



Department  
of Health

Office of  
Mental Health

Office of Alcoholism and  
Substance Abuse Services

Office of Children  
and Family Services

# Children's Behavioral Health and Health Services Transformation

## Medicaid State Plan Provider Manual *Draft* – March 2016

Contents of this manual are subject to change. Any questions or concerns about this document can be sent to  
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## I. Introduction

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New York State is pleased to release the Children's Behavioral Health and Health Services Medicaid State Plan Provider Manual as a guide for the six new children's behavioral health and health Medicaid State Plan services, to be implemented in 2017. The Office of Mental Health (OMH), Office of Alcoholism and Substance Abuse Services (OASAS), Office of Children and Family Services (OCFS), and the Department of Health (DOH) have worked in collaboration to identify six services to benefit New York State's children from birth up to 21 years of age. These six services will be available to any child eligible for Medicaid who meets relevant medical necessity criteria.

One of the themes developed by the Children's Medicaid Redesign Team (MRT) Behavioral Health Subcommittee included the desire to improve the children's service system, which prompted the augmentation of children's benefits under Medicaid. The vision of the design is that *children receive the right services, at the right time and in the right dose*.

At the beginning of the planning process, the Children's MRT Behavioral Health Subcommittee identified themes to guide the State's work, namely:

- Intervening early in the progression of behavioral and physical health needs is effective and reduces cost.
- Accountability for outcomes across all payers is needed for children's behavioral and physical health.
- Solutions should address unique needs of children in a unified, integrated approach.
- The current behavioral/physical healthcare system for children and their families need improvement.
- Children in other public or private health plans should have access to a reasonable range of behavioral and physical health benefits.

No two children's journeys are the same. Through appropriate identification, evaluation and treatment, children and adolescents with behavioral health and health needs can embrace the hope of recovery. They can achieve success in school, in work, in family life, and in building relationships. Nonetheless, the overwhelming majority of children with behavioral health and health needs fail to be identified, lack access to treatment and needlessly struggle throughout their lives. Stigma persists, and as a result, thousands of young people in New York State are left behind or go without appropriate, necessary care.

The main goal of the additional services in New York's State Medicaid Plan is to:

- Identify needs early on in a child's life;
- Maintain the child at home with support and services;
- Maintain the child in the community in the least restrictive settings possible;
- Prevent the need for long-term and/or more expensive services; and

- To increase the delivery of services following trauma-informed care principles.

With these goals in mind, the proposed services will be available to all children who are Medicaid eligible, as long as they meet the medical necessity criteria for the individual service. Cross-systems providers are encouraged to provide the proposed Medicaid State Plan services to encourage and result in better service delivery.

The proposed services are intended to be delivered in a culturally competent manner. Providers should have an awareness and acceptance of cultural differences, an awareness of their own cultural values, an understanding of the “dynamics of differences” in the helping process, a comprehensive knowledge about the child’s culture, knowledge of the child’s environment, and the ability to adapt practice skills to fit the child’s cultural context.

The proposed services are also intended to be trauma-informed. Complex trauma affects a child’s sense of safety, ability to regulate emotions and capacity to relate well to others. Since complex trauma often occurs in the context of the child’s relationship with a caregiver, it interferes with the child’s ability to form secure attachments, especially during the earliest years of life. Consequently, an important aim of service delivery is to help children and youth develop positive social-emotional functioning, beginning in early childhood, intervening as early as possible to prevent the development of serious behavioral health and health conditions, restore appropriate developmental functioning and reestablish healthy relationships. Providers are to ensure that services are trauma informed, and take into consideration the child and families’ strengths, assets, needs, and any history of adverse experiences that may have affected their ability to cope or self-advocate. In addition, services are to be provided in a manner that is not only appropriate for the child’s age, but anchored to the child’s developmental, social and emotional stage.

To accomplish the vision and goals, the following services will be implemented:

- Crisis Intervention
- Community Psychiatric Supports & Treatment
- Family Peer Support Services
- Youth Peer Advocacy and Training
- Other Licensed Practitioners
- Psychosocial Rehabilitation Services

The new set of Medicaid State Plan services will enable New York State to focus on prevention and wellness and improving integration of behavioral health and health focused services earlier in a child’s life. The array of services will allow interventions to be delivered in natural community-based settings where children and their families live. The focus of this array of Medicaid State Plan services is to bolster lower intensity services to prevent the need for more restrictive settings and higher intensity services. Community-based services are key to this – for example, before going into day treatment, practitioners may surround the child with a blend of outpatient clinic and community based services. Additionally, the proposed Medicaid State Plan services

provide NYS with an avenue to incentivize the delivery of proven Evidence Based Practices that, delivered well, can result in better outcomes for children and families.

The proposed Medicaid State Plan services will be under the Early Periodic Screening, Diagnosis and Treatment benefits (known commonly as EPSDT). EPSDT is an array of Medicaid benefits for children under 21 years of age, and has been focused primarily on children's preventive medical care (e.g., well baby visits, vaccinations, and screenings at designed ages).

This provider manual will guide Plans and providers in understanding the new Children's Behavioral Health and Health Medicaid State Plan services and the requirements with their delivery.

The activities utilized must be intended to achieve identified treatment plan goals or objectives.

The treatment plan should:

- Be revised or a new treatment plan should be developed in a person-centered manner with the active participation of the child/youth, family and providers;
- Be based on the child/youth's condition and the standards of practice for the provision of these specific rehabilitative services;
- Identify the medical or remedial services intended to reduce the identified condition as well as the anticipated outcomes of the child/youth;
- Include a reevaluation that involves the child/youth, family and providers and determines whether services have contributed to meeting the stated goals;
- Be revised if there is no measureable reduction of disability or restoration of functional level and Identify different rehabilitation strategy with revised goals and services.

The treatment plan must:

- Specify the amount, duration and scope of services;
- Be signed by the licensed practitioner responsible for developing the plan, with the child/youth (or authorized representative) also signing to note concurrence with the treatment plan; and,
- Specify a timeline for reevaluation of the plan that is at least annually.

Providers must maintain medical records that include a copy of the treatment plan; the name of the child/youth; dates of service; nature, content and units of rehabilitation services provided; progress made toward functional improvement on the goals identified in the treatment plan.

Services provided to children and youth must include communication and coordination with the family, caregiver and/or legal guardian. Coordination with other child-serving systems should occur as needed to achieve the treatment goals. All coordination must be documented in the child/youth's medical record. Services may be provided at an

office, in the community, or in the individual's place of residence as outlined in the treatment plan. Components that are not directed exclusively toward the treatment of the Medicaid eligible child/youth are not eligible for Medicaid reimbursement.

Services provided at a work site must not be job task oriented and must be directly related to the treatment of a Medicaid eligible youth 14 years old and above. Any services or components of services that supplant housekeeping, homemaking, or basic services for the convenience of a person receiving covered services (including housekeeping, shopping, child care, and laundry services) are non-covered. Services cannot be provided in an institution for mental disease (IMD). Room and board are excluded from any rates provided in a residential setting.

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## II. Glossary of Terms

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**Advocacy:** The spirit of this work is one that promotes effective parent/caregiver-professional-systems partnerships. Advocacy in this role does not include legal consultation or representation. It is defined as constructive, collaborative work with and on behalf of families to assist them to obtain needed services and supports to promote positive outcomes for their children.

**Community Setting:** Any mention of community setting within the provider manual is intended to be **any** setting, very broadly defined, that is not a medical institution (e.g., hospital or nursing facility) where children and families live, play and work.

**Crisis Event:** A seriously acute psychological/emotional change a beneficiary is experiencing which results in a marked increase in personal distress and which exceeds the abilities and the resources of those involved (e.g., collateral, provider, community member) to effectively resolve it are eligible.

**Crisis Plan-** A tool utilized by providers for children/youth in order to assist in: reducing or managing crisis related symptoms; promoting healthy behaviors; addressing safety measures; and/or preventing or reducing the risk of harm or diffusion of dangerous situations. The child/youth/family will be an active participant in the development of the crisis plan. With the family's consent, the crisis plan may be shared with collateral contacts also working with that child/youth/family who might provide crisis support or intervention in the future. Sharing the crisis plan helps to promote future providers' awareness of and ability to support the strategies being implemented by the child/youth/family

**Cultural Competency:** An awareness and acceptance of cultural differences, an awareness of individual cultural values, an understanding of how individual differences affect those participating in the helping process, a basic knowledge about the clients culture, knowledge of the client's environment, and the ability to adapt practice skills to fit the individual or family cultural context.

**Developmental Disability:** Section 1.03(22) of the New York State Mental Hygiene Law is the legal base for eligibility determination and defines Developmental Disability as: A disability of a person that: (a)(1) Is attributable to an intellectual disability cerebral palsy, epilepsy, neurological impairment or autism; (2) Is attributable to any other condition of a person found to be closely related to an intellectual disability because such condition results in similar impairment of general intellectual functioning or adaptive behavior to that of intellectually disabled persons or requires treatment and services similar to those required for such persons; or (3) Is attributable to dyslexia resulting from a disability described in (1) or (2); (b) Originates before such person attains age twenty-two; (c) Has continued or can be expected to continue indefinitely; and (d) Constitutes a substantial handicap to such person's ability to function normally in society. *Source: OPWDD, OMRDD Advisory Guideline--Determining Eligibility for Services:*

**Early Periodic Screening and Diagnostic Testing (EPSDT):** Provides comprehensive and preventive health care services for children under age 21 who are enrolled in Medicaid. EPSDT is key to ensuring that children and adolescents receive appropriate preventive, dental, mental health, developmental, and specialty services.

**Evidenced-Based Practice:** The Institute of Medicine (IOM) defines "evidence-based practice" as a combination of the following three factors: (1) best research evidence, (2) best clinical experience, and (3) consistent with patient values (*Institute of Medicine, 2001. Crossing the quality chasm: A new health system for the 21st century. Washington, DC: National Academy Press*). These factors are also relevant for child welfare. New York State has adopted the Institute of Medicine's definition for evidence-based practice with a slight variation that incorporates child welfare language: Best Research Evidence, Best Clinical Experience, and Consistent with Family/Client Values. This definition builds on a foundation of scientific research while honoring the clinical experience of child welfare practitioners, and being fully cognizant of the values of the families served.

**Family:** Family is defined as the primary caregiving unit and is inclusive of the wide diversity of primary caregiving units in our culture. Family is a birth, foster, adoptive or self-created unit of people residing together, with significant attachment to the individual, consisting of adult(s) and/or child(ren), with adult(s) performing duties of parenthood/caregiving for the child(ren) even if the individual is living outside of the home.

**“Family of One”:** A commonly used phrase to describe a child that becomes eligible for Medicaid through use of institutional eligibility rules for certain medically needy individuals. These rules allow a budgeting methodology for children to meet Medicaid financial eligibility criteria as a “family of one,” using the child’s own income and disregarding parental income.

**Home Setting or Community Setting:** Home setting or community setting means the setting in which children primarily reside or spend time, as long as it is not a hospital nursing facility, , Intermediate Care Facility (ICF), or psychiatric nursing facility. Note: this is distinguished from a Home and Community Based setting. These State Plan services do not have to comply with the HCBS settings rule, 42 CFR 441.301 and 530.

**Medicaid Eligible Child:** Any child in New York State who is eligible for Medicaid, whether eligible via income consideration, medically needy definitions or categorical eligibility (e.g., foster care).

**Medically Fragile:** A “medically fragile child” (MFC) is defined as an individual who is under 21 years of age and has a chronic debilitating condition or conditions, and who requires a complex medication regimen or medical interventions to maintain or to improve their health status.

**Licensed Practitioner of the Healing Arts:** An individual professional who is licensed as a Registered Professional Nurse, Nurse Practitioner, Psychiatrist, Licensed Psychologist, Licensed Psychoanalyst, Licensed Master Social Worker (LMSW), Licensed Clinical Social Worker (LCSW), Licensed Marriage & Family Therapist, Licensed Mental Health Counselor, or Physician (per OMH 599 regulations) and practicing within the scope of their State license to recommend Rehabilitation services. Clinical Nurse Specialist, Licensed Master Social Worker, and Physician Assistants who are licensed and practicing within the scope of their State license may recommend Rehabilitation services, only where noted in the approved State Plan and manual.

**Natural Supports:** Natural supports are individuals and informal resources that a family/caregiver can access, independent of formal services. These supports are a significant source of culturally relevant emotional support and caring friendships for children and families. Natural supports can be short-term or long-term and are usually sustainable and available to the child and family/caregiver after formal services have ended.

**Non-Physician Licensed Behavioral Health Professional (NP-LBHP):** NP-LBHPs include individuals licensed and able to practice independently for which reimbursement is authorized under the Other Licensed Practitioner section of the Medicaid State Plan.

Note: Non-physician Licensed Behavioral Health Practitioner (NP-LBHP) includes:

- Licensed Psychoanalyst
- Licensed Clinical Social Worker (LCSW)
- Licensed Marriage & Family Therapist (LMFT)
- Licensed Mental Health Counselor (LMHC)

A NP-LBHP also includes the following individuals who are licensed to practice under supervision or direction of a Licensed Clinical Social Worker (LCSW), a Licensed Psychologist, or a Psychiatrist:

- Licensed Master Social Worker (LMSW)

Note: Psychiatrists, Licensed Physician Assistants, Licensed Physicians, Psychologists, and Licensed Nurse Practitioners are also licensed, but services by these practitioners authorized for Medicaid reimbursement under another authority in the Medicaid State Plan. Information regarding the service reimbursement of these practitioners is included in this manual for the convenience of provider agencies.

**Person-Centered Care:** Services should reflect a child and family's goals and emphasize shared decision-making approaches that empower families, provide choice, and minimize stigma. Services should be designed to optimally treat illness, improve clinical and psychosocial outcomes, and emphasize wellness and attention to the family's overall well-being and the child's full community inclusion.

**Physical Disability:** “Disability” under Social Security is based on one’s inability to work. A person is considered disabled under Social Security rules if: they cannot do work that s/he did before; SSA decides that s/he cannot adjust to other work because of his/her medical condition(s); and his/her disability has lasted or is expected to last for at least one year or to result in death.

**Psychoeducation:** Assisting the child and family members or other collateral supports to identify strategies or treatment options associated with:

- The child’s behavioral health needs;
- The goal of preventing or minimizing the negative effects of mental illness symptoms or emotional disturbances; or
- Substance use or associated environmental stressors which interfere with the child’s daily living, academic progress, resilience, family/caregiver and/or interpersonal relationships, and community integration.

**Recommend:** A Licensed practitioner of the healing arts may advise or suggest State Plan services for a child/youth, as specified, within operation of scope of their State License. Recommendation of services for a child/youth shall be based on the child/youth’s identified needs. Federal regulations require that a licensed practitioner of the healing arts recommend services under the Rehabilitation Authority in order to be reimbursed by Medicaid.

**Recovery-Oriented:** Services should be provided based on the principle that all individuals have the capacity to recover from mental illness and/or substance use disorders. Specifically, services should support the acquisition of living, vocational, and social skills and be offered in home and community-based settings that promote hope and encourage each person to establish an individual path towards recovery.

**Rehabilitative services-** Within the context of these State Plan Services for children under 21 years of age, rehabilitative services refer to behavioral health services that help a child/youth keep, restore, or improve skills and functioning for daily living and skills related to communication that have been lost or impaired. Rehabilitative services under the new children’s State Plan Amendment are primarily provided by unlicensed practitioners within qualified provider agencies complying with the requirements outlined in this policy manual.

**Restoration:** Returning to a previous level of functioning.

**School Setting:** The place in which a child/youth attends school.

**Serious Emotional Disturbance (SED):** A designated mental illness diagnosis according to the most current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) for a child or adolescent who has experienced functional limitations due to emotional disturbance over the past 12 months on a continuous or intermittent

basis. The functional limitations must be moderate in at least two of the following areas or severe in at least one of the following areas:

- Ability to care for self (e.g. personal hygiene; obtaining and eating food; dressing; avoiding injuries); or
- Family life (e.g. capacity to live in a family or family like environment; relationships with parents or substitute parents, siblings and other relatives; behavior in family setting); or
- Social relationships (e.g. establishing and maintaining friendships; interpersonal interactions with peers, neighbors and other adults; social skills; compliance with social norms; play and appropriate use of leisure time); or
- Self-direction/self-control (e.g. ability to sustain focused attention for a long enough period of time to permit completion of age-appropriate tasks; behavioral self-control; appropriate judgment and value systems; decision-making ability); or
- Ability to learn (e.g. school achievement and attendance; receptive and expressive language; relationships with teachers; behavior in school).

**Service Provider:** Individuals/organizations that provide and are paid to provide services to the youth and family/caregiver.

**Substance Use Disorder (SUD):** A diagnosis of a substance use disorder is based on a pathological pattern of behaviors related to the use of the substance. The diagnosis of a substance use disorder is based on criteria defined in the current Diagnostic and Statistical Manual of Mental Disorders (DSM) and can be applied to all ten classes of drugs including: alcohol; cannabis; hallucinogens; inhalants; opioids; sedatives, hypnotics, anxiolytics; stimulants; tobacco; and other (or unknown) substances.

**Telemedicine:** The use of interactive audio and video telecommunications technology to support "real time" interactive patient care and consultations between healthcare practitioners and patients at a distance. The medical specialist providing the consultation or service is located at a distant site or "hub." The referring healthcare practitioner and patient are located at the originating site or "spoke." NYS has outlined requirements on how telemedicine can be utilized and reimbursed in the context of Medicaid service delivery (<http://public.leginfo.state.ny.us/lawssrch.cgi?NVLWO> and Select LAWS; select PBH; select Article 28; select 2805U).

**Trauma-Informed:** Trauma-informed services are based on an understanding of the vulnerabilities or triggers experienced by trauma survivors that may be exacerbated through traditional service delivery approaches so that these services and programs can be modified to be more supportive and avoid re-traumatization. All programs should engage all individuals with the assumption that trauma has occurred within their lives (SAMHSA, 2014).

**Treatment Plan:** A treatment plan describes the child's condition and services that will be needed, detailing the practices to be provided, expected outcome, and expected

duration of the treatment. The treatment plan should be culturally relevant, trauma informed, and person-centered.

**Warm handoff:** An approach in which a current provider of a child/family facilitates an introduction to another provider to which the child/family is being referred and/or schedules a follow up appointment.

**Youth:** Individuals generally 14 years of age and older

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### III. State Plan Service Definitions

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#### Other Licensed Practitioner

##### Definition

A non-physician licensed behavioral health practitioner (NP-LBHP) is an individual who is licensed in the State of New York to prescribe, diagnose, and/or treat individuals with a physical, mental illness, substance use disorder, or functional limitations at issue, operating within the scope of practice defined in State law and in any setting permissible under State practice law. This service allows for the delivery of services in the community in order to effectively engage children and youth. Services delivered in the community are to be within appropriate parameters.

This Medicaid reimbursement authority reimburses qualified NP-LBHP providing services within their scope of practice in a variety of settings and billed using CPT codes.

- Similar to Physician Service Authority in the Medicaid State Plan, OLP authority outlines the practitioner type licensed under state law and any prohibitions under Medicaid reimbursement.
- Unlike the Rehabilitation Authority in the Medicaid State Plan, the OLP authority does not outline every activity that Medicaid reimburses the NP-LBHP, and instead, only lists limitations.
- OLP is the authority that covers the services provided by the NP-LBHP listed in this section of the State Plan.

##### Activities

Activities would include:

- Recommending treatment that also considers trauma-informed, cultural variables and nuances
- Individual, family, and/or group outpatient psychotherapy and behavioral health assessment, evaluation, and testing consistent with the American Medical Association (AMA) definitions of the covered Current Procedural Terminology (CPT) codes and other activities within the scope of all applicable state laws and their professional license.
  - Licensed practitioners who are licensed in the State to prescribe, diagnose and/or treat individuals with mental disability or functional limitations at issue, and operating within the scope of practice defined in State law (only includes: Psychologist, Licensed Marriage and Family Therapist, Licensed Mental Health Counselor, Licensed Clinical Social Worker or Advance Practice Registered Nurse). OLPs are encouraged to receive up-to-date evidence-based training that can be incorporated into their practices on an on-going basis – such as trauma-focused Cognitive Behavior Therapy. If certification is required to provide a specific therapy, the licensed practitioners must obtain the certification to offer the therapy. At a minimum, licensed practitioners will provide assessment,

person-centered individualized treatment planning, individual, family and group therapy, and behavioral interventions as medically necessary to restore the individual's functioning. There must be at least a reevaluation of the plan on a periodic basis recommended to be 90-180 days. If at the time of reevaluation the individual has not made progress, the practitioner should modify the treatment plan or suggest another level of care which might include discharge or additional treatment to assist the individual.

### **Modality**

- Individual
- Family
- Groups. Composition of members should share common characteristics, such as related experiences, developmental age, chronological age, challenges or treatment goals.

### **Setting**

Services should be offered in the setting best suited for desired outcomes, including home, or other community- based setting in compliance with State practice law, including telemedicine as per New York State requirements.

Consultations, office visits, individual psychotherapy and pharmacological management services may be reimbursed when provided via telecommunication technology. Any use of telemedicine for the purposes of OLP must be within the NYS guidelines governing the services and professions allowed to conduct services in that manner (<http://public.leginfo.state.ny.us/lawssrch.cgi?NVLWO> and Select LAWS; select PBH; select Article 28; select 2805U).

### **Admissions/Continued Stay/Discharge Criteria**

*[MARCH 2016 NOTE: More defined medical necessity criteria is in development. Upon finalization, language will be added to the Provider Manual.]*

Service included in benefit plan:

All Medicaid eligible children under the age of 21 who meet medical necessity may receive this service.

Medical necessity includes any treatment that:

- Corrects or ameliorates chronic conditions that are found through an EPSDT screening OR
- Addresses the prevention, diagnosis, and treatment of health impairments; the ability to achieve age-appropriate growth and development; and the ability to attain, maintain or regain functional capacity.

## EXAMPLES:

- A child is diagnosed with mild depression as a result of anxiety. An assessment and two therapy visits are provided within the home to assist the child with developmentally appropriate activities.
- A child who uses a wheel chair for mobility is feeling isolated. He is unable to get to the clinic and the OLP provides psychotherapy to him in the home.
- A child with developmental disabilities is struggling with social skills and anxiety. The LFMT meets with the child within the community to foster engagement and socialization skills.
- If a child needs assistance in the schools (educationally necessary) and a school employee will be providing the service, the service must be on the child's Individualized Education Plan (IEP) (504 plan services are not reimbursable by Medicaid).
- If a child requires medically necessary services that are best delivered in the school setting by a community provider the service needs to be detailed on the treatment plan.

## Discharge Criteria:

- The child has successfully reached individually-established goals for discharge.
- The child/youth/family has been involved in the discharge process.

## Limitations/Exclusions

- Groups should not exceed more than 6-8 members. Consideration may be given to a smaller limit of members if participants are younger than eight years of age.
- Inpatient hospital visits by these licensed practitioners are limited to those ordered by the child's physician.
- Visits to nursing facilities are allowed for licensed professionals other than social workers if a Preadmission Screening and Resident Review (PASRR) indicate it is medically necessary treatment. Social worker visits are included in the Nursing Facility Visit and may not be billed separately.
- Visits to Intermediate Care Facilities for Individuals with Mental Retardation (ICF-MR) are non-covered.
- All NP-LBHP services provided while a person is a resident of an Institution for Mental Diseases (IMD), such as a free standing psychiatric hospital or psychiatric residential treatment facility, are part of the institutional service and not otherwise

reimbursable by Medicaid.

*[MARCH 2016 NOTE: There will be additional limitations, which are under development. Once finalized, the Provider Manual will be updated.]*

## **Certification/Provider Qualifications**

### **Provider Agency Qualification:**

- Any practitioner providing behavioral health services must operate within a child serving agency or agency with children's behavioral health and health experience that is licensed, certified or designated by DOH, OASAS, OCFS, or OMH in settings permissible by that designation.

In addition, DOH, OASAS, OCFS, or OMH may designate additional provider agencies as needed to address particular accessibility needs of the child behavioral health population using the process noted in the Appendix. In all cases, the newly designated provider agency meet and must comply with the following requirements:

- Providers and practitioners adhere to all Medicaid requirements in this manual and in other applicable provider manuals, regulations and statutes.
- Providers shall adhere to cultural competency guidelines (See Appendix A.)
- Providers must be knowledgeable and have experience in trauma-informed care and working with individuals from the cultural groups of those being served.
- These provider agencies shall ensure that staff receive Mandated Reporting training which is provided throughout New York State and Personal Safety in the Community training prior to service delivery.
- The provider agency will ensure that practitioners maintain the licensure necessary to provide services under their scope of practice under State law.
- The provider agency will ensure that any insurance required by the designating state agency is obtained and maintained.
- The provider agency will ensure that any safety precautions needed to protect the child population served are taken as necessary and required by the designating State agency.

*[MARCH 2016 NOTE: The provider designation criteria and process is under development. Once finalized, it will be incorporated into this Provider Manual.]*

### **Individual Staff Qualifications:**

NP-LBHPs include individuals licensed and able to practice independently as a:

- Licensed Psychoanalyst
- Licensed Clinical Social Worker (LCSW)
- Licensed Marriage & Family Therapist
- Licensed Mental Health Counselor

A NP-LBHP also includes the following individuals who are licensed to practice under supervision or direction of a Licensed Clinical Social Worker (LCSW), a Licensed Psychologist, or a Psychiatrist:

- Licensed Masters Social Workers (LMSW)

Note: Psychiatrists, Licensed Physician Assistants, Licensed Physicians, Psychologists, and Licensed Nurse Practitioners are already covered in the State Plan under different State Plan Authorities. References to these practitioners are included in this manual to simplify billing instructions for provider agencies. See coding and scope of practice as outlined below.

### **Training Requirements**

- In addition to licensure, service providers that offer addiction services must demonstrate competency as defined by the Department of Health, state law and regulations (14 NYCRR 853.2).
- Evidence-Based Practices (EBP) require prior approval, designations, and fidelity reviews on an ongoing basis as determined necessary by New York State EBP Review Team.
  - The Institute of Medicine (IOM) defines "evidence-based practice" as a combination of the following three factors: (1) best research evidence, (2) best clinical experience, and (3) consistent with patient values (Institute of Medicine, 2001. *Crossing the quality chasm: A new health system for the 21st century*. Washington, DC: National Academy Press).
  - Implemented interventions using evidence-based techniques may ameliorate targeted symptoms and/or recover the person's capacity to cope with or prevent symptom manifestation.
  - Guidelines and instructions on how to become designated to deliver a specific EBP under OLP can be found in (Appendix D).

### **Billing Codes**

A unit of service is defined according to the Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) approved code set consistent with the National Correct Coding Initiative unless otherwise specified.

*[MARCH 2016 NOTE: As billing methodology and coding structure are finalized, this section of the Provider Manual will be augmented.]*

## Crisis Intervention (CI)

### Definition

All children/youth who are identified as experiencing a seriously acute psychological/emotional change which results in a marked increase in personal distress and which exceeds the abilities and the resources of those involved (e.g., collateral, provider, community member) to effectively resolve it are eligible for crisis intervention.

Crisis Intervention (CI) services are provided to a child under age 21, and his/her family/caregiver, who is experiencing a psychiatric or substance use (behavioral health) crisis, and are designed to:

- Interrupt and/or ameliorate the crisis experience
- Include an assessment that is culturally and linguistically sensitive
- Result in immediate crisis resolution and de-escalation
- Development of a Safety plan

Family is defined as the primary care-giving unit and is inclusive of the wide diversity of primary caregiving units in our culture. Family is a birth, foster, adoptive, or self-created unit of people residing together, with significant attachment to the individual, consisting of adult(s) and/or child(ren), with adult(s) performing duties of parenthood/caregiving for the child(ren) even if the individual is living outside of the home.

The goals of CI are engagement, symptom reduction, stabilization, and restoring individuals to a previous level of functioning or developing the coping mechanisms to minimize or prevent the crisis in the future.

### Service Components

Crisis Intervention services are provided on weekdays/evenings/weekend hours. CI services should follow any established crisis plan already developed for the beneficiary, if it is known to the team to the extent possible. If there isn't an established crisis plan, the CI team is expected to develop a crisis plan which should include components addressing safety with the child and family/caregiver. The CI activities must be intended to achieve identified care plan goals or objectives.

CI services include the following components:

- 24/7 availability and capacity to respond within one hour of call
- Callers are connected to a crisis specialist who triages the call
  - Triage may include an option of transferal to 911 if individual or others are in immediate danger.
  - The CI team should be dispatched in conjunction with 911.
- An assessment of risk, mental status and medical stability; and the need for further evaluation or other health/behavioral health services.
  - Includes engagement with the child, family/caregiver or other collateral sources (e.g. school personnel) that is culturally and linguistically

sensitive, child centered and family focused in addition to trauma-informed to:

- Determine level of safety, risk, and to plan for the next level of services, including treatment and/or referral to other alternative mental health/chemical dependency services at an appropriate level.
- CI includes crisis resolution and de-briefing with the identified Medicaid eligible child, the child's family/caregiver, and the treatment provider
- Development of a crisis plan which is expected to address safety measures in the appropriate reading levels of the child and wherever possible in the preferred language of recipient, addressing cultural issues. The safety plan addresses:
  - Immediate circumstances
  - Prevention of future crises
  - Signing of appropriate consent for releases for follow up referrals to services and/or collaboration with existing providers of recipients.
- Consultation with a physician or other licensed practitioner of the healing arts to assist with the child's specific crisis and planning for future service access.
- Follow-up with the child and family/caregiver within 24 hours of initial contact/response should include, whenever possible, informing any existing primary care, behavioral health treatment provider or care coordinator of the developed crisis plan. The entity that the person is referred to conducts an evaluation/assessment for additional longer term service.
- Referral and linkage to appropriate community services to avoid more restrictive levels of treatment.
  - It is the expectation that there will be documented follow-up to referrals of needed services to ensure that child and caregiver are linked to those services.

### **Modality**

Individual face-to-face intervention with the child and their caregiver/collateral with expected follow-up in person or by phone.

### **Setting**

Service delivery can occur in a variety of settings, including an emergency room or health/behavioral health clinic setting, or other community locations where the child lives, attends school, works, engages in services (e.g. provider office sites), and/or socializes. Coordination between emergency room staff and crisis service providers will divert from inpatient admissions when appropriate.

## **Admissions/Continued Stay/Discharge Criteria**

The service is recommended by any of the following licensed practitioners of the healing arts operating within the scope of their practice of their State license, who may or may not be part of the crisis intervention team: Psychiatrist, Physician, Licensed Psychoanalyst, Registered Professional Nurse, Nurse Practitioner, Clinical Nurse Specialist, Licensed Clinical Social Worker (LCSW), Licensed Marriage and Family Therapist, Licensed Mental Health Counselor, or Licensed Psychologist. All activities must occur within the context of a potential or actual behavioral health crisis with a desired outcome of diverting an emergency room visit and/or inpatient admission, when appropriate.

- The family/caregiver may request assistance with a crisis as defined by the family/caregiver to prevent out-of-home placement or violence, to maintain safety of the child or others in the home, or to address other conflicts as necessary for the emotional health, development and safety of the child.
- Screening for Substance Use Disorders should be addressed in an integrated fashion as it may add to the risk and increase the need for engagement in care. Crisis services should not be denied based upon the use of alcohol and/or drugs. Crisis Team members should be trained on screening for substance use disorders.

Discharge criteria:

- The child demonstrates engagement, symptom reduction, stabilization, and restoration or developing the coping mechanisms to pre-crisis level of functioning.
- It is the expectation that 24-hour follow up should be facilitated.
- It is the expectation that a warm handoff to needed services should be facilitated. Documentation must reflect resolution of the crisis which marked the end of the episode upon warm handoff to needed services; to include a referral for chemical dependency services, if indicated.
- The child/youth/family has been involved in the discharge process.

## **Limitations/Exclusions**

Within the 72 hour timeframe of a crisis, de-escalation techniques are utilized in an attempt to calm the child; information is gathered from the child, family, and/or other collateral supports on what may have triggered the crisis; information is gathered on the child's history; review of medications occurs, as appropriate, and a crisis plan is developed with the child/family. Warm handoff to providers of needed services should also be occurring following these expectations.

The following activities are excluded: financial management, supportive housing, supportive employment services, and basic skill acquisition services that are habilitative in nature.

Once the current crisis episode and follow up exceeds 72 hours, then it shall be considered a new crisis intervention episode or will be transferred to a longer term service for rehabilitation skill-building such as CPST. An episode is defined as starting with the initial face to face contact with the child.

The child's chart must reflect resolution of the crisis within the 72 hour period which marks the end of the episode. If the child has another crisis within the 72 hour timeframe of an episode, it shall be considered part of that episode and a new episode will not be billable. Warm handoff to follow up services with a developed plan should follow.

## **Certification/Provider Qualifications**

### **Provider Agency Qualification:**

CI practitioners must work within agencies that possess a current license to provide crisis and/or crisis treatment services (i.e., clinic, Comprehensive Psychiatric Emergency Programs - CPEP), or any child serving agency or agency with children's behavioral health and health experience that is licensed, certified or designated by DOH, OASAS, OCFS, or OMH to provide comparable and appropriate crisis services referenced in the definition.

*[MARCH 2016 NOTE: The provider designation criteria and process is under development. Once finalized, it will be incorporated into this Provider Manual.]*

### **Individual Staff Qualifications:**

- Services should be provided by a culturally competent, trauma-informed, and linguistically responsive multidisciplinary team (at least two individuals), for programmatic or safety purposes, which includes two licensed practitioners among these professions: Licensed Clinical Social Worker (LCSW), Licensed Master Social Worker (LMSW), Licensed Mental Health Counselor, Licensed Psychologist, Licensed Marriage and Family Therapist, or Nurse Practitioner with experience/background treatment mental health and/or substance use disorders.

OR

One practitioner from the above list and one practitioner from the following:

- Credentialed alcoholism and substance abuse counselor
- Credentialed family peer advocate with lived experience as a family member  
Certified Recovery Peer Advocate- Family

- Credentialed Rehabilitation Counselor
- Registered Professional Nurse

If one member of the crisis intervention team is a Peer support specialist, the Peer support provider must have a credential as either: 1) an OMH established Family Peer Advocate, or 2) an OASAS established Certified Recovery Peer-Family Advocate–

Family Peer Support will be delivered by a New York State Credentialed Family Peer Advocate (FPA). To be eligible for the FPA Credential, the individual must:

- Demonstrate ‘lived experience’ as a parent or primary caregiver who has navigated multiple child serving systems on behalf of their child(ren) with social, emotional, developmental, health and/or behavioral healthcare needs.
- Have a high school diploma, high school equivalency preferred or a State Education Commencement Credential (e.g. SACC or CDOS)
- Complete Level One and Level Two of the Parent Empowerment Program (PEP) training or approved comparable training.
- Submit three letters of reference attesting to proficiency in and suitability for the role of a Family Peer Advocate (FPA) including one from the FPA’s supervisor.
- Agree to practice according to the Family Peer Advocate Code of Ethics.
- Complete 20 hours of continuing education and renew their FPA credential every two years.

An FPA may obtain a provisional credential that will allow services they provide to be billed if the applicant has:

- Demonstrated ‘lived experience’ as a parent or primary caregiver who has navigated multiple child serving systems on behalf of their child(ren) with social, emotional, developmental, health and/or behavioral healthcare needs.
- A high school diploma, high school equivalency preferred or a State Education Commencement Credential (e.g. SACC or CDOS)
- Complete Level One of the Parent Empowerment Program (PEP) training or approved comparable training.
- Submitted two letters of reference attesting to proficiency in and suitability for the role of a Family Peer Advocate (FPA).

An FPA with a Level One provisional credential must complete all other requirements of the full credential within 18 months of employment as an FPA. OR

Family Peer Support will be delivered by a Certified Recovery Peer Advocate (CRPA) with a Family Specialty. To be certified as CPRA-Family, the individual must be at least 18 years of age and have the following:

- Have lived experience as a family member impacted by youth substance use disorders. The CRPA – Family may be in recovery themselves.
- Have a high school diploma or a State Education Commencement Credential or General Equivalency Degree (GED)
- Complete a minimum of 46 hours of content specific training, covering the topics: advocacy ,mentoring/education, recovery/wellness support, medication assisted treatment and ethical responsibility
- Document 1,000 hours of related work experience, or document at least 500 hours of related work experience if they: have a bachelor’s degree; are credentialed by OASAS as a CASAC, CASAC Trainee, or Prevention Professional; or completed the 30-Hour Recovery Coach Academy training
- Provide evidence of at least 25 hours of supervision specific to the performance domains of advocacy, mentoring/education, recovery/wellness support, and ethical responsibility. Supervision must be provided by an organization documented and qualified to provide supervision per job description.
- Pass the NYCB/IC&RC Peer Advocate Exam or other exam by an OASAS designated certifying body
- Submit two letters of recommendation
- Demonstrate a minimum of 16 hours in the area of Family Support
- Complete 20 hours of continuing education earned every two years, including six hours of Ethics.

NOTE: The peer may **NOT** provide the following service components of Crisis Intervention:

- Assessment
  - Assessment of risk, mental status, medical stability, and the need for further evaluation and/or other health/behavioral health services.
- Service Planning
  - Development of a safety plan, which addresses the immediate circumstances and the prevention of future crisis, and signing of appropriate releases.
- Care Coordination
  - Consultation with a licensed practitioner to assist with the child’s specific crisis and planning for future service access.
  - Referral and linkage to other Medicaid services to avoid more restrictive levels of treatment.
  - Documented follow up within 24 hours of initial contact/response.

**Supervisor Qualification:**

- The supervisor must be at least a Licensed Clinical Social Worker (LCSW) but may include: Licensed Psychologists, or Physicians. The supervisor must practice within the State health practice laws and ensure that providers are

supervised as required under state law. For example, if a psychiatric nurse practitioner is on the team with fewer than 3,600 hours of experience, a psychiatrist must be on the team and supervise him/her.

- Supervisors must also be aware of and sensitive to trauma informed care and the cultural needs of the population of focus and how to best meet those needs, and be capable of training staff regarding these issues.

### Training Requirements:

- Peer support providers must have a certification as one of the following:
  - OMH established Family Peer Advocate
  - OASAS established Certified Recovery Peer Advocate- Family
- All Practitioners delivering Crisis Intervention services must have training provided in the following areas:

Service Type	Trainings Required	Requirement Completion Timeframe	Recertification Timeframe
Crisis Intervention (CI)	<ul style="list-style-type: none"> <li>• First Aid</li> <li>• Cardiopulmonary Resuscitation (CPR)</li> <li>• Crisis De-escalation, Resolution and Debriefing</li> <li>• Suicide Prevention (e.g. SAFETALK)</li> <li>• Safety Plan Development</li> </ul>	Prior to delivery of the service	

### Service Specific Training Recommendations:

Training:	Content Areas:	Training Resources Available:
<u>Domestic Violence: Signs and Intervention</u>	<ul style="list-style-type: none"> <li>• Key components of domestic violence (DV)</li> <li>• Tactics of coercive control</li> <li>• Different types of DV</li> <li>• Characteristics of batterers and what they are like as parents</li> <li>• Impact on victims and their parenting</li> <li>• Impact of DV on children – trauma-its effect on developing brain</li> <li>• Characteristics of children exposed to DV and how other factors may influence a child's response</li> <li>• Screening and risk assessment tools</li> <li>• How to introduce topic of DV to a potential victim</li> <li>• What not to do</li> </ul>	<a href="http://www.nyscadv.org/training-and-technical-assistance/">http://www.nyscadv.org/training-and-technical-assistance/</a>  <a href="http://www.ncdsv.org/ncd_upcomingtrainings.html#Ongoing">http://www.ncdsv.org/ncd_upcomingtrainings.html#Ongoing</a>  <a href="http://www.opdv.ny.gov/">http://www.opdv.ny.gov/</a>

	<ul style="list-style-type: none"> <li>• Interventions- safety assessment and planning</li> <li>• Documentation</li> <li>• Referrals</li> </ul>	
<u>Linkage Facilitation (Bridging and Transition Support)</u>		
<u>Medications: Intended effects; Interactions; and Side Effects</u>		
<u>Motivational Interviewing</u>		
<u>Personal Safety in the Community</u>		
<u>Substance Use: Signs/Symptoms</u>	<ul style="list-style-type: none"> <li>• Frequently Abused Drugs and Drug Combinations</li> </ul>	

Practitioners are encouraged to review knowledge base and skills the State recommends for providers who will be delivering the new State Plan services to children in order to demonstrate competency (See Appendix B).

### **Staffing Ratio/Caseload Size**

N/A

### **Billing**

A unit of service is defined according to the Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) approved code set consistent with the National Correct Coding Initiative unless otherwise specified.

*[MARCH 2016 NOTE: As billing methodology and coding structure are finalized, this section of the Provider Manual will be augmented.]*

## Community Psychiatric Support and Treatment (CPST)

### Definition

CPST services are goal-directed supports and solution-focused interventions intended to achieve identified goals or objectives as set forth in the child's treatment plan.

CPST is designed to provide community-based services to children and families who may have difficulty engaging in formal office settings, but can benefit from community based rehabilitative services. CPST allows for delivery of services within a variety of permissible of settings including community locations where the beneficiary lives, works, attends school, engages in services (e.g. provider office sites), and/or socializes, or in an office.

Family is defined as the primary care-giving unit and is inclusive of the wide diversity of primary caregiving units in our culture. Family is a birth, foster, adoptive or self-created unit of people residing together, with significant attachment to the individual, consisting of adult(s) and/or child(ren), with adult(s) performing duties of parenthood/caregiving for the child(ren) even if the individual is living outside of the home.

### Service Components

The service may include one or more of the following components tailored to meet the needs of the individuals, including:

#### 1. Rehabilitative Psychoeducation:

- Assisting the child and family members or other collateral supports to identify appropriate strategies or treatment options associated with:
  - The child's behavioral health needs;
  - The goal of preventing or minimizing the negative effects of mental illness symptoms or emotional disturbances;
  - Substance use or associated environmental stressors which interfere with the child's daily living, academic progress, resilience, family/caregiver and/or interpersonal relationships, and community integration;
  - Rehabilitative supports in the community; and,
  - Provide restoration, rehabilitation, and support to the child and family members, caregiver, or other collateral supports to develop skills necessary to meet the child's employment housing and education goals, and to sustain the identified community goals.

#### 2. Intensive Interventions:

- Assist the child with social, interpersonal, self-care, daily living, and independent living skills to restore stability, to support functional gains and to adapt to community living through providing:
  - Individual treatment and counseling and/or relationship based supportive counseling

- Solution focused interventions
- Harm Reduction
- Emotional, cognitive, and behavioral management
- Problem behavior analysis

This includes the implementation of interventions using evidence-based techniques, drawn from cognitive-behavioral therapy and/or other evidence-based psychotherapeutic interventions with prior authorization from the New York State EBP Review Team (See Appendix D) that ameliorate targeted symptoms and/or recover the person's capacity to cope with or prevent symptom manifestation.

**3. Strengths based treatment planning -**

- Facilitating participation in and utilization of strengths-based planning for Medicaid services and treatments related to the child's behavioral health/health needs which include:
  - Assisting the child and family members, caregiver, or other collateral supports with identifying strengths and needs, resources, and natural supports, within the context of the client's culture
  - Developing goals and objectives to utilize personal strengths, resources, and natural supports to address functional deficits associated with their behavioral health disorder

**4. Rehabilitative Supports:** Restoration, rehabilitation and support to minimize the negative effects of behavioral health symptoms or emotional disturbances that interfere with the individual's daily living. This includes improving life safety skills such as ability to access emergency services, basic safety practices and evacuation, physical and behavioral health care (maintenance, scheduling physician appointments), recognizing when to contact a physician, self-administration of medication for physical and mental health or substance use disorder conditions, understanding the purpose and possible side effects of medication prescribed for conditions, and other common prescription and non-prescription drugs and drug uses.

**5. Crisis Avoidance:**

- Assisting the child and family/caregiver with effectively responding to or preventing identified precursors or triggers that would risk the child remaining in a natural community location, including:
  - Assisting the child and family members, caregivers, or other collateral supports with identifying a potential psychiatric or personal crisis
  - Practicing de-escalation skills
  - Developing a crisis management plan
  - Assessment of the step-by-step plan before a crisis occurs
  - Strategies to take medication regularly
  - Seeking other supports to restore stability and functioning

## 6. Intermediate term crisis management:

- Provide intermediate term crisis management to families following a crisis (beyond 72-hour period), as stated in the crisis management plan. Crisis Intervention may or may not have been provided first depending upon whether or not the child was already receiving services. This service is intended to be stability focused and relationship based for existing clients of CPST services or children needing longer term crisis management services. The purpose of this activity is to:
  - Stabilize the child/youth in the home and natural environment
  - Assist with goal setting to focus on the issues identified from mobile crisis intervention, emergency room crisis, and other referrals

### Modality

- Individual face-to-face intervention
- Group face-to-face may occur for Rehabilitative Supports
  - Group should not exceed more than 6-8 members. Consideration may be given to a smaller limit of members if participants are younger than eight years of age.

### Setting

Services should be offered in the setting best suited for desired outcomes, including home or other community-based settings where the beneficiary lives, works, attends school, engages in services (e.g. provider office sites), socializes,

### Admissions/Continued Stay/Discharge Criteria

A child with a single developmental disability diagnosis is ineligible to receive this rehabilitative service.

*[MARCH 2016 NOTE: More defined medical necessity criteria is in development. Upon finalization, language will be added to the Provider Manual.]*

Services included in benefit plan:

This service is recommended by any of the following licensed practitioners of the healing arts operating within the scope of their practice under State license: Licensed Master Social Worker (LMSW), Licensed Clinical Social Worker (LCSW), Licensed Mental Health Counselor, Licensed Creative Arts Therapist, Licensed Marriage and Family Therapist, Licensed Psychoanalyst, Licensed Psychologist, Physician's Assistant, Psychiatrist, Physician, Registered Professional Nurse, Nurse Practitioner

- The service is included in the child's Care Plan
- The service is needed to allow the child the best opportunity to remain in the community (avoiding medical institutionalization)

- The service is directed at developing skills or achieving specific outcome(s) such as: increasing community tenure/ inclusion/participation, enhance personal relationships; establishing positive peer support networks; decreasing the use of alcohol and/other substances, and promoting abstinence from the misuse of alcohol and/or other drugs, increasing independence/ productivity; developing daily living skills to improve self-management of the effects of psychiatric or emotional symptoms that interfere with daily living; effectively responding to or avoiding identified precursors or triggers that result in functional impairments; increasing or maintaining personal self-sufficiency; and/or developing coping strategies and effective functioning in a social environment, including home, work and school
  - The child requires involvement of a licensed practitioner to help develop and achieve these outcomes
- The frequency and intensity of the service aligns with the unique needs of the child.

Examples include:

- Henry, a 15 year old boy, and his family are experiencing difficulties due to his alcohol and drug use. His substance use is inhibiting his daily functioning, personal growth, and interpersonal relationships. Henry attends group sessions, led by a licensed practitioner, for teens who are using drugs and alcohol. The masters level individual (CPST provider) visits the family at home to work on the identified goals within Henry's treatment plan. The CPST provider focuses on psycho education to inform Henry and his family about the negative effects of substance use and develop positive strategies to promote recovery. A child and his/her family who have a goal of improving their relationship, identifies the need for CPST once every two weeks to assess progress and make modifications when indicated.
- This service is designed to provide community-based services to children and families who may have difficulty engaging in formal office settings of programs or services, but can benefit from or prefer community based rehabilitative services.
- This service also includes but is not limited to relational based counseling for young children who currently have a mental health diagnosis or who are at risk of developing a mental health diagnosis.
  - (e.g., a designated mental health diagnosis under DC: 0-3R as per equivalent DSM or ICD codes).

Discharge criteria:

- The child has successfully reached individually-established treatment plan goals for discharge.
- The child/youth/family has been involved in the discharge process.

## Limitations/Exclusions

- CPST service delivery may also include collateral contact.
- Evidence-Based Practices (EBP) require prior approval, designations, and fidelity reviews on an ongoing basis as determined necessary by New York State EBP Review Team. (See Appendix D)
  - The Institute of Medicine (IOM) defines "evidence-based practice" as a combination of the following three factors: (1) best research evidence, (2) best clinical experience, and (3) consistent with patient values (IOM, 2001).<sup>1</sup>
  - Implemented interventions using evidence-based techniques may ameliorate targeted symptoms and/or recover the person's capacity to cope with or prevent symptom manifestation.
  - Guidelines and instructions on how to become designated to deliver a specific EBP under CPST can be found in (Appendix D).

*[MARCH 2016 NOTE: There will be additional limitations, which are under development. Once finalized, the Provider Manual will be updated.]*

## Certification/Provider Qualifications

### Provider Agency Qualification:

- Any child serving agency or agency with children's behavioral health and health experience that is licensed, certified, or designated by DOH, OASAS, OCFS, or OMH to provide comparable and appropriate services referenced in definition.

In addition, DOH, OASAS, OCFS, or OMH may designate additional provider agencies as needed to address particular accessibility needs of the child behavioral health population using the process noted in the Appendix. In all cases, the newly designated provider agency meet and must comply with the following requirements:

- Providers and practitioners adhere to all Medicaid requirements in this manual and in other applicable provider manuals, regulations and statutes.
- Providers shall adhere to cultural competency guidelines (See Appendix A.)
- Providers must be knowledgeable and have experience in trauma-informed care and working with individuals from the cultural groups of those being served.
- These provider agencies shall ensure that staff receive Mandated Reporting training which is provided throughout New York State and Personal Safety in the Community training prior to service delivery.

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<sup>1</sup> Institute of Medicine. (2001). *Crossing the quality chasm: A new health system for the 21st century*. Washington, DC: National Academy Press.

- The provider agency will ensure that the practitioners maintain the licensure necessary to provide the services under their scope of practice under State law.
- The provider agency will ensure that any insurance required by the designating state agency is obtained and maintained.
- The provider agency will ensure that any safety precautions needed to protect the child population served are taken as necessary and required by the designating State agency.

*[MARCH 2016 NOTE: The provider designation criteria and process is under development. Once finalized, it will be incorporated into this Provider Manual.]*

**Individual Staff Qualifications:**

- At least a bachelor’s degree level with a minimum of two years of applicable experience in children’s mental health, addiction, and/or foster care/child welfare/juvenile justice.
  - Practitioners with a bachelor’s degree may only perform the following activities under CPST: Rehabilitative Psychoeducation, Strengths based Treatment Planning, or Rehabilitative Supports.
- OR
- At least a bachelor’s degree level, certified in an Evidenced Based Practice, and designated by the State.
  - Practitioners with a bachelor’s degree and certification in an Evidence-Based Practice may perform all activities in CPST except: Intermediate Term Crisis Management
- OR
- A master’s degree level in social work, psychology, or in related human services plus one year of applicable experience OR who has been certified in an Evidenced Based Practice
- These practitioners include: Registered Professional Nurses with one year of behavioral health experience, Licensed Occupational Therapists, and Licensed Creative Arts Therapists to the extent they are operating under the scope of their license.
  - Practitioners with a master’s degree may perform any of the activities under CPST without any exclusions

**Supervisor Qualifications:**

- Individuals providing services under CPST must receive regularly scheduled supervision from a professional meeting the qualifications of at least a Licensed Clinical Social Worker (LCSW), Licensed Mental Health Counselor, Licensed Creative Arts Therapist, Licensed Marriage and Family Therapists, Licensed Psychoanalyst, Licensed Psychologist, Physician’s Assistant, Psychiatrist, Physician, Registered Professional Nurse, or Nurse Practitioner operating within the scope of their practice, with at least 2-3 years of work experience.

- Supervisors must also be aware of and sensitive to trauma informed care and the cultural needs of the population of focus and how to best meet those needs, and be capable of training staff regarding these issues.
- The interventions and skill building identified by the CPST practitioner and family may be implemented by the child and family with the assistance of a peer, Psychosocial Rehabilitation practitioner, or the CPST practitioner, if necessary.

### Training Requirements

Service Type	Trainings Required	Requirement Completion Timeframe	Recertification Timeframe
Community Psychiatric Support and Treatment (CPST)	<ul style="list-style-type: none"> <li>• Crisis Management and Avoidance Planning</li> <li>• Suicide Prevention (e.g. SAFETALK)</li> <li>• Individual, Group, Family Counseling (Within The Scope of License)</li> <li>• Solution-Focused Interventions (Within Scope of License)</li> <li>• Emotional, Cognitive and Behavior Management Techniques</li> <li>• Evidenced Based Practice certification (as appropriate per State designation)</li> </ul>		

Guidelines and instructions on how to become designated to deliver a specific EBP under CPST can be found in (Appendix D).

### Service Specific Training Recommendations:

Training:	Content Areas:	Training Resources Available:
<u>Domestic Violence: Signs and Intervention</u>	<ul style="list-style-type: none"> <li>• Key components of domestic violence (DV)</li> <li>• Tactics of coercive control</li> <li>• Different types of DV</li> <li>• Characteristics of batterers and what they are like as parents</li> <li>• Impact on victims and their parenting</li> <li>• Impact of DV on children – trauma-its effect on developing brain</li> <li>• Characteristics of children exposed to DV and how other factors may influence a child's response</li> <li>• Screening and risk assessment tools</li> <li>• How to introduce topic of DV to a potential victim</li> <li>• What not to do</li> <li>• Interventions- safety assessment and planning</li> </ul>	<a href="http://www.nyscadv.org/training-and-technical-assistance/">http://www.nyscadv.org/training-and-technical-assistance/</a>  <a href="http://www.ncdsv.org/ncd_upcomingtrainings.html#Ongoing">http://www.ncdsv.org/ncd_upcomingtrainings.html#Ongoing</a>  <a href="http://www.opdv.ny.gov/">http://www.opdv.ny.gov/</a>

	<ul style="list-style-type: none"> <li>• Documentation</li> <li>• Referrals</li> </ul>	
<u>Motivational Interviewing</u>		
<u>Personal Safety in the Community</u>		

Practitioners are encouraged to review knowledge base and skills the State recommends for providers who will be delivering the new State Plan services to children in order to demonstrate competency (See Appendix B).

### **Staffing Ratio/Caseload Size**

The caseload size must be based on the needs of the child/youth and families with an emphasis on successful outcomes, individual satisfaction, and meeting the needs identified in the treatment plan.

### **Billing**

A unit of service is defined according to the Healthcare Common Procedure Coding System (HCPCS) approved code set consistent with the National Correct Coding Initiative unless otherwise specified.

*[MARCH 2016 NOTE: As billing methodology and coding structure are finalized, this section of the Provider Manual will be augmented.]*

## Psychosocial Rehabilitation Services (PSR)

### Definition

Psychosocial Rehabilitation Services (PSR) are designed to work with children and their families to implement interventions outlined in the treatment plan to compensate for or eliminate functional deficits and interpersonal and/or environmental barriers associated with a child/youth's behavioral health needs. The intent of PSR is to restore, rehabilitate, and support a child/youth's functional level as much as possible and as necessary for the integration of the child/youth as an active and productive member of their community and family with minimal ongoing professional interventions. Activities included must be task oriented and intended to achieve the identified goals or objectives as set forth in the child/youth's individualized treatment plan.

Family is defined as the primary care-giving unit and is inclusive of the wide diversity of primary caregiving units in our culture. Family is a birth, foster, adoptive, or self-created unit of people residing together, with significant attachment to the individual, consisting of adult(s) and/or child(ren), with adult(s) performing duties of parenthood/caregiving for the child(ren) even if the individual is living outside of the home.

### Service Components

Service Components for PSR are defined broadly so that they may be provided to children within the context of each child's treatment plan.

**1. Personal and Community Competence** – Using rehabilitation interventions and individualized, collaborative, hands-on training to build developmentally appropriate skills. The intent is to promote personal independence, autonomy, and mutual supports by developing and strengthening the individual's independent community living skills and support community integration in the domains of employment, housing, education, in both personal and community life. This includes:

- **Social and Interpersonal Skills**, with the goal to restore, and support :
  - Increasing community tenure and avoiding more restrictive placements
  - Enhancing personal relationships
  - Establishing support networks
  - Increasing community awareness
  - Developing coping strategies and effective functioning in the individual's social environment, including home, work, and school locations.
- **Daily Living Skills**, with the goal to restore, rehabilitate and support:
  - Improving self-management of the negative effects of psychiatric, emotional, physical health, developmental, or substance use symptoms that interfere with a person's daily living
  - Support the individual with the development and implementation of daily living skills and daily routines necessary to remain in the home, school, work and community.
    - Wellness skills, such as:

- 
- Meal planning
    - Healthy shopping and meal preparation
    - Nutrition awareness
    - Exercise options
  - Personal autonomy skills, such as:
    - Learning to manage stress, unexpected daily events, and disruptions, behavioral health and physical health symptoms with confidence
    - Learning self-care
    - Developing and pursuing leisure and recreational interests
    - Managing free time comfortably
    - Transportation navigation
    - Managing money
    - Developing daily living skills specific to managing their own medications and learning self-care consistent with the directions of prescribers (e.g., setting an alarm to remind the child/youth when it is time to take a medication, developing reminders to take certain medications with food, writing reminders on a calendar when it is time to refill a medication)
    - Managing medications consistent with the directions of prescribers
    - Developing methods of communication with prescribers about medication side effects or medication issues (e.g., help the child/youth prepare for an upcoming appointment by encouraging them to write down questions or concerns to discuss with the prescribing clinician)
    - Gaining and/or regaining the ability to make independent choices and to take a proactive role in treatment, including discussing questions or concerns about medications, diagnoses, or treatment approaches with their treatment provider.
    - Using community resources
  - **Intervention Implementation**
    - Implementing learned skills (that may have been developed through CPST or OLP) so the child/youth can remain in a natural community location and achieve developmentally appropriate functioning in the following areas
      - **Social skills, such as:**
        - Positive recreational/leisure activities
        - Developing interpersonal skills when interacting with peers, establishing and maintaining friendships/a supportive social network while engaged in recovery plan.
        - Developing conversation skills and a positive sense of self to result in more positive peer interactions
        - Coaching on interpersonal skills and communication
        - Training on social etiquette

- Developing self-regulation skills including anger management
    - Engendering civic duty and volunteerism
  - Health skills, such as:
    - Developing constructive and comfortable interactions with health-care professionals
    - Relapse prevention planning strategies
    - Managing symptoms and medications
    - Re-Establishing good health routines and practices
  - Assisting the individual with effectively responding to or avoiding identified precursors or triggers that result in functional impairments
- Supporting the identification and pursuit of personal interests and hobbies
  - e.g., creative arts, reading, exercise, faith-based pursuits, cultural exploration
  - identify resources where interests can be enhanced and shared with others in the community
  - identify and connect to natural supports and resources, including family, community networks, and faith-based communities

### **Modality**

- Individual face-to-face intervention
- Group face-to-face intervention. Composition of members should share common characteristics, such as related experiences, developmental age, chronological age, challenges or treatment goals.
- PSR may include collateral contact, as long as the contact is directly related to the recipient's goals and treatment plan

### **Setting**

PSR can occur in a variety of settings including community locations where the child/youth lives, works, attends school, engages in services (e.g. provider office sites), and/or socializes.

### **Admissions/Continued Stay/Discharge Criteria**

*[MARCH 2016 NOTE: More defined medical necessity criteria is in development. Upon finalization, language will be added to the Provider Manual.]*

Service included in benefit plan:

- This service is recommended by any of the following licensed practitioners of the healing arts operating within the scope of their practice under State license: Licensed Master Social Worker (LMSW), Licensed Clinical Social Worker (LCSW), Licensed Mental Health Counselor, Licensed Creative Arts

Therapist, Licensed Marriage and Family Therapist, Licensed Psychoanalyst  
Licensed Psychologist, Physician's Assistant, Psychiatrist, Physician,  
Registered Professional Nurse, or Nurse Practitioner

- The service is included in the child/youth's Care Plan
- The service is needed to allow the child/youth the best opportunity to remain in the community.
- This service is directed at implementing the interventions already outlined in the treatment plan including developing skills or achieving specific outcome(s) such as: demonstration of autonomy, self-care, ability to perform activities of daily living, self-regulation, engagement in overall health regimen, awareness of community supports for discharge.
- The frequency and intensity of the service aligns with the unique needs of the child.

Examples:

- A child/youth is interested in playing soccer but has difficulties in socializing with other children. The child's clinician would recommend PSR in the individualized treatment plan with the intended goal of the child acquiring healthy social skills with others during soccer practice. The PSR provider assists the child in developing self-regulation techniques to prevent inappropriate outbursts during the child's soccer practice.
- Susie is a seventeen year old who is struggling with obesity. She attends outpatient therapy and developed a treatment plan with her licensed practitioner. One of the goals developed was to work on acquiring healthy wellness skills. The PSR provider has collateral contact with the licensed practitioner and is focusing on assisting Susie with meeting this goal in the community. The PSR provider works with Susie to improve her nutritional awareness and formulate a menu plan. Once a week, the PSR provider takes Susie to the local grocery store and helps her choose healthier food options when shopping.

Discharge criteria:

- The child/youth has successfully reached individually-established treatment plan goals for discharge.
- The child/youth/family has been involved in the discharge process.

### **Limitations/Exclusions**

- Group should not exceed more than 6-8 members. Consideration may be given to a smaller limit of members if participants are younger than eight years of age.
- The treatment plan should identify the medical or remedial services intended to reduce the identified condition as well as the anticipated outcomes of the individual. The treatment plan must specify the amount, duration and scope of

services. The treatment plan must be signed by the licensed mental health practitioner or physician responsible for developing the plan with the child/youth (or authorized representative) also signing to note concurrence with the treatment plan. The plan will specify a timeline for reevaluation of the plan that is at least a quarterly review. The reevaluation should involve the child/youth, family and providers and include a reevaluation of plan to determine whether services have contributed to meeting the stated goals. A new treatment plan should be developed if there is no measureable reduction of disability or restoration of functional level. The new plan should identify different rehabilitation strategy with revised goals and services.

- A licensed CPST practitioner or OLP must develop the treatment plan, with the PSR worker implementing the interventions identified on the services/plan.

*[MARCH 2016 NOTE: There will be additional limitations, which are under development. Once finalized, the Provider Manual will be updated.]*

## **Certification/Provider Qualifications**

### **Provider Agency Qualifications:**

- Any child serving agency or agency with children's behavioral health and health experience that is licensed, certified, or designated by DOH, OASAS, OCFS, or OMH to provide comparable and appropriate services referenced in definition.

In addition, DOH, OASAS, OCFS, or OMH may designate additional provider agencies as needed to address particular accessibility needs of the child behavioral health population using the process noted in the Appendix. In all cases, the newly designated provider agency meet and must comply with the following requirements:

- Providers and practitioners adhere to all Medicaid requirements in this manual and in other applicable provider manuals, regulations and statutes.
- Providers shall adhere to cultural competency guidelines (See Appendix A.)
- Providers must be knowledgeable and have experience in trauma-informed care and working with individuals from the cultural groups of those being served.
- These provider agencies shall ensure that staff receive Mandated Reporting training which is provided throughout New York State and Personal Safety in the Community training prior to service delivery.
- The provider agency will ensure that the practitioners maintain the licensure necessary to provide the services under their scope of practice under State law.
- The provider agency will ensure that any insurance required by the designating state agency is obtained and maintained.
- The provider agency will ensure that any safety precautions needed to protect the child population served are taken as necessary and required by the designating State agency.

*[MARCH 2016 NOTE: The provider designation criteria and process is under development. Once finalized, it will be incorporated into this Provider Manual.]*

**Individual Staff Qualifications:**

- Must be 18 years old and have a high school diploma, high school equivalency preferred, or a State Education Commencement Credential (e.g. SACC or CDOS); with a minimum of three years’ experience in children’s mental health, addiction and/or foster care
- The practice of PSR by unlicensed individuals does not include those activities that are restricted under Title VIII.

**Supervisor Qualifications:**

- The PSR provider must receive regularly scheduled supervision from a Licensed Clinical Social Worker (LCSW), Licensed Mental Health Counselor, Licensed Creative Arts Therapist, Licensed Marriage and Family Therapist, Licensed Psychoanalyst, Licensed Psychologist, Physician’s Assistant, Psychiatrist, Physician, Registered Professional Nurse, or Nurse Practitioner operating within the scope of their practice.
- Supervisors must also be aware of and sensitive to trauma informed care and the cultural needs of the population of focus and how to best meet those needs, and be capable of training staff regarding these issues.

**Training Requirements**

Service Type	Trainings Required	Requirement Completion Timeframe
Psychosocial Rehabilitation (PSR)	<ul style="list-style-type: none"> <li>• Engagement and follow through</li> <li>• Group Facilitation</li> <li>• Identification and Delivery of Functional Skill Building Interventions- Personal, Health (including medication advocacy &amp; coaching), Autonomy, and Community Competence</li> </ul>	

**Service Specific Training Recommendations:**

Training:	Content Areas:	Training Resources Available:
<u>Domestic Violence: Signs and Intervention</u>	<ul style="list-style-type: none"> <li>• Key components of domestic violence (DV)</li> <li>• Tactics of coercive control</li> <li>• Different types of DV</li> <li>• Characteristics of batterers and what they are like as parents</li> <li>• Impact on victims and their parenting</li> <li>• Impact of DV on children – trauma-</li> </ul>	<a href="http://www.nyscadv.org/training-and-technical-assistance/">http://www.nyscadv.org/training-and-technical-assistance/</a>  <a href="http://www.ncdsv.org/ncd_upcomingtrainings.html#Ongoing">http://www.ncdsv.org/ncd_upcomingtrainings.html#Ongoing</a>  <a href="http://www.opdv.ny.gov/">http://www.opdv.ny.gov/</a>

	<p>its effect on developing brain</p> <ul style="list-style-type: none"> <li>• Characteristics of children exposed to DV and how other factors may influence a child's response</li> <li>• Screening and risk assessment tools</li> <li>• How to introduce topic of DV to a potential victim</li> <li>• What not to do</li> <li>• Interventions- safety assessment and planning</li> <li>• Documentation</li> <li>• Referrals</li> </ul>	
<u>Motivational Interviewing</u>		
<u>Personal Safety in the Community</u>		

Practitioners are encouraged to review knowledge base and skills the State recommends for providers who will be delivering the new State Plan services to children in order to demonstrate competency (See Appendix B).

### **Staffing Ratio/Caseload Size**

The caseload size must be based on the needs of the child/youth and families with an emphasis on successful outcomes, individual satisfaction, and meeting the needs identified in the individual treatment plan.

### **Billing**

A unit of service is defined according to the Healthcare Common Procedure Coding System (HCPCS) approved code set consistent with the National Correct Coding Initiative unless otherwise specified.

*[MARCH 2016 NOTE: As billing methodology and coding structure are finalized, this section of the Provider Manual will be augmented.]*

## Family Peer Support Services

### Definition

Family Peer Support Services (FPSS) are an array of formal and informal services and supports provided to families caring for/raising a child who is experiencing social, emotional, developmental, medical, substance use, and/or behavioral challenges in their home, school, placement, and/or community. FPSS provide a structured, strength-based relationship between a Family Peer Advocate (FPA) and the parent/family member/caregiver for the benefit of the child/youth.

The service is needed to allow the child the best opportunity to remain in the community. Activities included must be intended to achieve the identified goals or objectives as set forth in the child/youth's treatment plan.

Family is defined as the primary care-giving unit and is inclusive of the wide diversity of primary caregiving units in our culture. Family is a birth, foster, adoptive, or self-created unit of people residing together, with significant attachment to the individual, consisting of adult(s) and/or child(ren), with adult(s) performing duties of parenthood/caregiving for the child(ren) even if the individual is living outside of the home.

### Service Components

- Engagement, Bridging, and Transition Support
  - Based on the strengths and needs of the youth and family, connect them with appropriate services and supports. Accompany the family when visiting programs.
  - Facilitate meetings between families and service providers.
  - Assist the family to gather, organize and prepare documents needed for specific services.
  - Address any concrete or subjective barriers that may prevent full participation in services.
  - Serve as a bridge between families and service providers, supporting a productive and respectful partnership by assisting the families to express their strengths, needs and goals.
  - Support and assist families during stages of transition which may be unfamiliar (e.g. placements, in crisis, and between service systems etc.).
  - Promote continuity of engagement and supports as families' needs and services change.
  
- Self-Advocacy, Self-Efficacy, and Empowerment:
  - Train families to advocate on behalf of themselves to promote shared decision-making.
  - Regularly consult with families and providers to ensure that the family's perspectives are included in all planning and decision-making.

- Coach and model shared decision-making and skills that support collaboration, in addition to providing opportunities for families to self-advocate.
  - Model strengths-based interactions by accentuating the positive.
  - Support the families in discovering their strengths and concerns. Assist families to identify and set goals and short term objectives.
  - Prepare families for meetings and accompany them when needed.
  - Empower families to express their fears, expectations and anxieties to promote positive effective communication.
  - Assist families to frame questions to ask providers.
  - Provide opportunities for families to connect to and support one another.
  - Support and encourage family participation in community, regional, state, national activities to develop their leadership skills and expand their circles of support.
  - Provide leadership opportunities for families who are receiving Family Peer Support Services.
  - Empower families to make informed decisions regarding the nature of supports for themselves and their child through:
    - Sharing information about resources, services and supports and exploring what might be appropriate for their child and family
    - Exploring the needs and preferences of the family and locating relevant resources.
    - Helping families understand eligibility rules
    - Helping families understand the assessment process and identify their child's strengths, needs and diagnosis.
- Parent Skill Development:
    - Supports the efforts of families in caring for and strengthening their children's mental, and physical health, development and well-being of their children.
    - Helps the family learn and practice strategies to support their child's positive behavior.
    - Assist the family to implement strategies recommended by clinicians.
    - Assist families in talking with clinicians about their comfort with their treatment plans.
    - Provide emotional support for the family on their parenting journey to reduce isolation, feelings of stigma, blame and hopelessness.
    - Provide individual or group parent skill development related to the behavioral and medical health needs of the child (i.e., training on special needs parenting skills).
    - Support families as children transition from out of home placement.
    - Assist families on how to access transportation.

- Support the parent in their role as their child's educational advocate by providing: information, modeling, coaching in how to build effective partnerships, and exploring educational options with families and school staff.
- Community Connections and Natural Supports:
  - Enhance the quality of life by integration and supports for families in their own communities
  - Help the family to rediscover and reconnect to natural supports already present in their lives.
  - Utilize the families' knowledge of their community in developing new supportive relationships.
  - Help the family identify and become involved in leisure and recreational activities in their community.
  - In partnership with community leaders, encourage families who express an interest to become more involved in faith or cultural organizations.
  - Arrange support and training as needed to facilitate participation in community activities.
  - Conduct groups with families to strengthen social skills, decrease isolation, provide emotional support and create opportunities for ongoing natural support.
  - Work collaboratively with schools to promote family engagement.

### **Modality**

- Individual face-to-face intervention
- Group face-to-face intervention. Composition of members should share common characteristics, such as related experiences, developmental age, chronological age, challenges or treatment goals.
- Components that are not provided, or directed exclusively toward the benefit of the Medicaid eligible child/youth are not eligible for Medicaid reimbursement.

### **Setting**

Services should be offered in a variety of settings including community locations, the family or caregiver's home, or where the beneficiary lives, works, attends school, engages in services (e.g. provider office sites), and/or socializes.

### **Admissions/Continued Stay/Discharge Criteria**

Service included in benefit plan:

- This service is recommended by a licensed practitioner of the healing arts including: Licensed Master Social Worker (LMSW), Licensed Clinical Social Worker (LCSW), Licensed Mental Health Counselor, Licensed Creative Arts Therapist, Licensed Marriage and Family Therapist, Licensed Psychoanalyst, Licensed Psychologist, Physician's Assistant, Psychiatrist, Physician,

Registered Professional Nurse, or Nurse Practitioner, operating within the scope of their practice.

- The service is needed to allow the child the best opportunity to remain in the community
- This service is directed at achieving specific outcome(s) such as: strengthening the family unit, building competency within the family for the benefit of the child, promoting empowerment within the family, and strengthening overall supports in the child's environment
- The frequency and intensity of the service aligns with the unique needs of the family for the benefit of the child.
- Examples:
  - A family is experiencing difficulties with raising their child who is struggling behaviorally at home. The family receives family peer support services weekly, in the home, to practice strategies to support their child's positive behavior.
  - A family is concerned about their daughter's eating disorder. A treatment plan goal is for the daughter to safely remain within the home. The mom is struggling with finding available resources for her daughter. The family peer advocate meets with the mom to explore available resources, services, and supports in the community. The family peer advocate works with the mom to explore the needs and preferences of the family and helps empower her to make informed choices regarding available programs. The family peer advocate then assists the family to facilitate appointments with potential service providers.
  - A grandmother has custody of her grandson that has behavioral concerns. Family peer support services is meeting weekly with the grandmother to assist the grandmother to implement parenting strategies recommended by her grandson's doctor and assist her in facilitating meeting with providers to ensure shared decision making.

Discharge criteria:

- The family outcomes have been achieved to help in allowing the child the best opportunity to remain in the community.
- The family has shown progress in their ability to care for their child's overall behavioral health/health needs, connect to their natural supports, engage, and advocate for themselves.
- The family has been involved in the discharge process.

*[MARCH 2016 NOTE: More defined medical necessity criteria is in development. Upon finalization, language will be added to the Provider Manual.]*

## Limitations/Exclusions

- A group is composed of two or more families and cannot exceed more than six families composed of no more than 12 individuals in total.  
The intervention plan should identify the medical or remedial services intended to reduce the identified condition as well as the anticipated outcomes of the individual. The intervention plan must specify the amount, duration and scope of services. The intervention plan must be signed by the licensed mental health practitioner or physician responsible for developing the plan with the participant (or authorized representative) also signing to note concurrence with the treatment plan. The plan will specify a timeline for reevaluation of the plan that is at least a quarterly review. The reevaluation should involve the individual, family and providers and include a reevaluation of plan to determine whether services have contributed to meeting the stated goals. A new intervention plan should be developed if there is no measureable reduction of disability or restoration of functional level. The new plan should identify different rehabilitation strategy with revised goals and services.

*[MARCH 2016 NOTE: There will be additional limitations, which are under development. Once finalized, the Provider Manual will be updated.]*

## Certification/Provider Qualifications

### Provider Agency Qualifications:

- Any child serving agency or agency with children's behavioral health and health experience that is licensed, certified, or designated by DOH, OASAS, OCFS, or OMH to provide comparable and appropriate services referenced in definition.

In addition, DOH, OASAS, OCFS, or OMH may designate additional provider agencies as needed to address particular accessibility needs of the child behavioral health population using the process noted in the Appendix. In all cases, the newly designated provider agency meet and must comply with the following requirements:

- Providers and practitioners adhere to all Medicaid requirements in this manual and in other applicable provider manuals, regulations and statutes.
- Providers shall adhere to cultural competency guidelines (See Appendix A.)
- Providers must be knowledgeable and have experience in trauma-informed care and working with individuals from the cultural groups of those being served.
- These provider agencies shall ensure that staff receive Mandated Reporting training which is provided throughout New York State and Personal Safety in the Community training prior to service delivery.
- The provider agency will ensure that the practitioners maintain the licensure necessary to provide the services under their scope of practice under State law.

- The provider agency will ensure that any insurance required by the designating state agency is obtained and maintained.
- The provider agency will ensure that any safety precautions needed to protect the child population served are taken as necessary and required by the designating State agency.

*[MARCH 2016 NOTE: The provider designation criteria and process is under development. Once finalized, it will be incorporated into this Provider Manual.]*

### **Individual Staff Qualifications:**

- Family Peer Support will be delivered by a New York State Credentialed Family Peer Advocate (FPA). To be eligible for the FPA Credential, the individual must:
  - Demonstrate 'lived experience' as a parent or primary caregiver who has navigated multiple child serving systems on behalf of their child(ren) with social, emotional, developmental, health and/or behavioral healthcare needs.
  - Have a high school diploma, high school equivalency preferred or a State Education Commencement Credential (e.g. SACC or CDOS)
  - Complete Level One and Level Two of the Family Peer Advocate Core Training/ Parent Empowerment Program (PEP) training or approved comparable training.
  - Submit three letters of reference attesting to proficiency in and suitability for the role of a Family Peer Advocate (FPA) including one from FPAs supervisor.
  - Agree to practice according to the Family Peer Advocate Code of Ethics.
  - Complete 20 hours of continuing education and renew their FPA credential every two years.

A FPA may obtain a provisional credential that will allow services they provide to be billed if the applicant has:

- Demonstrated 'lived experience' as a parent or primary caregiver who has navigated multiple child serving systems on behalf of their child(ren) with social, emotional, developmental, health and/or behavioral healthcare needs.
  - A high school diploma, high school equivalency preferred or a State Education Commencement Credential (e.g. SACC or CDOS). This educational requirement can be waived by the State if the person has demonstrated competencies and has relevant life experience sufficient for the peer certification.
- Completed Level One of the Parent Empowerment Program (PEP) training or approved comparable training.
- Submitted two letters of reference attesting to proficiency in and suitability for the role of a Family Peer Advocate (FPA).

A FPA with a Level One provisional credential must complete all other requirements of the full credential within 18 months of employment as a FPA.

OR

- Family Peer Support will be delivered by a Certified Recovery Peer Advocate (CRPA) with a Family Specialty. To be certified as CPRA-Family, the individual must be at least 18 years of age and have the following:
  - Have lived experience as a family member impacted by youth substance use disorders. The CRPA – Family may be in recovery themselves.
  - Have a high school diploma or a State Education Commencement Credential or General Equivalency Degree (GED).
  - Complete a minimum of 46 hours of content specific training, covering the topics: advocacy ,mentoring/education, recovery/wellness support and ethical responsibility
  - Document 1,000 hours of related work experience, or document at least 500 hours of related work experience if they: Have a Bachelor’s Degree; Are credentialed by OASAS as a CASAC, CASAC Trainee, or Prevention Professional; or Completed the 30-Hour Recovery Coach Academy training
  - Provide evidence of at least 25 hours of supervision specific to the performance domains of advocacy, mentoring/education, recovery/wellness support, and ethical responsibility. Supervision must be provided by an organization documented and qualified to provide supervision per job description.
  - Pass the NYCB/IC&RC Peer Advocate Exam or other exam by an OASAS designated certifying body
  - Submit two letters of recommendation
  - Demonstrate a minimum of 16 hours in the area of Family Support
  - Complete 20 hours of continuing education earned every two years, including 6 hours of Ethics.
- Certified Recovery Peer Advocate with a Family Specialty as defined by NYS OASAS:

An individual who is supervised by a credentialed or licensed clinical staff member to provide outreach and peer support services based on clinical need as identified in the patient’s treatment/recovery plan which occurs on the premises of a certified program.

  - An individual who is supervised by a credentialed or licensed clinical staff member to provide outreach and peer support services based on clinical need as identified in the youth’s treatment/recovery plan which occurs on the premises of a certified program.
  - See section below: *Training Requirements* for Certified Recovery Peer Advocate credential eligibility

### Supervisor Qualifications:

- FPAs will be supervised by: 1) Individuals who have a minimum of 4 years providing FPSS services, at least 1 year of which is as a credentialed FPA with access to clinical consultation as needed. The clinical supervision may be provided by a staff member or through a contract OR 2) A mental health professional with a) training in FPSS and the role of FPAs b) with access to discipline specific clinical consultation on a planned, regular basis, and c) efforts are made as the program gains experience to transition to supervision by experienced FPAs within the organization
- A competent behavioral health professional meets the qualifications of either:
  - a professional who meets the criteria for a "qualified mental health staff person" found in 14 NYCRR 594 or 14 NYCRR 595
  - 14 NYCRR 594
    - *Qualified mental health staff person means:*
      - a physician who is currently licensed as a physician by the New York State Education Department; or
      - a psychologist who is currently licensed as a psychologist by the New York State Education Department; or
      - a social worker who is either currently a licensed master social worker or as a licensed clinical social worker by the New York State Education Department or has a master's degree in social work from a program approved by the New York State Education Department; or
      - a registered nurse who is currently licensed as a registered professional nurse by the New York State Education Department; or
      - an individual having a master's or bachelor's degree in a human services related field; or
      - a creative arts therapist who is currently licensed as a creative arts therapist by the New York State Education Department; or
      - a marriage and family therapist who is currently licensed as a marriage and family therapist by the New York State Education Department; or
      - a mental health counselor who is currently licensed as a mental health counselor by the New York State Education Department; or
      - a psychoanalyst who is currently licensed as a psychoanalyst by the New York State Education Department; or

- a nurse practitioner who is currently certified as a nurse practitioner by the New York State Education Department; or
  - Other professional disciplines which receive the written approval of the Office of Mental Health.
- 14 NYCRR 595
    - *Qualified mental health staff person* means:
      - a physician who is currently licensed as a physician by the New York State Education Department;
      - a psychologist who is currently licensed as a psychologist by the New York State Education Department;
      - a social worker who is either currently licensed as a licensed master social worker or as a licensed clinical social worker by the New York State Education Department or has a master's degree in social work from a program approved by the New York State Education Department;
      - a registered nurse who is currently licensed as a registered professional nurse by the New York State Education Department;
      - a creative arts therapist who is currently licensed as a creative arts therapist by the New York State Education Department;
      - a marriage and family therapist who is currently licensed as a marriage and family therapist by the New York State Education Department;
      - a mental health counselor who is currently licensed as a mental health counselor by the New York State Education Department;
      - a psychoanalyst who is currently licensed as a psychoanalyst by the New York State Education Department;
      - a nurse practitioner who is currently certified as a nurse practitioner by the New York State Education Department;
      - an individual having education, experience and demonstrated competence, as defined below:
        - a master's or bachelor's degree in a human services related field;
        - an associate's degree in a human services related field and three years' experience in human services;
        - a high school degree and five years' experience in human services; or

- Other professional disciplines which receive the written approval of the Office of Mental Health.

OR

- A Certified Alcohol and Substance Abuse Counselor (CASAC) working within an OASAS certified program.

The individual providing consultation, guidance, mentoring, and on-going training need not be employed by the same agency.

- Supervision of these activities may be delivered in person or by distance communication methods. One hour of supervision must be delivered for every 40 hours of Family Peer Support Services duties performed.
- There may be an administrative supervisor who provides administrative oversight including time, signs the family peer specialist's timesheet and attendance responsibility and is the primary contact on other related human resource management issues.

Supervisors must also be aware of and sensitive to the cultural needs of the population of focus and how to best meet those needs, and be capable of training staff regarding these issues.

### **Training Requirements**

Family Peer Support will be delivered by a New York State Credentialed Family Peer Advocate (FPA). To be eligible for the FPA Credential, the individual must:

- Demonstrate 'lived experience' as a parent or primary caregiver who has navigated multiple child serving systems on behalf of their child(ren) with social, emotional, developmental, health and/or behavioral healthcare needs.
- Have a high school diploma, high school equivalency preferred or a State Education Commencement Credential (e.g. SACC or CDOS)
- Complete Level One and Level Two of the Parent Empowerment Program (PEP) training or approved comparable training.
- Submit three letters of reference attesting to proficiency in and suitability for the role of a Family Peer Advocate (FPA) including one from FPAs supervisor.
- Agree to practice according to the Family Peer Advocate Code of Ethics.
- Complete 20 hours of continuing education and renew their FPA credential every two years.

An FPA may obtain a provisional credential that will allow services they provide to be billed if the applicant has:

- Demonstrated 'lived experience' as a parent or primary caregiver who has navigated multiple child serving systems on behalf of their child(ren) with social, emotional, developmental, health and/or behavioral healthcare needs.

- A high school diploma, high school equivalency preferred or a State Education Commencement Credential (e.g. SACC or CDOS). This educational requirement can be waived by the certifying agency if the person has demonstrated competencies and has relevant life experience sufficient for the peer certification.
- Complete Level One of the Parent Empowerment Program (PEP) training or approved comparable training.
- Submitted two letters of reference attesting to proficiency in and suitability for the role of a Family Peer Advocate (FPA).

An FPA with a Level One provisional credential must complete all other requirements of the full credential within 18 months of employment as an FPA.

OR

Family Peer Support will be delivered by a Certified Recovery Peer Advocate (CRPA) with a Family Specialty. To be certified as CPRA-Family, the individual must at least 18 years of age and have the following:

- Have lived experience as a family member impacted by youth substance use disorders. The CRPA – Family may be in recovery themselves.
- Have a high school diploma, high school equivalency preferred or a State Education Commencement Credential (e.g. SACC or CDOS). Complete a minimum of 46 hours of content specific training, covering the topics: advocacy, mentoring/education, recovery/wellness support, medication-assisted treatment, and ethical responsibility
- Document 1,000 hours of related work experience, or document at least 500 hours of related work experience if they: have a bachelor's degree; are credentialed by OASAS as a CASAC, CASAC Trainee, or Prevention Professional; or have completed the 30-hour Recovery Coach Academy training
- Provide evidence of at least 25 hours of supervision specific to the performance domains of advocacy, mentoring/education, recovery/wellness support, and ethical responsibility. Supervision must be provided by an organization documented and qualified to provide supervision per job description.
- Pass the NYCB/IC&RC Peer Advocate Exam or other exam by an OASAS designated certifying body
- Submit two letters of recommendation
- Demonstrate a minimum of 16 hours in the area of Family Support
- Complete 20 hours of continuing education earned every two years, including six hours of Ethics.

## Service Specific Training Recommendations:

Training:	Content Areas:	Training Resources Available:
<u>Domestic Violence: Signs and Intervention</u>	<ul style="list-style-type: none"> <li>• Key components of domestic violence (DV)</li> <li>• Tactics of coercive control</li> <li>• Different types of DV</li> <li>• Characteristics of batterers and what they are like as parents</li> <li>• Impact on victims and their parenting</li> <li>• Impact of DV on children – trauma-its effect on developing brain</li> <li>• Characteristics of children exposed to DV and how other factors may influence a child's response</li> <li>• Screening and risk assessment tools</li> <li>• How to introduce topic of DV to a potential victim</li> <li>• What not to do</li> <li>• Interventions- safety assessment and planning</li> <li>• Documentation</li> <li>• Referrals</li> </ul>	<a href="http://www.nyscadv.org/training-and-technical-assistance/">http://www.nyscadv.org/training-and-technical-assistance/</a>  <a href="http://www.ncdsv.org/ncd_upcomingtrainings.html#Ongoing">http://www.ncdsv.org/ncd_upcomingtrainings.html#Ongoing</a>  <a href="http://www.opdv.ny.gov/">http://www.opdv.ny.gov/</a>
<u>Motivational Interviewing</u>		
<u>Personal Safety in the Community</u>		

Practitioners are encouraged to review knowledge base and skills the State recommends for providers who will be delivering the new State Plan services to children in order to demonstrate competency (See Appendix B).

### Staffing Ratio/Caseload Size

The caseload size must be based on the needs of the child/youth and families with an emphasis on successful outcomes, individual satisfaction, and meeting the needs identified in the treatment plan.

### Billing

A unit of service is defined according to the Healthcare Common Procedure Coding System (HCPCS) approved code set consistent with the National Correct Coding Initiative unless otherwise specified.

*[MARCH 2016 NOTE: As billing methodology and coding structure are finalized, this section of the Provider Manual will be augmented.]*

## Youth Peer Support and Training

### Definition

Youth Peer Support and Training (YPST) services are youth formal and informal services and supports provided to youth who are experiencing social, emotional, medical, developmental, substance use, and/or behavioral challenges in their home, school, placement, and/or community centered services. These services provide the training and support necessary to ensure engagement and active participation of the youth in the treatment planning process and with the ongoing implementation and reinforcement of skills learned throughout the treatment processes are the focus of this service.

Youth peer advocacy activities must be intended to develop and achieve the identified goals and/or objectives as set forth in the youth's individualized treatment plan. The Youth Peer Support and Training services delivered are based on the treatment plan developed by the licensed practitioner working with the child/youth.

The structured, scheduled activities provided by this service emphasize the opportunity for the youth to expand the skills and strategies necessary to move forward in meeting their personal, individualized life goals, develop self-advocacy skills, and to support their transition into adulthood.

Family is defined as the primary care-giving unit and is inclusive of the wide diversity of primary caregiving units in our culture. Family is a birth, foster, adoptive, or self-created unit of people residing together, with significant attachment to the individual, consisting of adult(s) and/or child(ren), with adult(s) performing duties of parenthood/caregiving for the child(ren) even if the individual is living outside of the home.

### Service Components

- **Skill Building:**
  - Develop skills for coping with and managing psychiatric symptoms, trauma, and substance use disorders
  - Develop skills for wellness, resiliency and recovery support
  - Develop skills to independently navigate the service system
  - Develop goal-setting skills
  - Build community living skills
- **Coaching:** Enhance resiliency/recovery oriented attitudes, i.e., hope, confidence, and self-efficacy
  - Promote wellness through modeling.
  - Provide mutual support, hope, reassurance and advocacy that include sharing one's own "personal recovery/resiliency story" as the YPA deems appropriate as beneficial to both the youth and themselves. YPA's may

also share their recovery with parents as a means to engage parents and help them “see” youth possibilities for future in a new light.

- Engagement, Bridging, and Transition Support
  - Act as a peer partner in transitioning to different levels of care and into adulthood. Help youth understand what to expect and how and why they should be active in developing their treatment plan and natural supports.
- **Self-Advocacy, Self-Efficacy, & Empowerment:**
  - Help youth develop self-advocacy skills (e.g., may attend a Committee on Preschool or Special Education meeting with the youth and parent, coaching the youth to articulate his educational goals).
  - Assist youth with gaining and regaining the ability to make independent choices and assist youth in playing a proactive role in their own treatment (assisting/mentoring them in discussing questions or concerns about medications, diagnoses or treatment approaches with their treating clinician).The YPA will guide the youth to effectively communicate their individual perspective to providers and families.
  - Develop, link, and facilitate the use of formal and informal services, including connection to peer support groups in the community
  - Serve as an advocate, mentor, or facilitator for resolution of issues
  - Assist in navigating the service system
  - Assist youth in developing skills to advocate for needed services and benefits and seeking to effectively resolve unmet needs.
  - Assist youth in understanding their treatment plan and help to ensure the plan is person/family centered
- **Community Connections and Natural Supports:**
  - Connect youth to community resources and services. The YPA may accompany youth to appointments and meetings for the purpose of mentoring and support but not for the sole purpose of providing transportation for the youth.
  - Help youth develop a network for information and support from others who have been through similar experiences, including locating similar interest programs, peer-run programs, and support groups.
  - Facilitate or arrange youth peer resiliency/recovery support groups.

### **Modality**

YPST services should be provided as:

- Individual face-to-face intervention

- Group face-to-face intervention. Composition of members should share common characteristics, such as related experiences, developmental age, chronological age, challenges or treatment goals.

### **Setting**

YPST can occur in a variety of settings including community locations where the youth lives, works, attends school, engages in services (e.g. provider office sites), and/or socializes.

### **Admissions/Continued Stay/Discharge Criteria**

- Service included in benefit plan: This service is recommended by any following licensed practitioners of the healing arts operating within the scope of their practice under State license: a Licensed Master Social Worker (LMSW), Licensed Clinical Social Worker (LCSW), Licensed Mental Health Counselor, Licensed Creative Arts Therapist, Licensed Marriage and Family Therapist , Licensed Psychoanalyst, Licensed Psychologist, Physician’s Assistant, Psychiatrist, Physician, Registered Professional Nurse, Nurse Practitioner, operating within the scope of their practice with the youth, family/caregiver or other collateral supports. The activities implemented by the Youth Peer Support and Training should be identified and/or developed by a licensed practitioner.
- The service is needed to allow the youth the best opportunity to remain in the community
- This service is directed at developing skills or achieving specific outcome(s) such as: enhancing youth/families ability to effectively manage comprehensive health needs, maintaining a recovery oriented lens, strengthening resiliency, and developing competence to utilize resources and supports in the community.
- The amount, duration and scope of the service aligns with the unique needs of the youth.

#### **Example:**

- Johnny is a high school junior who has an upcoming Committee on Special Education (CSE) meeting. Johnny invited his YPA to support him at the meeting. The YPA may attend the CSE meeting with the parent and Johnny to support and assist him in verbalizing his goals and practice self-advocacy skills that they have been working on.

#### **Discharge criteria:**

- The child has successfully reached the individually-established goals included in the treatment plan.

- The youth has shown progress in their ability to expand their skills and learn strategies to help in successfully moving forward to meet their individualized goals.
- The youth/family has been involved in the discharge process.

*[MARCH 2016 NOTE: More defined medical necessity criteria is in development. Upon finalization, language will be added to the Provider Manual.]*

### **Limitations/Exclusions**

- A group is composed of two or more youth and cannot exceed more than 12 individuals total.
- The intervention plan should identify the medical or remedial services intended to reduce the identified condition as well as the anticipated outcomes of the individual. The intervention plan must specify the amount, duration and scope of services. The intervention plan must be signed by the licensed mental health practitioner or physician responsible for developing the plan with the participant (or authorized representative) also signing to note concurrence with the treatment plan. The plan will specify a timeline for reevaluation of the plan that is at least a quarterly review. The reevaluation should involve the individual, family and providers and include a reevaluation of plan to determine whether services have contributed to meeting the stated goals. A new treatment plan should be developed if there is no measureable reduction of disability or restoration of functional level. The new plan should identify different rehabilitation strategies with revised goals and services.

*[MARCH 2016 NOTE: There will be additional limitations, which are under development. Once finalized, the Provider Manual will be updated.]*

### **Certification/Provider Qualifications**

#### **Provider Agency Qualifications:**

- Any child serving agency or agency with children's behavioral health and health experience that is licensed, certified, or designated by DOH, OASAS, OCFS, or OMH to provide comparable and appropriate services referenced in definition.
- In addition, DOH, OASAS, OCFS, or OMH may designate additional provider agencies as needed to address particular accessibility needs of the child behavioral health population using the process noted in the Appendix. In all cases, the newly designated provider agency meet and must comply with the following requirements:
  - Providers and practitioners adhere to all Medicaid requirements in this manual and in other applicable provider manuals, regulations and statutes.

- Providers shall adhere to cultural competency guidelines (See Appendix A.)
- Providers must be knowledgeable and have experience in trauma-informed care and working with individuals from the cultural groups of those being served.
- These provider agencies shall ensure that staff receive Mandated Reporting training which is provided throughout New York State and Personal Safety in the Community training prior to service delivery.
- The provider agency will ensure that the practitioners maintain the licensure necessary to provide the services under their scope of practice under State law.
- The provider agency will ensure that any insurance required by the designating state agency is obtained and maintained.
- The provider agency will ensure that any safety precautions needed to protect the child population served are taken as necessary and required by the designating State agency.

*[MARCH 2016 NOTE: The provider designation criteria and process is under development. Once finalized, it will be incorporated into this Provider Manual.]*

#### **Individual Staff Qualifications:**

YPST is delivered by a New York State Youth Peer Advocate Credential. To be eligible for the Youth Peer Advocate Credential, an individual must:

- Be an individual 18 to 28 years who has self-identified as a consumer recipient of behavioral health services, special education services or foster care.
- Have a high school diploma, high school equivalency preferred or a State Education Commencement Credential (e.g. SACC or CDOS). This educational requirement can be waived by the certifying agency if the person has demonstrated competencies and has relevant life experience sufficient for the peer certification.
- Complete Level One online components, Level Two in-person training and a minimum of three consultation calls.
- Submit three letters of reference attesting to proficiency in and suitability for the role of an YPA including one from YPAs supervisor.
- Agree to practice according to the Youth Peer Advocate Code of Ethics.
- Document 600 hours of experience providing Youth Peer Support services within 18 months
- Complete *20 hours* of continuing education *every 2 years*
- Demonstrate qualities of leadership, including:
  - Knowledge of advocacy
  - Group development and/or facilitation of peer-to-peer groups or activities

- Be able to use lived experience with a mental illness, juvenile justice, special education, substance use disorder, and/or foster care to assist in supporting youth in their resiliency/recovery and wellness
- An individual with provisional credential may provide this service
- Be supervised by an individual who meets the criteria for a "qualified mental health staff person" found in 14 NYCRR 594 or 14 NYCRR 595,

An YPA may obtain a provisional credential that will allow services they provide to be billed if the applicant:

- Is an individual 18 to 30 years who has self-identified as a consumer recipient of behavioral health services, special education services or foster care.
- Has a high school diploma, high school equivalency preferred or a State Education Commencement Credential (e.g. SACC or CDOS). This educational requirement can be waived by the certifying agency if the person has demonstrated competencies and has relevant life experience sufficient for the peer certification.
- Completes required training (See Training Requirements below)
- Demonstrates qualities of leadership, including:
  - Knowledge of advocacy
  - Group development and/or facilitation of peer-to-peer groups or activities
- And is able to use lived experience with a mental illness, juvenile justice, special education, substance use disorder, and/or foster care to assist in supporting youth in their resiliency/recovery and wellness
- Completes Level One of the required training
- Submits two letters of reference attesting to proficiency in and suitability for the role of a YPA

OR

A Certified Recovery Peer Advocate – Youth is an individual 18 to 30 years of age and has the following:

- Lived experience defined as having been impacted or affected by substance use disorders and/or be in recovery from substance use disorders
- A high school diploma, high school equivalency preferred or a State Education Commencement Credential (e.g. SACC or CDOS)
- Complete a minimum of 46 hours of content specific training, covering topics of: advocacy, mentoring/education. Recovery/wellness support and ethical responsibility
- Document 1,000 hours of relative work experience, or document at least 500 hours of related work experience if they:

- Have a Bachelor's Degree, a credentialed by OASAS as a CASAC or CASAC trainee or Prevention Professional or completed the 30 hour Recovery Coach Academy training
- Provide evidence of at least 25 hours of supervision specific to the performance domains of advocacy, mentoring/education, recovery/wellness and ethical responsibility. Supervision must be provided by an organization documented and qualified to provide supervision per job description.
- Pass the NYCB/IC&RC Peer Advocate Exam or other exam by an OASAS designated certifying body
- Submit two letters of recommendation
- Demonstrate a minimum of 16 hours specifically related to Youth Peer Support Complete 20 hours of continuing education earned every two years, including 6 hours of ethics

**Supervisor Qualifications:**

YPAs will be supervised by: 1) Individuals who have a minimum of 4 years providing FPSS or YPAT services, at least 1 year of which is as a credentialed FPA or YPA with access to clinical consultation as needed OR 2) A mental health professional with a) training in YPAT and the role of YPAs b) with access to discipline specific clinical consultation on a planned, regular basis.

A certified YPST supervisor who is an individual working as a certified Family Peer Advocate or a certified Youth Peer Advocate, for a minimum of four years, in which 1 year should have been as a credential peer advocate or its equivalent including specialized training and/or experience as a supervisor.

- The individual providing consultation, guidance, mentoring, and on-going training need not be employed by the same agency.
  - Supervision of these activities may be delivered in person or by distance communication methods. It is required that one hour of supervision be delivered for every 40 hours of Peer Support and Training duties performed.
  - There may be an administrative supervisor who signs the youth peer specialist's timesheet and is the primary contact on other related human resource management issues.
- Supervisors must also be aware of and sensitive to the cultural needs of the population of focus and how to best meet those needs, and be capable of training staff regarding these issues.

OR

- The YPST provider must receive regularly scheduled supervision from a competent behavioral health professional meeting the qualifications of either:
  - 14 NYCRR 594
    - *Qualified mental health staff person means:*

- a physician who is currently licensed as a physician by the New York State Education Department; or
  - a psychologist who is currently licensed as a psychologist by the New York State Education Department; or
  - a social worker who is either currently licensed as a licensed master social worker or as a licensed clinical social worker by the New York State Education Department ; or has a master's degree in social work from a program approved by the New York State Education Department; or
  - a registered nurse who is currently licensed as a registered professional nurse by the New York State Education Department; or
  - an individual having a master's or bachelor's degree in a human services related field; or
  - a creative arts therapist who is currently licensed as a creative arts therapist by the New York State Education Department; or
  - a marriage and family therapist who is currently licensed as a marriage and family therapist by the New York State Education Department; or
  - a mental health counselor who is currently licensed as a mental health counselor by the New York State Education Department; or
  - a psychoanalyst who is currently licensed as a psychoanalyst by the New York State Education Department; or
  - a nurse practitioner who is currently certified as a nurse practitioner by the New York State Education Department; or
  - Other professional disciplines which receive the written approval of the Office of Mental Health.
- 14 NYCRR 595
    - *Qualified mental health staff person means:*
      - a physician who is currently licensed as a physician by the New York State Education Department;
      - a psychologist who is currently licensed as a psychologist by the New York State Education Department;
      - a social worker who is either currently licensed as a licensed master social worker or as a licensed clinical social worker by the New York State Education Department ;or has a master's degree in social work from a program approved by the New York State Education Department; a registered

- nurse who is currently licensed as a registered professional nurse by the New York State Education Department;
- a creative arts therapist who is currently licensed as a creative arts therapist by the New York State Education Department;
- a marriage and family therapist who is currently licensed as a marriage and family therapist by the New York State Education Department;
- a mental health counselor who is currently licensed as a mental health counselor by the New York State Education Department;
- a psychoanalyst who is currently licensed as a psychoanalyst by the New York State Education Department;
- a nurse practitioner who is currently certified as a nurse practitioner by the New York State Education Department;
- an individual having education, experience and demonstrated competence, as defined below:
  - a master's or bachelor's degree in a human services related field;
  - an associate's degree in a human services related field and three years' experience in human services;
  - a high school degree and five years' experience in human services; or
- Other professional disciplines which receive the written approval of the Office of Mental Health.

## **Training Requirements**

Youth Peer Advocates (YPAs) must complete the State approved training. The YPA training consists of both on-line and in-person components.

Training Components:

- Role of Youth Peer Advocate in the Managed Care System
- Peer Mentoring and Support
- Small Group Facilitation Skills
- Professional Expectations
- Self-Care and Support.
- Complete Level One and Level Two of the Youth Peer Advocate Core Training or approved comparable training.
- Pass the training completion test

## Service Specific Training Recommendations:

Training:	Content Areas:	Training Resources Available:
<u>Domestic Violence: Signs and Intervention</u>	<ul style="list-style-type: none"> <li>• Key components of domestic violence (DV)</li> <li>• Tactics of coercive control</li> <li>• Different types of DV</li> <li>• Characteristics of batterers and what they are like as parents</li> <li>• Impact on victims and their parenting</li> <li>• Impact of DV on children – trauma-its effect on developing brain</li> <li>• Characteristics of children exposed to dv and how other factors may influence a child's response</li> <li>• Screening and risk assessment tools</li> <li>• How to introduce topic of DV to a potential victim</li> <li>• What not to do</li> <li>• Interventions- safety assessment and planning</li> <li>• Documentation</li> <li>• Referrals</li> </ul>	<a href="http://www.nyscadv.org/training-and-technical-assistance/">http://www.nyscadv.org/training-and-technical-assistance/</a>  <a href="http://www.ncdsv.org/ncd_upcomingtrainings.html#Ongoing">http://www.ncdsv.org/ncd_upcomingtrainings.html#Ongoing</a>  <a href="http://www.opdv.ny.gov/">http://www.opdv.ny.gov/</a>
<u>Motivational Interviewing</u>		
<u>Personal Safety in the Community</u>		

Practitioners are encouraged to review knowledge base and skills the State recommends for providers who will be delivering the new State Plan services to children in order to demonstrate competency (See Appendix B).

### Staffing Ratio/Caseload Size

The caseload size must be based on the needs of the youth and families with an emphasis on successful outcomes, individual satisfaction, and meeting the needs identified in the treatment plan.

### Billing

A unit of service is defined according to the Healthcare Common Procedure Coding System (HCPCS) approved code set consistent with the National Correct Coding Initiative unless otherwise specified.

*[MARCH 2016 NOTE: As billing methodology and coding structure are finalized, this section of the Provider Manual will be augmented.]*

## IV. APPENDICES

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**A. Cultural Competency:** Is defined as an awareness and acceptance of cultural and linguistic differences, an awareness of individual cultural values, an understanding of how individual differences affect those participating in the helping process, a basic knowledge about the clients culture, knowledge of the client's environment, and the ability to adapt practice skills to best address the needs of a child and his/her family taking into account their cultural and linguistic context.

The provider shall promote and ensure the delivery of services in a culturally competent manner to all children, youth and families, including but not limited to those with limited English proficiency and diverse cultural and ethnic backgrounds as well as individuals with diverse sexual orientations, gender identities and members of diverse faith communities. Cultural competence means having the capacity to function effectively within the context of the cultural beliefs, behaviors, and needs presented by those receiving services and their communities across all levels of the provider's organization

The provider agency shall have the infrastructure to support the delivery of linguistically, culturally relevant, and appropriate services that incorporates:

- Continuous accountability and quality improvement measures to track, monitor, and manage disparities in care across cultural groups. To this end, providers shall utilize detailed data about cultural groups in order to identify disparities at the most "granular" level feasible.
- The achievement of care goals.
- Quality effectiveness and outcomes at the practice level and the child and family level.
- Processes to assess child and family satisfaction with services and care, which includes elements to determine if cultural and linguistic needs were met.
- Provide prompt access to qualified interpreters in order to adequately address the needs of individuals with limited-English proficiency and American Sign Language users.
- Adopt policies and procedures that incorporate the importance of honoring the family's beliefs, sensitivity to cultural diversity, fostering respect for their culture and cultural identity, and eliminating disparities across cultural groups.
- Perform internal cultural competence activities including completion of standardized cultural competence training, including training on the use of interpreters, for all participating providers' staff who have regular and substantial contact with clients.
- Provider agencies must be knowledgeable of, or familiarize themselves with, the individual's cultural group to adequately serve children, youth and families.

## **B. Knowledge Base/Skills Recommendations:**

These are the skills and knowledge base the State recommends for providers delivering the new State Plan services to children in order to demonstrate competency. This list is not exhaustive and it is expected that providers will augment the required training, detailed in each individual service section of this manual, and may include the following:

### **Knowledge Base**

- Basic Understanding of Medications
- Child and Adolescent Development
- Child Serving Systems
- Cultural and Linguistic Competence
- Domestic Violence: Signs and Basic Interventions
- Emotional, Cognitive, and Behavior Management Techniques
- Frequently Abused Drugs and Drug Combinations
- Harm Reduction
- Medication Assisted Treatment for Substance use disorder (SUD)
- Medications: Intended Effects; Interactions; and Side Effects
- Mental Health- Signs and Symptoms
- Service Continuum- Community Resources
- Substance Use Disorders- Signs and Symptoms
- Trauma Informed Care
- HIPAA, Consent and Confidentiality

### **Skills:**

- Assessment- Clinical (as applicable for some services)
- Assessment- Collaborative Family/Peer Appraisal (as applicable for some services)
- Crisis De-escalation, Resolution, and Debriefing
- Emergency Recommendation Response (e.g., Narcan/Naloxone Administration or EpiPen)
- Engagement and follow through
- Family Support
- Linkage facilitation (bridging and transition support)
- Meeting or Group Facilitation Skills
- Motivational Interviewing
- Safety Plan Development, Implementation, and Monitoring
- Therapeutic Use of Self-Disclosure
- Treatment planning and Implementation
- Therapeutic Use of Self-Disclosure

### **C. Staffing Guidelines:**

- I. Practitioners who are qualified by credentials, training, and experience to provide direct services related to the treatment of health and behavioral health issues under the Medicaid Agency will work for a child serving agency or agency with children's behavioral health experience that is licensed, designated or certified by OMH, OASAS, OCFS, or DOH or its' designee and shall include the following:
  - a. **CASAC:** Staff person who holds a credential by the NYS OASAS as a Credentialed Alcohol and Substance Abuse Counselor
  - b. **CASAC-T:** A CASAC Trainee who meets specific eligibility requirements and passes the Alcohol and Drug Counselor (ADC) examination
  - c. **Certified Recovery Peer Advocate (CRPA) with a Family Specialty:** To be certified as CRPA-Family, the individual must be at least 18 years of age and have the following:
    - Lived experience as a family member impacted by youth substance use disorders. The CRPA – Family may be in recovery themselves.
    - A high school diploma or a State Education Commencement Credential or General Equivalency Degree (GED)
    - A minimum of 46 hours of content specific training, covering the topics: advocacy, mentoring/education, recovery/wellness support, medication assisted treatment, and ethical responsibility
    - Documented 1,000 hours of related work experience, or document at least 500 hours of related work experience if they: have a bachelor's degree; are credentialed by OASAS as a CASAC, CASAC Trainee, or Prevention Professional; or have completed the 30-Hour Recovery Coach Academy training
    - Provided evidence of at least 25 hours of supervision specific to the performance domains of advocacy, mentoring/education, recovery/wellness support, and ethical responsibility. Supervision must be provided by an organization documented and qualified to provide supervision per job description.
    - Passed the NYCB/IC&RC Peer Advocate Exam or other exam by an OASAS designated certifying body
    - Submitted two letters of recommendation
    - Demonstrated a minimum of 16 hours in the area of Family Support
    - Completed 20 hours of continuing education earned every two years, including six hours of Ethics.

- d. **Certified Recovery Peer Advocate (CRPA):** Youth is an individual 18 to 30 years of age and have the following:
- Lived experience defined as having been impacted or affected by substance use disorders and/or be in recovery from substance use disorders
  - A high school diploma or a State Education Commencement Credential or General Equivalency Degree (GED)
  - Completed a minimum of 46 hours of content specific training, covering topics of: advocacy, mentoring/education. Recovery/wellness support and ethical responsibility
  - Documented 1,000 hours of relative work experience, or document at least 500 hours of related work experience if they:
    - Have a Bachelor's Degree, a credentialed by OASAS as a CASAC or CASAC trainee or Prevention Professional or completed the 30 hour Recovery Coach Academy training
  - Provided evidence of at least 25 hours of supervision specific to the performance domains of advocacy, mentoring/education, recovery/wellness and ethical responsibility. Supervision must be provided by an organization documented and qualified to provide supervision per job description.
  - Passed the NYCB/IC&RC Peer Advocate Exam or other exam by an OASAS designated certifying body
  - Submitted 2 letters of recommendation
  - Demonstrated a minimum of 16 hours specifically related to Youth Peer Support
  - Completed 20 hours of continuing education earned every two years, including 6 hours of ethics
- e. **Certified Rehabilitation Counselor (CRC)** is certified with a national Certified Rehabilitation Counselor (CRC) designation by the Commission on Rehabilitation Counselor Certification (CRCC) that states the standard for quality rehabilitation counseling services in the United States and Canada. All Vocational Rehabilitation staff within the OASAS treatment provider system must adhere to the Code of Ethics set forth by the NYS Ethics Commission (<http://www.nyintegrity.org/>) and/or the Commission on Rehabilitation Counselor Certification (CRCC) ([www.crccertification.com](http://www.crccertification.com)).
- f. **CPST Specialist**
- a. Bachelor's degree level with a minimum of two years of applicable experience is children's mental health, addiction, and/or foster care OR who has been certified in an Evidenced Based Practice. Practitioners with a bachelor's degree may only perform limited CPST activities.
  - b. Master's degree level in social work, psychology, or in related human services plus one year of applicable experience OR who has been certified in an Evidenced Based Practice

- c. These practitioners include licensed and currently registered practitioners such as: Registered Professional Nurses, Licensed Occupational Therapists and Licensed Creative Arts Therapists to the extent they are operating under the scope of their license. Practitioners with a master's degree may perform any of the activities under CPST.
- g. **Licensed Creative Arts Therapist** is an individual who is licensed and currently registered as a Creative Arts Therapist by the New York State Education Department possesses a creative arts therapist permit from the New York State Education Department.
- h. **Credentialed Family Peer Advocate (FPA):** Family Peer Support will be delivered by a New York State Credentialed Family Peer Advocate (FPA). To be eligible for the FPA Credential, the individual must:
  - o Demonstrate 'lived experience' as a parent or primary caregiver who has navigated multiple child serving systems on behalf of their child(ren) with social, emotional, developmental, health and/or behavioral healthcare needs.
  - o Have a high school diploma, high school equivalency preferred or a State Education Commencement Credential (e.g., SACC or CDOS). This educational requirement can be waived by the certifying agency if the person has demonstrated competencies and has relevant life experience sufficient for the peer certification.
  - o Complete Level One and Level Two of the Parent Empowerment Program (PEP) training or approved comparable training.
  - o Submit three letters of reference attesting to proficiency in and suitability for the role of a FPA including one from FPA's supervisor.
  - o Agree to practice according to the Family Peer Advocate Code of Ethics.
  - o Completed 20 hours of continuing education and renew their FPA credential every two years.

An FPA may obtain a provisional credential that will allow services they provide to be billed if the applicant has:

- o Demonstrated 'lived experience' as a parent or primary caregiver who has navigated multiple child serving systems on behalf of their child(ren) with social, emotional, developmental, health and/or behavioral healthcare needs.
- o A high school diploma, high school equivalency preferred or a State Education Commencement Credential (e.g. SACC or CDOS). This educational requirement can be waived by the State if the person has demonstrated competencies and has relevant life experience sufficient for the peer certification.
- o Completed Level One of the Parent Empowerment Program (PEP) training or approved comparable training.

- Submitted two letters of reference attesting to proficiency in and suitability for the role of a FPA.

A FPA with a Level One provisional credential must complete all other requirements of the full credential within 18 months of employment as a FPA.

- i. **Licensed Occupational Therapist** is an individual who is licensed and currently registered as an Occupational Therapist by the New York State Education Department
- j. **Licensed Practical nurse** is an individual who is currently licensed and currently registered as a licensed practical nurse by the New York State Education Department
- k. **Licensed Psychoanalyst** is an individual who is currently licensed and currently registered as a psychoanalyst by the New York State Education Department
- l. **Licensed Psychologist** is an individual who is currently licensed and currently registered as a psychologist by the New York State Education Department from the New York State Education Department and who possesses a doctoral degree in psychology.
- m. **Licensed Marriage and Family Therapist** is an individual who is licensed and currently registered as a marriage and family therapist by the New York State Education Department
- n. **Licensed Mental Health Counselor** is an individual who is licensed and currently registered as a mental health counselor by the New York State Education Department
  - o. **Nurse Practitioner** is an individual who is currently certified as a nurse practitioner by the New York State Education Department
  - p. **Physician** is an individual who is licensed and currently registered as a physician by the New York State Education Department
  - q. **Physician Assistant** is an individual who is currently registered as a physician assistant by the New York State Education Department
  - r. **Psychiatrist** is an individual who is licensed and currently registered to practice medicine in New York State, who (i) is a diplomat of the American Board of Psychiatry and Neurology or is eligible to be certified by that Board, or (ii) is certified by the American Osteopathic Board of Neurology and Psychiatry or is eligible to be certified by that Board.

s. **"Qualified mental health staff person"** found in 14 NYCRR 594 or 14 NYCRR 595

o 14 NYCRR 594

▪ *Qualified mental health staff person* means:

- a physician who is currently licensed as a physician by the New York State Education Department; or
- a psychologist who is currently licensed as a psychologist by the New York State Education Department; or
- a social worker who is either currently licensed as a licensed master social worker or as a licensed clinical social worker by the New York State Education Department or has a master's degree in social work from a program approved by the New York State Education Department; or
- a registered nurse who is currently licensed as a registered professional nurse by the New York State Education Department; or
- or
- a creative arts therapist who is currently licensed as a creative arts therapist by the New York State Education Department; or
- a marriage and family therapist who is currently licensed as a marriage and family therapist by the New York State Education Department; or
- a mental health counselor who is currently licensed as a mental health counselor by the New York State Education Department; or
- a psychoanalyst who is currently licensed as a psychoanalyst by the New York State Education Department; or
- a nurse practitioner who is currently certified as a nurse practitioner by the New York State Education Department; or
- Other professional disciplines which receive the written approval of the Office of Mental Health.

o 14 NYCRR 595

▪ *Qualified mental health staff person* means:

- a physician who is currently licensed as a physician by the New York State Education Department;
- a psychologist who is currently licensed as a psychologist by the New York State Education Department;

- a social worker who is either currently licensed as a licensed master social worker or as a licensed clinical social worker by the New York State Education Department or
  - a registered nurse who is currently licensed as a registered professional nurse by the New York State Education Department;
  - a creative arts therapist who is currently licensed as a creative arts therapist by the New York State Education Department;
  - a marriage and family therapist who is currently licensed as a marriage and family therapist by the New York State Education Department;
  - a mental health counselor who is currently licensed as a mental health counselor by the New York State Education Department;
  - a psychoanalyst who is currently licensed as a psychoanalyst by the New York State Education Department;
  - a nurse practitioner who is currently certified as a nurse practitioner by the New York State Education Department;
  - an individual having education, experience and demonstrated competence, as defined below:
    - a master's or bachelor's degree in a human services related field;
    - an associate's degree in a human services related field and three years' experience in human services;
    - a high school degree and five years' experience in human services; or
  - Other professional disciplines which receive the written approval of the Office of Mental Health.
- t. **Registered Professional Nurse** is an individual who is licensed and currently registered as a registered professional nurse by the New York State Education Department
- u. **Social Worker** is an individual who is either currently registered as a Licensed Master Social Worker (LMSW) or as a Licensed Clinical Social Worker (LCSW) by the New York State Education Department..

## **D. Provider Competencies in Evidence Based Practice (EBP) Designation under Community Psychiatric Support and Treatment (CPST) service**

### **Defining Evidence Based Practice**

Evidence Based Practice (EBP) is the use of systematic decision-making processes or provision of services which have been shown, through available scientific evidence, to consistently improve measurable outcomes for children and youth. EBP relies on data collected through experimental research and account for individual client characteristics and clinician expertise.

With the fields of behavioral health (i.e., mental health and substance use), child welfare and/or juvenile justice, an EBP is often discussed in terms of treatments or interventions which are effective. EBPs are interventions which have scientific findings to demonstrate their effectiveness or efficacy in improving client outcomes. EBP models are based on rigorous amount of research which have been statistically proven to be effective. Data sources used to make these evidence determinations include randomized experiments, which compare treatment with a control group or compare the intervention and treatment with another already established treatment; or single case design.

### **New York State's Aim**

The intent of any designated EBP should be to target children and youth under 21 years of age, who are Medicaid eligible and have needs that can be met by the behavioral health, child welfare and/or juvenile justice systems. In addition, the child/youth must meet Community Psychiatric Support and Treatment (CPST) medical necessity criteria, be determined by a licensed professional to need CPST and meet the target criteria of a specific designated EBP under CPST. To be eligible for designation, an EBP must have a behavioral health outcome as one of its primary goals. Specifically, NYS's intent is to designate EBPs that aim to achieve one or more of the following

- Promote a child's social-emotional development
- Promote positive child and family self-efficacy (social skills, self-concept, interpersonal relations, interpersonal competence), building on strengths while addressing goals highlighted in the treatment plan
- Reduce the child's risk of experiencing undesirable behavioral health outcomes (e.g., depression, substance use, traumatic stress), and
- Address existing behavioral health challenges in a manner that reduces symptoms, improves functioning, and reduces need for other Medicaid services and higher levels of services/care interventions.

There are a variety of Evidence Based Practices (EBPs) that have been determined to be highly effective with children who have identified deficits, challenges that impede functioning or other circumstances that effect development socially, emotionally or behaviorally and who are at risk of developing significant challenges later in life. These EBPs have been proven to help support children and their families and help best address their developmental needs or maintain children in their home environments.

NYS seeks to make the use of EBPs reimbursable through the Medicaid State Plan (i.e., Community Psychiatric Supports and Services or CPST for individuals under 21). This will further develop the capacity to provide behavioral health models of care for children, youth and families that have demonstrated effective outcomes and are based in scientific research.

Providers with experience delivering services to children/youth and their families (hereafter referred to as “Applicant”) that are currently delivering an EBP to model fidelity, or are in the process of pursuing certification to deliver an EBP, will be eligible to apply for designation for an enhanced reimbursement rate to support the delivery of the practice, as long as they maintain fidelity to the model. Once an Applicant becomes certified by an approved credentialing entity to provide an EBP, a provider is eligible to request EBP designation within New York State. It is the responsibility of the Applicant to ensure they maintain competent staff to uphold the model, delivering the intervention to fidelity, and certification renewal of the designated EBP. Guidelines for this process are described further in this Appendix. Once the Applicant has been approved to deliver the specific EBP, the Applicant will receive a NYS designation and be allowed to use specific rate codes related to the practice being delivered.

By making EBPs reimbursable through Medicaid authority, NYS hopes to build a statewide capacity to provide models of care that have a research base to show effective outcomes for children and their families.

### **Designation Process**

The EBP designation allows providers to bill enhanced Medicaid rates reimbursable through specific rate codes. New York State’s expectation is for designated EBP providers to: 1) meet the required Community Psychiatric Support and Treatment (CPST) qualifications; 2) be certified to offer an EBP for children and youth younger than 21 by a certifying body that meets with NYS’ EBP aim; 3) implement the EBP in fidelity to each model for which designation is sought and 4) maintain certification in the EBP for the length of time enhanced Medicaid rates are billed and paid.

Requests for EBP designation will be evaluated by the New York State EBP Review Team as indicated in this Appendix. The NYS EBP Review team is comprised of

representatives from four state agencies (DOH, OASAS, OCFS, and OMH). NYS reserves the right to seek input and advice from other experts.

A letter of support from the appropriate local government (i.e. LDSS, LGU or other) is required as part of the EBP application process, to ensure that the locality is aware of the application, supports the Applicant's request for EBP designation and confirms that Medicaid funding will not supplant other funding that may support the desired EBP in the community. The NYS EBP Review Team will review letters of support and reserves the right to discuss an application with local government staff as necessary to evaluate a designation application.

The State will make a determination on the Application upon submission of all required documentation. It is NYS's expectation that all EBPs operate within fidelity of the EBP model. All EBP models have different required documentation. It is the responsibility of the Applicant, not the NYS EBP Review Team, to understand all requirements needed to be approved for a particular EBP. The NYS EBP Review Team will consider EBPs for designation that meet the State's definition of EBP and the aim stated in this Appendix. If you have any questions pertaining to EBPs, please send e-mail to [OMH-Managed-Care@omh.ny.gov](mailto:OMH-Managed-Care@omh.ny.gov).

### **Application Submission Guidance**

The Applicant will state their intended dates of designation for the specific EBP for which the Applicant is applying. The date should be indicated on the cover sheet *Request of EBP Designation within New York State* (pg.71). The period of designation dates should coincide with the Applicant's time period of EBP certification. For example, if the Applicant has active certification for another two years from a certifying body, the period of time for EBP designation could be for the same time period.

Providers are required to submit documentation from a nationally recognized organization(s) reviewed research and evaluation of the EBP and has determined that the EBP has demonstrated outcomes. The studies must have utilized at least one experimental or quasi-experimental design and have been published in a peer reviewed journal.

Should the Applicant be approved for EBP designation under the State Medicaid benefit of CPST, the provider will receive an approval letter from NYS. This approval letter will include the Applicant's certification period for that EBP as well as their designation timeframe. The certification period will be consistent with the period approved by the EBP model proprietor. The Applicant is responsible for tracking when their certification period needs to be renewed; failure to renew may result in Medicaid disallowances or designation inactivation. New York State's expectations are that providers maintain a current, up to date certification and ensure recertification is completed in the month

before expiration. Proof of recertification will need to be submitted to the State to ensure continued utilization of enhanced Medicaid payment rates under CPST.

Any existing EBP provider that was operational before the issuance of this guidance will need to apply for designation, if the provider wishes to be considered for an enhanced reimbursement. The NYS EBP review process is separate and will not interface with any EBP designation process currently operating in the State of New York. Agencies must submit applications, and be approved by NYS, to be reimbursed by Medicaid for the EBP under CPST.

An Applicant attests that they maintain appropriate staff to remain in fidelity of the model and to claim the enhanced Medicaid reimbursement.

If an individual practitioner receives EBP training and certification at one agency and then moves to another agency, the new agency (i.e., new employer) must be certified in that EBP and designated by NYS before the transitioning practitioner's activities under the specific EBP can be reimbursed under Medicaid.

For applications that are rated as having insufficient evidence for EBP status, the summary of results sent to applicants will identify criteria where the application did not meet the requirements.

### **Resubmission of Applications**

There is no appeal process and all NYS EBP Review Team decisions are final. Applicants may resubmit an application with missing information or new evidence in a future calendar year quarter. The applicant must indicate that it is a resubmission and identify the criteria for which new evidence is being provided as well as address prior application deficits previously identified by the NYS EBP Review Team.

## **Guidelines for Evidenced Based Practice Designation under CPST**

Applicant is certified under an EBP by credentialing entity and is under the oversight and monitoring of the credentialing entity to assure fidelity to the EBP model. EBPs must meet NYS definition and aim.

Applicant completes designation cover sheet submitting all required documentation, including a letter of support from the appropriate local government entity. Applicant must have proof of active certification in EBP and specify expiration date of certification within request.

Applicant submits all required documentation to the New York State EBP Review Team

The New York State EBP Review Team receives request and contacts the provider to confirm receipt of application within 15 business days. NYS reserves the right to request additional information from provider, if needed.

The New York State EBP Review Team assesses request during quarterly meetings

The New York State EBP Review Team sends out a letter to the Applicant, notifying them of the review team's decision on the EBP designation request

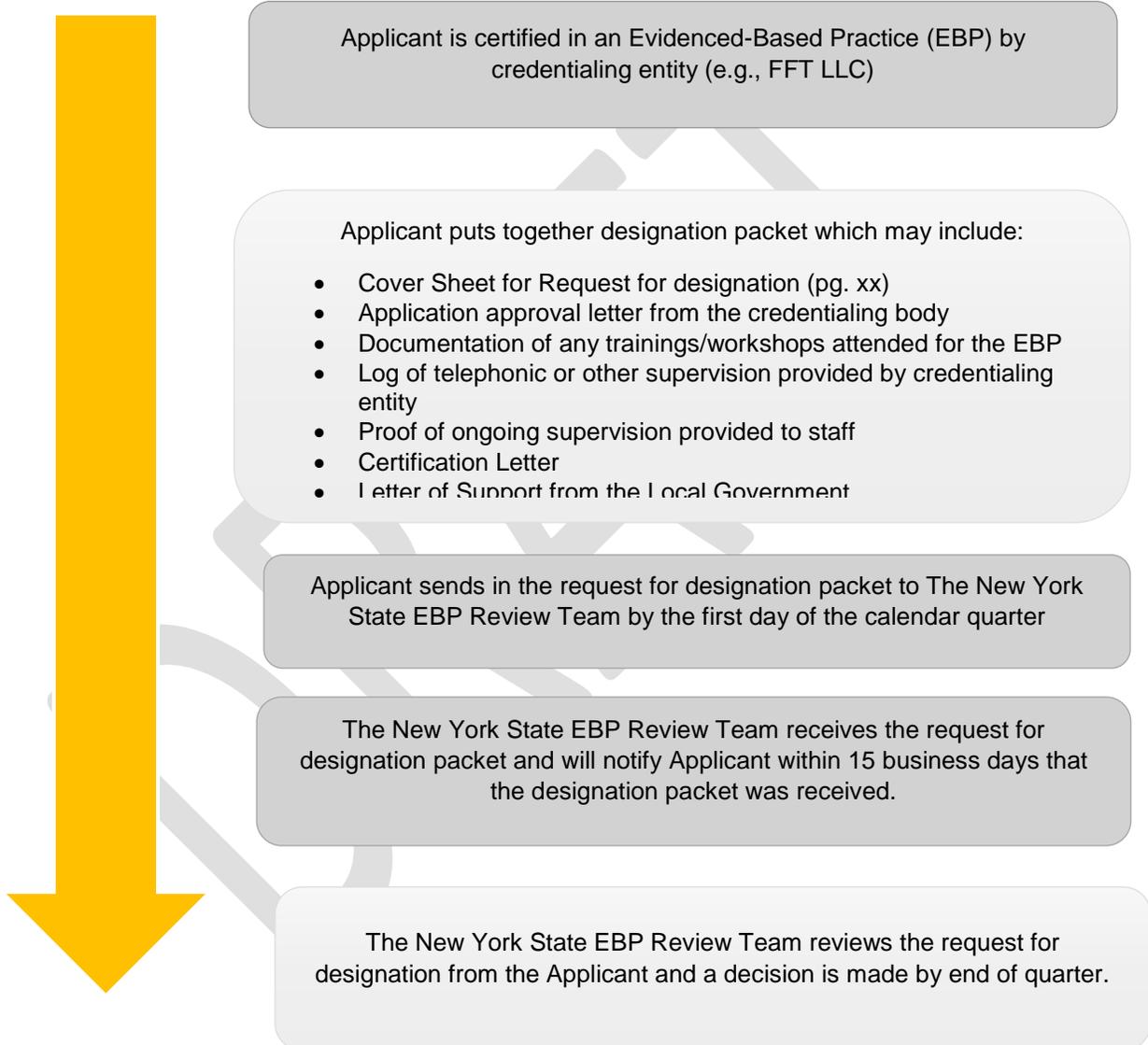
A denial letter is sent to Applicant

Approval letter is sent to Applicant granting EBP designation within NYS. Letter includes dates of effective designation as well as the billing mechanism for this designation

Following receipt of letter, Applicant may submit additional information required to NYS for reconsideration of EBP designation request

## **Example of Documentation Process to New York State for Designation under CPST in an Evidenced Based Practice (EBP)**

The NYS EBP Review Team requires all Applicants to submit appropriate documentation in order to be considered for designation to deliver an Evidenced Based Practice (EBP) under the Medicaid State Plan Community Psychiatric Support and Treatment (CPST) service in New York State. The NYS EBP Review Team recognizes that the following examples of documentation may not be applicable within all EBPs and may differ depending on the EBP model requested. Please Note: The EBP Request for Designation Cover Sheet can be found on (pg. xx) of this manual and is required when applying.



**Evidenced Based Practice (EBP) Request for Designation under Community  
Psychiatric Support and Treatment (CPST)  
Designation Cover Sheet**

Instructions: Please complete and attach this form to the packet of information needed for consideration for Medicaid reimbursement under Community Psychiatric Support and Treatment (CPST) to deliver an Evidenced Based Practice (EBP), specified on (pg. xx). Applicants requesting consideration for more than one EBP are required to fill out a separate cover sheet with required documentation for each EBP. This cover sheet and all additional information should be submitted to New York State (contact information at the end of this form).

**Applicant Agency Name:** \_\_\_\_\_

**Applicant Contact Information:**

Primary Contact Person Full Name: \_\_\_\_\_

E-mail Address: \_\_\_\_\_

Phone Number: (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_

Fax Number: (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_

Address: \_\_\_\_\_

**Designation is being requested for the following EBP:**

- Name of EBP applying for designation: \_\_\_\_\_
- Proprietor/Owner of EBP Model: \_\_\_\_\_
- County(ies) (locality) to be served: \_\_\_\_\_
- Target Population(s): \_\_\_\_\_
- Estimated Annual Capacity: \_\_\_\_\_

**Attached Documentation (please detail):** \_\_\_\_\_

**Current EBP Certification Period from EBP model proprietor**

Effective from \_\_\_\_\_ to \_\_\_\_\_

*To be completed by New York State only:*

Date Received By the State \_\_\_/\_\_\_/\_\_\_

Provider notified 15 business days upon submission \_\_\_/\_\_\_/\_\_\_

Date Sent to the Review Team \_\_\_/\_\_\_/\_\_\_

Decision:

- Approved
- Denied
- More information is needed
- Letter sent to provider with result of review

*When complete, please mail your agency's forms to*