
PROGRAM IMPLEMENTATION GUIDE

Community Psychiatric Support and Treatment (CPST) — Community

A practical guide for providers on standing up and running a compliant CPST-Community program — program development, staffing, service delivery, supervision, caseloads, and billing.

Virginia Department of Medical Assistance Services (DMAS)

Aligned to CPST Provider Manual (Community) – Draft 3 (06.08.2026)

About This Guide

This guide translates the CPST - Community Provider Policy Appendix within the Mental Health Services Manual into an operational roadmap. It is written for agency leadership, clinical directors, supervisors, and program managers who are building a new CPST-Community program. It walks through how to stand up the program, hire and train the team, structure individual and group service delivery, handle travel and community-based work, set caseloads, run supervision and team meetings, and bill correctly.

How to use it

This guide is operational, not regulatory. Where it summarizes a requirement, the CPST Provider Manual and its Attachment 1 remain the controlling source. Section references throughout point back to the manual.

Two tiers, two populations. CPST is delivered as Tier 1 or Tier 2, to Adults or Youth. Requirements that differ by tier or population are flagged as they arise.

"Shall" means required. Language marked as a requirement reflects a manual "shall." Recommendations are labeled as such.

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1. What CPST Is

Community Psychiatric Supportive Treatment (CPST) is a **trauma-informed, team-based service** for adults and youth, delivered in natural, community-based settings, where people live, work, learn, and socialize. It pairs assessment, treatment planning, and psychotherapy with restorative life-skills training, care coordination, and crisis support, all driven by a person-centered Individual Service Plan (ISP).

Delivering services in the community is central to the model. Skills are built where people will actually use them, which fosters real community integration, reduces stigma, and strengthens the natural supports that sustain long-term recovery.

1.1 Tier 1 vs. Tier 2

	CPST Tier 1	CPST Tier 2
Team	LMHP, plus optionally an additional LMHP, LMHP-type, QMHP, or QMHP-T	All Tier 1 roles, and may add a Behavioral Health Technician (BHT) for the rehabilitation skills practice component only
Face-to-face contact	Individual interacts regularly with one or two team members	Individual interacts with two team members, and may interact with three
Distinct component	Assessment, Treatment Planning, Restorative life skills, care coordination, crisis support and psychotherapy if needed.	Adds Rehabilitation Skills Practice (in-person, one-to-one)
Weighted caseload value	Counts as 1	Counts as 2.5

Collaborative Behavioral Health Service

CPST is delivered by a team of two or more professional and paraprofessional staff under § 54.1-3500. Every team member serving an individual or family must communicate and collaborate to meet supervision, oversight, and documentation requirements. It is not a solo service.

2. Standing Up the Program

Before a single unit is billed, the agency needs its licensure, enrollment, Cardinal Care Managed Care Organization (CCMCO) contracting and accreditation pathway, and core policies in place. Work these startup steps in parallel where possible — several have clocks that start on your DMAS enrollment effective date.

2.1 Licensure, enrollment sequence and CCMCO contracting

- 1. Obtain the correct DBHDS license.** Adult/Community = 03-020 (MH Non-Center-Based CPST for Adults). Youth/Community = 03-021 (CPST for Children and Adolescents). The license must be active and in good standing.
- 2. Enroll with DMAS.** Provider type 156 or 456; specialty 926 (Adult) or 925 (Youth); taxonomy 251S00000X; organizational (Type 1) NPI tied to the 03-020/03-021 license.
- 3. Submit required enrollment attachments.** The DBHDS license(s) and evidence you have initiated accreditation.
- 4. Submit required CCMCO contracting application.** Submit application to each CCMCO.
- 5. Complete accreditation within 18 months** of the specialty's effective date in the DMAS Provider Enrollment System and keep accreditation updates submitted within 30 days of any change.
- 6. List staff on the CPST Directory.** Submit each CPST staff member's qualifications to the Center for Evidence-Based Partnerships (CEP-VA) CPST Directory and keep it current.

Keep these clocks visible

30 days 30 days to submit accreditation updates.

18 months to complete accreditation; 18 months for LMHP/LMHP-types to earn the MAP credential (Youth).

12 months for all staff to complete required skills-training curricula.

2.2 Policies you must have in place

The manual requires the agency to maintain written policies and procedures across several areas. Build these before go-live:

- 1. EBP identification** — which evidence-based protocols, principles, practices, and policies you are incorporating, and how staff are trained in each.
- 2. Crisis consultation & 24/7 availability** — how an experienced LMHP (1+ year with SMI/SED) is reachable on-call around the clock, and how after-hours triage can access crisis mitigation plans in real time.
- 3. Caseload protection** — how staff are protected from high caseloads, how cases are covered during leave, and what happens when staff leave the agency.

- 4. Outside-employment disclosure** — requiring staff to disclose other Medicaid-billed employment (relevant to the 750-unit monthly cap).
- 5. In-person support arrangement** — how the Clinical Director's or the on-call LMHP in-person availability is arranged within a clinically appropriate timeframe, including travel to an individual's location when needed.
- 6. Clinical best-practice guidelines** — maintained and updated for common presenting problems.

3. Staffing the Team

CPST is built on a tiered workforce. Understanding who can do what — and who oversees whom — is the foundation for scheduling, supervision, and billing.

3.1 Roles at a glance

Role	Who / credential	Core responsibilities
CPST Clinical Director	Full-time LMHP, current active unrestricted VA (DHP) license	Overall clinical + programmatic oversight; accountable for quality, integrity, and compliance; may also serve as LMHP Clinical Supervisor and carry a caseload if it does not compromise oversight
LMHP Clinical Supervisor	LMHP (fully licensed to practice independently)	Recommends, oversees, and supervises services; authorizes ISPs; provides/delegates clinical supervision
LMHP-type	LMHP-R, LMHP-RP, or LMHP-S (resident/supervisee)	Assessment, treatment planning, psychotherapy; Performs LMHP activities only where the manual allows; assessments require LMHP review & co-signature
QMHP / QMHP-T	Qualified Mental Health Professional (incl. trainee)	Restorative life skills, care coordination, crisis support; may assist LMHP with assessment/treatment-planning info gathering
BHT	Behavioral Health Technician (Tier 2 only)	Rehabilitation Skills Practice component only

One Clinical Director rule

A CPST Clinical Director cannot serve as Clinical Director for more than one DBHDS-licensed agency. Within the same licensed agency, one director may oversee both a youth and an adult CPST program. Through 06/30/2029, DMAS allows the Director and LMHP Clinical Supervisors to hold LMHP-type status with 50% or fewer supervision hours remaining, and honors specific DBHDS variances.

3.2 Who can deliver each service component

Match staffing to the component. This table also determines who bills which code/modifier combination (see Section 8).

Service component	Qualified staff	Delivery notes
Assessment (incl. CANS Lifetime)	LMHP, LMHP-type	One-to-one; in person; LMHP-type requires LMHP co-signature; QMHP/QMHP-T may assist (CANS-certified)
Treatment Planning / ISP	LMHP, LMHP-type	Face-to-face; QMHP/QMHP-T may assist with info gathering & documentation
Psychotherapy	LMHP, LMHP-type	Individual or group; telemedicine if clinically appropriate
Restorative Life Skills Training	LMHP, LMHP-type, QMHP, QMHP-T	Community-based; individual or group; ≥ half of units in person
Care Coordination	LMHP, LMHP-type, QMHP, QMHP-T	One-to-one; telehealth permitted
Crisis Support	LMHP, LMHP-type, QMHP, QMHP-T	One-to-one; 24/7/365; telehealth or in person
Rehabilitation Skills Practice (Tier 2)	LMHP, LMHP-type, QMHP, QMHP-T, BHT	In person only; one-to-one; no telehealth

3.3 Required training by credential

All staff complete a foundational curriculum plus role-specific training, accessed through the DBHDS Learning Management System. Staff have **12 months** from the agency's DMAS enrollment effective date (or from hire date, for new staff) to finish. Documentation flows to CEP-VA at VCU.

Credential	Foundational	Role-specific — Youth	Role-specific — Adult
LMHP / LMHP-type	Foundational Skills Curriculum (FSC)	MAP Credentialed Therapist CANS Lifetime certification for anyone completing assessments	Training/credential in one required EBP (e.g., a CBT variant) CANS Lifetime certification for anyone completing assessments
QMHP / QMHP-T	Foundational Skills Curriculum (FSC)	CPST Intermediate Skills (IS)	CPST Intermediate Skills (IS)

Credential	Foundational	Role-specific — Youth	Role-specific — Adult
		CANS Lifetime certification if assisting with assessments	CANS Lifetime certification if assisting with assessments
BHT	DBHDS BHT Academy	CPST Intermediate Skills (IS)	CPST Intermediate Skills (IS)

MAP credential (Youth programs)

Every youth-serving agency must have at least one LMHP who is a MAP Credentialed Therapist. All LMHP/LMHP-types who provide or supervise youth CPST must be MAP-credentialed or actively working toward it, with **18 months** from enrollment or hire to complete the PracticeWise Direct Services Curriculum, six months of consultation, and the Therapist Portfolio review.

4. Delivering Service: Individual, Group & Community Time

4.1 Individual (one-to-one) vs. group

Most CPST components are delivered one-to-one, but two components may be delivered in groups when clinically appropriate and approved by the LMHP Clinical Supervisor. Know which is which.

Component	One-to-one required?	Group ratios & rules
Assessment / CANS Lifetime	Yes	Group not permitted
Treatment Planning / ISP	Yes	Group not permitted
Care Coordination	Yes	Group not permitted
Crisis Support	Yes	Group not permitted
Rehabilitation Skills Practice (Tier 2)	Yes	Group not permitted
Restorative Life Skills Training	Individual or group	Group ≤ 1 staff : 6 youth / 1 staff : 10 adults
Psychotherapy	Individual or group	Group ≤ 1 LMHP/LMHP-type : 6 youth / 1 : 10 adults

The in-person / individual minimums that trip people up

Restorative Life Skills: at least half of units per authorization must be in person; telemedicine may not exceed half of the units billed per week.

Tier 2 Restorative Life Skills: at least half of units per authorization must be delivered individually (one team member per individual); the remainder may be group.

Rehabilitation Skills Practice: 100% in person, one-to-one — never telehealth, never group.

4.2 Working in the community — and the office cap

Covered components are provided primarily in natural, community-based settings — the home, workplace, schools, libraries, parks, places of worship, community centers. Services delivered in the provider's DBHDS-licensed CPST office are capped at **three (3) hours per week (Sun–Sat) per individual** and must be for the individual's documented benefit. Each service location is documented in the ISP and tied to a specific goal or objective.

4.3 Travel time

Community-based delivery means staff travel — but the billing rule is strict and worth stating plainly to every new hire:

Travel is not billable

Providers bill only for time spent face-to-face with the individual (or with the family/caregiver for the individual's benefit). Travel time to and from an encounter is not a billable CPST unit. The only exceptions to the face-to-face billing rule are telehealth used for Care Coordination or Crisis Support.

Plan schedules and geographic caseload distribution with unbillable travel in mind — it is a real cost that productivity targets and caseload assignments must absorb, not bill around.

4.4 Telehealth boundaries

- 1. Restorative Life Skills:** telemedicine allowed if clinically appropriate, documented in the ISP and note, not exceeding half of weekly units.
- 2. Psychotherapy:** telemedicine allowed when clinically appropriate, in consultation with the LMHP Clinical Supervisor and individual.
- 3. Care Coordination & Crisis Support:** telehealth permitted (and are the only components billable via telehealth without face-to-face).
- 4. Rehabilitation Skills Practice, Assessment, CANS:** in person / one-to-one — no telehealth.

5. Caseloads

Caseload limits exist to protect quality and staff sustainability. There are two distinct caps: a weighted caseload cap for staff delivering the primary service components, and an oversight cap for the LMHP supervising cases.

5.1 Weighted staff caseload (primary-component staff)

For staff providing the primary components, Restorative Life Skills Training, Care Coordination, and/or Crisis Support, the **weighted caseload shall not exceed 20**. Blended Tier 1 / Tier 2 caseloads are recommended.

Weighted caseload formula

Weighted caseload = (Tier 2 clients × 2.5) + (Tier 1 clients) — must not exceed 20

Example: 4 Tier 2 clients (4 × 2.5 = 10) + 10 Tier 1 clients = 20. At capacity.

Compliance is measured as a **6-month rolling monthly average**, from an ongoing formal caseload log kept for each staff member. License-eligible staff providing *only* Assessment, Treatment Planning (and 90-day follow-up), and Psychotherapy follow the general caseload-policy requirements rather than the weighted cap.

5.2 Non-licensed staff unit cap

750 units / month

Non-licensed staff (LMHP-types, QMHP, QMHP-T, BHT) may bill no more than 750 CPST units per calendar month, **across all agencies where they are employed**. Assessed on a rolling 6-month average and subject to audit, which is why outside-employment disclosure is a required policy.

5.3 LMHP oversight (supervision of cases) caps

Separate from delivering services, a single LMHP is limited in how many cases they can clinically oversee per month. A single LMHP shall not oversee more than **120 unweighted cases** in a calendar month, and the cap tightens with team composition:

Oversight scenario	Max cases / month
Oversight primarily of fully-licensed LMHPs / LMHP-types doing assessment, treatment planning, psychotherapy	120
Mixed team (LMHP-types + paraprofessionals) — Director sets cap by documented composition	Up to 100
Oversight primarily of QMHPs / QMHP-Ts / BHTs (LMHP directly provides assessment & treatment planning)	75

The Clinical Director determines how many cases can be managed with appropriate attention to quality and safety — the numbers above are ceilings, not targets.

6. Supervision & Team Meetings

Supervision in CPST is relationship-based, work-focused education and oversight. It serves three functions and is delivered on a required monthly cadence that scales with credential and workload.

6.1 The three functions of supervision

- 1. Educational / Clinical:** teaching therapeutic skills and building the team's self-awareness and clinical judgment.
- 2. Regulatory Compliance:** translating policy and accountability into practice standards, documentation, licenses, certifications, continuing education. May be handled by a separate QA/compliance role if documented.
- 3. Supportive:** helping staff manage the emotional demands of the work; increases competence and reduces burnout.

6.2 Minimum supervision by credential

These are the DMAS minimums. Where a DHP licensing board requires more (e.g., for residents/supervisees), the higher standard governs.

Credential & workload	Frequency	Min. individual + group / month	Min. individual, group + related activities / month
LMHP, full-time	Monthly	1 hour	1 hour
LMHP-type, QMHP, QMHP-T, BHT — full-time, or part-time with 10+ cases	Weekly	2 hours (≥ 1 hr individual)	4 hours
LMHP-type, QMHP, QMHP-T, BHT — part-time with < 10 cases	Weekly	1 hour	2 hours

6.3 What counts as supervision time

Supervision-related activities that may count towards the monthly totals include:

Individual supervision sessions	Group supervision	Case consultation
Clinical documentation review	Clinical case oversight (collaborative BH)	Rehabilitative skills practice planning
Direct observation	Co-treatment sessions	Performance evaluation
Training and education	Crisis intervention oversight	Ethical & legal guidance
Professional development planning		

Team meetings and collaborative oversight

Because CPST is a collaborative behavioral health service, the team must actively communicate. Two activities structure this: **clinical case oversight** — two-way

communication and collaborative treatment planning between the staff doing assessment/treatment-planning/psychotherapy and those doing skills, care coordination, crisis, and rehab-skills-practice; and **rehabilitative skills practice planning** — collaborative activity planning with the Tier 2 rehab-skills staff. Build recurring team meetings that produce this documented, two-way collaboration.

6.4 Documentation of supervision

1. All supervision and supervision-related activities shall be documented and accessible on request.
2. Supervision under 12VAC35-105 is provided in addition to these CPST requirements.
3. The Clinical Director and all LMHP Clinical Supervisors ensure non-licensed staff practice within scope and never deliver services requiring licensure.

7. The Clinical Operating Rhythm

Once staffed and trained, the program runs on a set of recurring clinical obligations. Building these into scheduling and EHR workflows prevents authorization and audit problems.

Cadence	Obligation
Before authorization	CANS Lifetime completed ≤ 30 days before the preservice request (or a prior CANS ≤ 12 months old reviewed and attested by the admitting LMHP); youth assessed and referred for any qualifying standalone EBP
Within 1 business day of admission	Preservice service authorization request submitted
Within 30 days of admission	Crisis mitigation plan completed and signed by all team members and the youth/representative.
Every 90 days (minimum)	LMHP/LMHP-type face-to-face; formal ISP review face-to-face
After 180 days without significant progress	Provider and CCMCO develop an alternative ISP
Annually	CANS Lifetime reassessment (every 365 days until discharge); crisis mitigation plan reviewed
At 18 months at the same Level of Need	Reassess and refer to clinically appropriate standalone EBPs; notify CCMCO; update ISP with transition plan; authorization period drops to 3 months
24/7/365	Crisis support accessible; experienced LMHP on call (≤ 15 min instructional day / ≤ 30 min otherwise)

Crisis: internal first

CPST providers prioritize internal crisis support and prevention before escalating to external resources and establish the CPST provider as the individual's primary crisis contact. Individuals are encouraged to contact the provider before 911 when it is safe to do so — but nothing limits an individual's right to contact 911 or 988 directly at any time, and that decision is never discouraged. Acute conditions (immediate danger, active SI/HI with plan and means where a safe in-person response can't be initiated, needed medical assessment, or an unreachable individual in an unknown location) require immediate external escalation.

8. Billing Essentials

CPST is billed in 15-minute units against the base code H0036 with component- and population-specific modifiers. The right combination depends on the service component, the staff credential, and whether it is Adult or Youth.

8.1 Core billing rules

- 1. Bill only face-to-face time** with the individual (or family/caregiver for the individual's benefit). Exceptions: telehealth for Care Coordination or Crisis Support. Travel time is never billable.
- 2. Rate unit is 15 minutes** for every component.
- 3. Simultaneous billing is limited.** Only Assessment and Treatment Planning may be billed by two staff at once (an LMHP/LMHP-type and a QMHP), when clinically needed and documented. No other component may be billed simultaneously by more than one person.
- 4. Extra psychotherapy units:** where an authorization includes the additional 16 units/month for psychotherapy, those units may be billed only for the psychotherapy component.

9. Implementation Checklist

A consolidated readiness checklist for launching or realigning a CPST program.

Licensure & enrollment

- 1.** DBHDS license obtained (03-020 Adult and/or 03-021 Youth), active and in good standing
- 2.** DMAS enrollment complete (type 156/456; specialty 926/925; taxonomy 251S00000X; org NPI)
- 3.** Accreditation initiated; full accreditation on track within 18 months
- 4.** Staff qualifications submitted to the CEP-VA CPST Directory and kept current

Staffing & training

- 1.** Full-time LMHP Clinical Director designated
- 2.** LMHP Clinical Supervisor(s) identified; oversight caps mapped to team composition

3. Youth: at least one MAP Credentialed Therapist; MAP pathway underway for all youth LMHP/-types
4. FSC / IS / BHT Academy enrollment underway; 12-month completion clock tracked
5. Adult: each LMHP/-type in training for one required EBP

Operations & policy

1. Required policies drafted: EBP identification, 24/7 crisis consultation, caseload protection, outside-employment disclosure, in-person support arrangement, clinical best-practice guidelines
2. Caseload logs established; weighted-caseload and 750-unit trackers built with 6-month rolling averages
3. Supervision schedule set to credential-based minimums; documentation workflow in place
4. Recurring team meetings scheduled to produce documented collaborative case oversight
5. Clinical cadence built into EHR: 30-day crisis plan, 90-day face-to-face/ISP review, 365-day CANS, 18-month EBP re-evaluation

Billing

1. Billing system configured with H0036 + component/credential/population modifiers
2. Face-to-face-only rule and non-billable travel communicated to all staff
3. Simultaneous-billing rule (Assessment/Treatment Planning only) configured and documented

This guide summarizes operational requirements from the CPST Provider Manual (Community), Draft V3, for provider implementation. It does not supersede the manual or DBHDS licensing regulations (12VAC35-105). Verify all specifics against the current published manual and MCO requirements before go-live.