simultaneously. No other service components are allowed to be billed simultaneously by more than one staff person.
5. The initial CANS Lifetime assessment and the annual reassessment shall be billed using H0031. All other assessment activities shall be billed with H0036 HO and HB or H0036 HO and HA.