Children and Family Treatment and Support Services (CFTSS)

Provider Manual

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Contents of this manual are subject to change. Any questions or concerns about this document can be sent to OMH-Managed-Care@omh.ny.gov

Table of Contents

I. BACKGROUND

The Children and Family Treatment and Support Services (CFTSS) Provider Manual is a guide for the six children's health and behavioral health services reimbursable through Medicaid, Managed Care and Fee-for-Service, and Child Health Plus[1]. These services are an outgrowth of NYS' Medicaid Redesign efforts and the valuable direction of the NYS Children's Medicaid Redesign Subcommittee. In collaboration with the Subcommittee, the Office of Mental Health (OMH), Office of Addiction Services and Supports (OASAS), Office of Children and Family Services (OCFS), and the Department of Health (DOH) worked to identify six services to benefit New York State's children from birth up to 21 years of age.

These Children and Family Treatment and Support Services are authorized under the *Early and Periodic Screening, Diagnosis and Treatment* benefits (known commonly as EPSDT). EPSDT is an array of Medicaid benefits for children under 21 years of age, which historically have been focused primarily on children's preventive medical care (e.g., well baby visits, vaccinations, and screenings at designed ages). This set of Medicaid State Plan services will enable a greater focus on prevention and early intervention by providing a greater array of available services and the capacity to intervene earlier in a child/youth's life.

The addition of these new services offers opportunities to better meet the behavioral health needs at earlier junctures in a child/youth's life to prevent the onset or progression of behavioral health conditions. This expansion of access to and range of these services will also help to prevent the need for more restrictive and higher intensity services for children and youth. These following six services will be available to any child eligible for Medicaid and Child Health Plus who meets relevant medical necessity criteria:

- Other Licensed Practitioner
- Crisis Intervention
- Community Psychiatric Supports & Treatment
- Psychosocial Rehabilitation
- Family Peer Support
- Youth Peer Support

[1] As of January 1, 2023, CFTSS became a covered benefit under Child Health Plus (CHP). v

This array of services will allow interventions to be delivered in the home and other natural community-based settings where children/youth and their families live. By providing a greater level of flexibility and the capacity for more individualized service delivery, NYS hopes to achieve the guiding force behind the Medicaid benefit redesign, for children and their families to receive "*the right services, at the right time and in the right amount*".

II. INTRODUCTION

The development of the six Children and Family Treatment and Support Services State Plan services are intended to better meet children's needs, expand access to clinical treatment services, and provide a greater array of approaches for rehabilitative interventions. By creating these services, children and families/caregivers can more readily access the services regardless of what "door" they may have entered. Therefore, any child who is Medicaid or Child Health Plus eligible and is identified as having a health or behavioral health need can access services with greater flexibility and choice.

The implementation of the Children and Family Treatment and Support Services are designed to foster and promote the health and wellness of children/youth and their families/caregivers. As such, these services are guided by core principles inherent in the children's behavioral health system, known to many as the CASSP Core Principles.

The CASSP (Child and Adolescent Service System Program) is based on a well-defined set of principles for behavioral health services for children and adolescents with or at risk of developing severe emotional disorders and their families/caregivers. These principles are summarized in six core statements.

- **Child-centered:** Services are planned to meet the individual needs of the child, rather than to fit the child into an existing service. Services consider the child's family and community contexts, are developmentally appropriate and child-specific, and build on the strengths of the child and family to meet the mental health, social and physical needs of the child.

- **Family-focused**: The family is the primary support system for the child and it is important to help empower the family to advocate for themselves. The family participates as a full partner in all stages of the decision-making and treatment planning process including implementation, monitoring and evaluation. A family

may include biological, adoptive and foster parents, siblings, grandparents, other relatives, and other adults who are committed to the child.

- **Community-based**: Whenever possible, services are delivered in the child's home community, drawing on formal and informal resources to promote the child's successful participation in the community. Community resources include not only mental health professionals and provider agencies, but also social, religious, cultural organizations and other natural community support networks.

- **Multi-system**: Services are planned in collaboration with all the child-serving systems involved in the child's life. Representatives from all these systems, the child and the family collaborate to define the goals, develop a service plan, identify the necessary resources to implement the plan, provide appropriate support to the child and family, and evaluate progress.

- **Culturally competent**: Culture determines our worldview and provides a general design for living and patterns for interpreting reality that are reflected in our behavior. Therefore, services that are culturally competent are provided by individuals who have the skills to recognize and respect the behavior, ideas, attitudes, values, beliefs, customs, language, rituals, ceremonies and practices characteristic of a particular group of people.

- **Least restrictive/least intrusive**: Services take place in settings that are the most appropriate and natural for the child and family and are the least restrictive and intrusive available to meet the needs of the child and family.

The Children and Family Treatment and Support Services are designed to work individually or in a coordinated, comprehensive manner, depending upon the unique needs of the child/youth and family. The need for services may vary depending upon the child's age, developmental stage, needs of the family/caregiver, whether the child has an identified behavioral health need, and/or the degree of the child's complex clinical needs. Based on these variances, children/youth can access the services in variety of ways.

The utilization of the Children and Family Treatment and Support Services is intended to be individualized to the needs of the child at any point in their development or treatment trajectory. Therefore, a behavioral health need can be identified by multiple sources including parents and other caregivers, pediatricians, care managers,

clinicians, school personnel, or the young person themselves. Anyone can make a referral for services, but the determination for medical necessity must be made by a Licensed Practitioner of the Healing Arts (LPHA).

Generally speaking, a child in need can be referred for "Other Licensed Practitioner" services at which time a licensed practitioner will make a determination for the provision of the service. A child/youth is not required to have an established behavioral health diagnosis in order to receive Other Licensed Practitioner (OLP) services but must meet the medical necessity criteria for eligibility for the service. OLP may be used to conduct a clinical evaluation for the purposes of determining a behavioral health diagnosis, the nature and scope of a behavioral health need and/or to make recommendations for other services (e.g., CFTSS or Home and Community Based Services (HCBS)). However, an OLP evaluation is not needed to access services when a child has already received a recommendation for the service(s) from another LPHA. For the remaining four rehabilitative services, which include Community Psychiatric Supports & Treatment, Psychosocial Rehabilitation, Family Peer Support, and Youth Peer Support, each must be *recommended* (see Glossary) by a LPHA who determines medical necessity.

III. SERVICES

OTHER LICENSED PRACTITIONER (OLP)

Definition:

Other Licensed Practitioner ("OLP") is a term that refers to *non-physician licensed behavioral health practitioners* ("*NP-LBHPs*"). *NP-LBHPs* are licensed clinicians operating within scope of practice in accordance with the New York State Education Department Office of the Professions. *NP-LBHPs* authorized under OLP include the following:

- Licensed Psychologists
- Licensed Psychoanalysts
- Licensed Clinical Social Workers
- Licensed Marriage and Family Therapists
- Licensed Mental Health Counselors
- Licensed Master Social Workers when under the supervision of Licensed Clinical Social Workers (LCSWs), Licensed Psychologists, or Licensed Psychiatrists
- Licensed Creative Arts Therapist

This OLP allows services provided by NP-LBHPs to be reimbursable when delivered in the home and/or community, or other site-based settings when appropriate, as permissible under State practice law. The delivery of services by NP-LBHPs in these natural settings expands the range of treatment options for families/caregivers by allowing greater flexibility and choice based on the needs of the child or youth. It is also expected to more effectively engage those children, youth and families/caregivers who may have difficulty engaging in traditional clinic-based settings.

The clinical services provided under OLP are intended to help prevent the progression of exhibited behavioral health needs through early identification and intervention and may be provided to children/youth in need of assessment for whom behavioral health conditions have not yet been diagnosed, including but not limited to children ages birth-5. In instances where behavioral health needs have been identified but a diagnosis is not yet known and/or not specified, providers can use an unspecified ICD-10 diagnosis code, such as R69 (illness, unspecified), F99 (mental disorder, not otherwise specified), or an appropriate Z-code (see Appendix B) when billing for OLP. Throughout the course of the screening and assessment process, should another diagnosis, or need outside of behavioral health be identified, then that child/youth should be referred to the appropriate service and/or resource for the condition identified (e.g., children/youth assessed as I/DD should be referred to OPWDD; children/youth assessed for infant or early childhood needs may be referred to Early Intervention).

Services are also intended to provide treatment for children/youth with an existing diagnosis for whom flexible community-based treatment is needed to correct or ameliorate conditions identified during an assessment process, such as problems in functioning or capacity for healthy relationships. In addition, an assessment of needs may result in the recommendation of further medically necessary services, such as rehabilitative services. Services are delivered in a trauma informed, culturally and linguistically competent manner.

Children may be referred to any agency designated to provide clinical services under OLP. Referrals may come from a variety of routine sources such as schools, pediatricians, etc., or may be a result of self-identification by a parent/caregiver or the child/youth. Under OLP, the NP-LBHP may conduct a comprehensive clinical assessment to diagnose, and/or determine medical necessity to develop a treatment plan with the child/family to restore functioning and/or ameliorate behavioral health symptoms.

In many instances, the treatment plan may also include service needs beyond those provided by NP-LBHPs and incorporate medically necessary rehabilitative State Plan services (such as those described below in this manual) to effectively address the needs of the child/family. By recommending and including rehabilitative services, the treatment plan serves as the mechanism to develop a comprehensive rehabilitative service package and to support a child and family whose needs may be complex and/or require flexible nontraditional approaches.

Service Components

Licensed Evaluation (Assessment) – process of identifying a child/youth individual's behavioral strengths and weaknesses, problems and service needs, through the observation and a comprehensive evaluation of the child/youth current mental, physical and behavioral condition and history. The assessment is the basis for establishing a diagnosis where needed, and treatment plan, and is conducted within the context of the child/youth self-identified needs, goals, and ethnic, religious and cultural identities. Assessment should result in the identification of services and practices medically necessary to meet the child/youth's behavioral health needs, which may include other services.

All NP-LBHPs have the capacity to conduct a comprehensive assessment within the scope of their practice.

- **Treatment Planning** - process of describing the child/youth's condition and services needed for the current episode of care, detailing the scope/practices to be provided, expected outcome, and expected frequency and duration of the treatment for each provider. Treatment planning is part of the assessment process, with the child/family's active participation. The services identified within a treatment plan must be medically necessary to help the child/youth attain, maintain or regain functional capacity. The treatment plan should be culturally relevant, trauma informed, and child- and family-centered.

Individual and Family Psychotherapy - therapeutic communication and interaction for the purpose of alleviating symptoms or functional limitations associated with a child/youth's diagnosed behavioral health disorder, reversing or changing maladaptive patterns of behavior, encouraging personal growth and development, and supporting the child/youth's capacity to achieve age–appropriate developmental milestones.

Crisis Intervention Activities - If the child-youth experiences psychiatric, behavioral, or situational distress in which the NP-LBHP is contacted as the treatment provider, the reimbursement categories below allow the NB-LBHP to provide the necessary interventions in crisis circumstances.

Crisis Triage (By telephone) - refers to activities provided by the treating clinician through OLP which are designed to address acute distress and associated behaviors when the child/youth's condition requires immediate attention due to an unplanned event that requires a rapid response. As such, crisis triage need not be anticipated in the treatment plan.

Crisis Off-Site (In-person) - refers to activities provided by the treating clinician through OLP which are designed to address acute distress and associated behaviors when the child/youth's condition requires immediate attention due to an unplanned event that requires a rapid response. As such, crisis off-site need not be anticipated in the treatment plan.

Crisis Complex Care (Follow up) - an ancillary service to psychotherapy provided by a clinician by telephone, with or without the child/youth. It is a clinical level service which may be necessary as a follow up to psychotherapy or a crisis episode for the purpose of preventing a change in community status or as a response to complex conditions. It is not a stand-alone service. It is a non-routine professional service designed to coordinate care.

Modality

- Individual
- Family
  - OLP service delivery may also include family contact *with or without* the child/youth present, as long as the contact is identified on and directly related to the child/youth's goals, in the treatment plan.
- Collateral
  - OLP service delivery may also include collateral contact *with or without the child/youth present*, as long as the contact is identified on and directly related to the child/youth's goals, in the treatment plan.
- Group

- Group limit refers to number of participants, regardless of payor. Groups should not exceed 8 individuals.
- Consideration may be given to smaller limit of members if participants are younger than 8 years of age.
- Consideration for group limits, or the inclusion of an additional group clinician/ facilitator, should be based on, but not limited to, the purpose/nature of the group, the clinical characteristics of the participants, age of participants, developmental level and severity of needs of the participants, inclusion of family and/or collaterals in group, and the experience and skill of the group clinician/facilitator.
- Groups may include youth and/or family/collaterals including youth-only, family-only, or both as long as the contact is directly related to the child/youth's treatment plan goals, for the benefit of the child/youth.

NOTE: The use of telehealth must be conducted in accordance with state-issued guidance. For OMH, agencies must secure required licensure/designation approval prior to telehealth utilization and adhere to 14 NYCRR 596 and Telehealth Services Guidance for OMH Providers. In addition, OASAS-certified providers must obtain OASAS certification to offer services via telehealth, in accordance with 4 NYCRR PART 830.5.

Setting

Services should be offered in the setting best suited for desired outcomes, including site-based, home, or other community-based setting in compliance with State practice law.

Limits and Exclusions

- 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 (PASSR) indicates it is medically necessary treatment. Social worker visits are included in the Nursing Facility visit and many not be billed separately. Visits to Intermediate Care Facilities for individuals with Mental Retardation (ICF-MR) are not covered.
- All NP-LBHP services provided while the person is a resident of an Institution for Mental Disease (IMD), such as free-standing psychiatric hospital or psychiatric

residential treatment facility, are part of the Medicaid institutional service and not otherwise 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.
- Individualized Education Plan (IEP) and 504 plan services are separate and apart from OLP and cannot be provided via CFTSS.
- Treatment services must be a part of a treatment plan including goals and activities necessary to correct or ameliorate conditions discovered during the initial assessment visits.

Certification/Provider Qualifications

Provider Agency Qualifications:

Services provided under Other Licensed Practitioner (OLP) are provided by identified non-physician behavioral health practitioners (NP-LBHP) who are licensed by the State of New York to treat mental illness or substance use disorder, acting within the scope of all applicable State laws and their professional license. Agencies authorized to deliver services via OLP are expected to employ licensed staff who, by their training and experience, are qualified to provide clinical services as permissible under this section.

- Any practitioner above must operate within a child serving agency that is licensed, certified, designated and/ or approved by OCFS, OMH, OASAS or DOH or its designee, in settings permissible by that designation.

- NP-LBHPs include the following practitioners; each is permitted to practice independently within his or her scope of practice under Title VIII of the Education Law and in any setting permissible under State law:
  - (1) Licensed Psychologists
  - (2) Licensed Psychoanalysts;
  - (3) Licensed Clinical Social Workers (LCSWs);
  - (4) Licensed Marriage and Family Therapists (LMFT);
  - (5) Licensed Creative Arts Therapists; (LCAT); and
  - (6) Licensed Mental Health Counselors (LMHC).
  - (7) Licensed Master Social Workers (LMSWs) under the supervision of Licensed Clinical Social Workers (LCSWs), Licensed Psychologists, or Psychiatrists.

- NP-LBHPs with a provisional or limited license can provide Other Licensed Practitioner services under the supervision of allowable licensed practitioners in accordance with requirements from the New York State Education Department Office of the Professions. When non-licensed staff are providing clinical services under OLP, it is especially critical that regular and appropriate supervision is provided and documented. Staff should only provide services which are within their scope of practice and level of competence and under supervision which is commensurate with their training, experience and identified needs.

- State recognized Evidenced-based practice (EBP) models for the purposes of the Children's Medicaid transformation plan, require approval, designations and fidelity reviews on an ongoing basis as determined necessary by New York State. For more information, see Appendix C.

NOTE: 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).

Training Requirements

Required Training: Mandated Reporter

Recommended Trainings: Practitioners are encouraged to review knowledge base and skills the State recommended for providers who will be delivering OLP services to children to demonstrate competency (See Appendix B).

CRISIS INTERVENTION (CI)

Definition:

Crisis Intervention (CI) services are mobile services provided to children/youth under age 21 who are identified as experiencing an 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., family, provider, community member) to effectively resolve it.

CI services are designed to interrupt or ameliorate the crisis experience and result in immediate crisis resolution. The goals of CI are engagement, symptom reduction,

stabilization, and restoring child/youth to a previous level of functioning or promoting coping mechanisms within the family unit to minimize or prevent crises in the future.

Mobile Crisis Intervention:

Mobile Crisis Intervention is an intervention that can occur in a variety of settings, including community locations where the child/youth lives, attends school, engages in services (e.g., office settings), socializes and/or works. CI services are delivered in a person-centered, family-focused, trauma-informed, culturally and linguistically responsive manner.

CI includes engagement with the child/youth, family/caregiver and other collateral sources (e.g., school personnel) as needed, to determine level of safety, risk, and plan for the next level of services. All activities must be delivered 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.

CI services are provided through a multi-disciplinary team to enhance engagement and meet the unique needs of the child/youth and family. Teams are encouraged to include a range of service providers as defined below (see: *Individual Qualifications)* to promote the multi-disciplinary approach, such as, the inclusion of a Credentialed Family Peer Advocate or Credentialed Alcoholism and Substance Abuse Counselor (CASAC). The team should be comprised of at least two professionals for safety purposes. One member of a two-person crisis intervention team must have experience with crisis intervention service delivery and be a licensed behavioral health professional: Psychiatrist, Physician, Physician Assistant, Licensed Psychoanalyst, Clinical Nurse Specialist, Addictionologist/Addiction Specialist, Licensed Clinical Social Worker (LCSW), Licensed Master Social Worker (LMSW), Licensed Mental Health Counselor (LMHC), Licensed Psychologist, Licensed Marriage and Family Therapist (LMFT), or Nurse Practitioner with experience/background in treatment of mental health and/or substance use disorders. The team may also be comprised of non-licensed behavioral health professionals: Credentialed Alcoholism and Substance Abuse Counselor (CASAC), Credentialed Family Peer Advocate, Certified Recovery Peer Advocate-Family, Certified Rehabilitation Counselor, or a Registered Professional Nurse (RN). If one member of the team is a Peer Advocate, the Peer Advocate must have a credential/certification as either an OMH established Family Peer Advocate Credential or an OASAS established Certified Recovery Peer Advocate-Family.

If determined through triage that only one team member is needed to respond to a psychiatric crisis, that team member must be a behavioral health professional and have

experience with crisis intervention. If determined through triage that only one team member is needed to respond, an unlicensed Psychologist employed by state or county government could respond. Similarly, a Credentialed Alcoholism and Substance Abuse Counselor (CASAC) may respond to a Substance Use Disorder crisis with a licensed behavioral health professional available via phone. A Peer Support specialist or other unlicensed practitioner may not respond alone, except for the CASAC as noted.

Substance use should be recognized and addressed in an integrated way as it elevates risk and impacts both the crisis intervention being delivered and the planning for ongoing care, further demonstrating the necessity of a multi-faceted team approach. As such, crisis services cannot be denied based upon substance use and crisis team members should be trained on screening for substance use disorders.

Referrals for mobile Crisis Intervention services may be made through a number of sources such as family members, school social workers, provider agencies, primary care doctors, law enforcement, etc. Upon receiving a call/request for crisis services, a preliminary assessment of risk and mental status is conducted. The preliminary assessment will determine if crisis services are necessary to further evaluate, resolve, and/or stabilize the crisis. This determination can be made by the following licensed practitioners of the healing arts, operating within their scope of practice, who may or may not be part of the crisis team: Psychiatrist, Physician, Addictionologist/Addiction Specialist, Licensed Psychoanalyst, Registered Professional Nurse, Nurse Practitioner, Clinical Nurse Specialist, Physician Assistant, Licensed Master Social Worker (LMSW), Licensed Clinical Social Worker (LCSW), Licensed Marriage and Family Therapist (LMFT), Licensed Mental Health Counselor (LMHC), or a Licensed Psychologist.

CI must provide 24/7/365 availability and respond within three (3) hours of the completion of the initial call to the crisis provider and upon the determination an in-person contact is required. A crisis intervention episode begins with the provider's initial contact with the child.

The CI team uses methods and techniques to engage and promote symptom reduction and stabilization to restore the child/youth to a previous level of functioning. Relevant information is gathered from the child, family, and/or other collateral supports to assess the risk of harm to self or others and to develop a crisis plan to address safety/mitigate risk. The crisis plan is developed in collaboration with the child/family and should follow to the extent possible, any established crisis plan already developed for the child/youth if it is known to the team.

Care coordination is provided and must include at a minimum, a follow up contact either by phone or in person within 24 hours of the initial contact/response to assure the child's continued safety and confirm that linkage to needed services has taken place. Follow up may, however, include further assessment of mental status and needs, continued supportive intervention (face-to-face or by phone, as clinically indicated), coordination with collateral providers, linkage to services or other collateral contacts for up to 14 days post-contact/response. The end of the CI episode will be defined by the resolution of the crisis and alleviation of the child/youth's acute symptoms, and/or upon transfer to the recommended level of care.

Crisis Intervention services must be documented in the individual's case record in accordance with Medicaid regulations. The child/youth's case record must reflect resolution of the crisis which marks the end of the episode. Warm handoff to follow up services (such as CPST, or other identified supports) with a developed plan should be clearly identified in the case record.

Service Components

Mobile Crisis Intervention may include the following components:

1. Assessment of risk, mental status and need for further evaluation and/or other health/behavioral health services.

2. Crisis Planning. The crisis planning minimally addresses:
    - Immediate safety/risk concerns
    - Prevention of future crises
    - Signing of appropriate consent for releases for follow up referrals to services and/or collaboration with existing providers of recipients.

3. Care Coordination, including:
    - 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.
    - Contact with collaterals focusing on the child's needs.
    - Follow-up with the child and family/caregiver within 24 hours of initial contact/response, including informing existing supports/providers of the developed crisis plan and up to 14 days post initial contact/response.
    - Documentation of follow-up services.

4. Crisis resolution and debriefing (counseling) with child and/or family/caregiver and treatment provider.

5. Peer Support, such as assisting in the resolution of issues through instilling confidence and support.

Modality

- All service components are meant to be provided by individual interventions to the child and/or family. Contact with collaterals to benefit the treatment of the child, with or without the child present, can be utilized but not in place of the individual intervention to the child and/or family.
- Follow-up may be conducted in person or by phone.

NOTE: The use of telehealth must be conducted in accordance with state-issued guidance. For OMH, agencies must secure required licensure/designation approval prior to telehealth utilization and adhere to 14 NYCRR 596 and Telehealth Services Guidance for OMH Providers. In addition, OASAS-certified providers must obtain OASAS certification to offer services via telehealth, in accordance with 4 NYCRR PART 830.5.

Setting

Service delivery can occur in a variety of settings or other community locations where the child lives, attends school, works, engages in services, and/or socializes.

Limitations/Exclusions

- Rehabilitative services do not include and FFP (Federal Financial Participation) is not available for any of the following:
  - educational, vocational, and job training services,
  - room and board,
  - habilitation services such as financial management, supportive housing, supportive employment services, and basic skill acquisition services that are habilitative in nature,
  - services to inmates in public institutions
  - services to individuals residing in institutions for mental diseases
  - recreational, or custodial (i.e., for the purpose of assisting in the activities of daily living such as bathing, dressing, eating, and maintaining personal

hygiene and safety; for maintaining the recipient's or anyone else's safety, and could be provided by persons without professional skills or training).
    - Services that must be covered under other Medicaid authorities (e.g. services within a hospital outpatient setting).
- Services also do not include services, supplies or procedures performed in a nonconventional setting including resorts, spas, therapeutic programs, and camps.

Certification/Provider Qualifications

Provider Agency Qualification:

- Crisis Intervention practitioners must work within a child serving agency or agency with children's behavioral health and health experience that is licensed, certified, designated, and/or approved by OMH, OASAS, OCFS, or DOH or its designee to provide comparable and appropriate crisis services.

Individual staff qualifications:
Staff qualifications are categorized in accordance with Mobile Crisis Intervention Service Components.

Qualifications for service components 1-2 (Assessment, Crisis Planning):

Psychiatrist, Physician, Physician Assistant, Addictionologist/Addiction Specialist, Licensed Psychoanalyst, Licensed Clinical Social Worker (LCSW), Licensed Master Social Worker (LMSW), Licensed Mental Health Counselor (LMHC), Licensed Psychologist, Unlicensed Psychologist employed by State or County Government, Licensed Marriage and Family Therapist (LMFT) or Nurse Practitioner with experience/background in treatment of mental health and/or substance use disorders, Credentialed Alcoholism and Substance Abuse Counselor (CASAC), Certified Rehabilitation Counselor, or a Registered Professional Nurse or Clinical Nurse Specialist, Licensed Creative Arts Therapist (LCAT).

Qualifications for service component 3 (Care Coordination):

Psychiatrist, Physician, Physician Assistant, Addictionologist/Addiction Specialist, Licensed Psychoanalyst, Licensed Clinical Social Worker (LCSW), Licensed Master Social Worker (LMSW), Licensed Mental Health Counselor (LMHC), Licensed

Psychologist, Unlicensed Psychologist employed by State or County Government, Licensed Marriage and Family Therapist (LMFT) or Nurse Practitioner with experience/background in treatment of mental health and/or substance use disorders, Credentialed Alcoholism and Substance Abuse Counselor (CASAC), Certified Rehabilitation Counselor, or a Registered Professional Nurse or Clinical Nurse Specialist, Licensed Creative Arts Therapist (LCAT), or a practitioner not meeting the qualifications of a Behavioral Health Professional including individuals with two-years' experience, a limited staff permit issued by New York State of Education Department program, a Credentialed Alcoholism and Substance Abuse Counselor (CASAC) or a Qualified Peer Specialist.

Qualifications for service component 4 (Crisis Resolution and Debriefing):

Psychiatrist, Physician, Physician Assistant, Addictionologist/Addiction Specialist, Licensed Psychoanalyst, Licensed Clinical Social Worker (LCSW), Licensed Master Social Worker (LMSW), Licensed Mental Health Counselor (LMHC), Licensed Psychologist, Unlicensed Psychologist employed by State or County Government, Licensed Psychoanalyst, Licensed Marriage and Family Therapist (LMFT), or Nurse Practitioner with experience/background in treatment of mental health and/or substance use disorders, Credentialed Alcoholism and Substance Abuse Counselor (CASAC), Credentialed Family Peer Advocate with lived experience as a family member, Certified Recovery Peer Advocate-family, Certified Rehabilitation Counselor, Registered Professional Nurse, Clinical Nurse Specialist. A practitioner not meeting the qualifications of a Behavioral Health Professional including individuals with two-years' experience, a limited staff permit issued by New York State of Education Department, a student within a Department of Health New York State of Education Department program, a Licensed Practical Nurse (LPN); or a Qualified Peer Specialist may also provide support during and after a crisis.

Qualifications for service component 5 (Peer Support):

NYS Credentialed Family Peer Advocate (FPA) or a Certified Recovery Peer Advocate-Family (CRPA-F)

- A Peer Advocate may not respond alone.
    - If one member of the crisis intervention team is a Peer Advocate, the Peer support provider must have a credential/certification as either: 1) an OMH established Family Peer Advocate, or 2) an OASAS established Certified Recovery Peer Advocate-Family.

- Services should be provided by a competent, trauma-informed, and linguistically responsive multidisciplinary team, for programmatic and safety purposes

NOTE: Individual staff qualifications for Credential Family Peer Advocate or Certified Peer Advocate can be found in Family Peer Support Service Section of this manual.

Supervisor Qualifications:

- The supervisor must provide regularly scheduled supervision and have the qualifications of at least a Licensed Clinical Social Worker (LCSW), Licensed Mental Health Counselor (LMHC), Licensed Creative Arts Therapist (LCAT), Licensed Marriage and Family Therapist (LMFT), 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 years of work experience. The supervisor must practice within the State of health practice laws and ensure that providers are supervised as required under state law. 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

Required Training: All members of the Crisis Intervention Team are required to have training in First Aid, Narcan training, CPR, Mandated Reporter, Crisis De-escalation, Resolution and Debriefing, Suicide Prevention (e.g. SafeTALK), and Crisis Plan Development. For the trainings listed that require refreshers to remain current, retraining must be provided at the required frequency to maintain qualifications.

Recommended Trainings: Practitioners are encouraged to review knowledge base and skills the State recommended for providers who will be delivering CI services to children in order to demonstrate competency (See Appendix B).

COMMUNITY PSYCHIATRIC SUPPORTS AND TREATMENT SERVICES (CPST)

Definition:

CPST services are goal-directed supports and solution-focused interventions intended to address challenges associated with a behavioral health need and to achieve

identified goals or objectives as set forth in the child's treatment plan. CPST services must be part of the treatment plan, which includes the activities necessary to prevent, correct or ameliorate conditions discovered during the initial assessment visits. CPST is an intervention with the child/youth, family/caregiver or other collateral supports. This is a multi-component service that consists of therapeutic interventions such as counseling, as well as functional supports.

Activities provided under CPST are intended to assist the child/youth and family/caregivers to achieve stability and functional improvement in daily living, personal recovery and/or resilience, family and interpersonal relationships in school and community integration. The family/caregiver, therefore, is expected to have an integral role in the support and treatment of the child/youth's behavioral health need. In instances where behavioral health needs have been identified but a diagnosis is not yet known and/or not specified, providers can use an unspecified ICD-10 diagnosis code, such as R69 (illness, unspecified), F99 (mental disorder, not otherwise specified), or an appropriate Z-code (see Appendix B). Throughout the course of the screening and assessment process, should another diagnosis or need outside of behavioral health be identified, then that child/youth should be referred to the appropriate service and/or resource for the condition identified (e.g., children/youth assessed as I/DD should be referred to OPWDD; children/youth assessed for infant or early childhood needs may be referred to Early Intervention).

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 home and/or community based rehabilitative services. CPST allows for delivery of services within a variety of permissible settings including, but not limited to, community locations where the child/youth lives, works, attends school, engages in services, and/or socializes.

CPST is also a service which is easily complemented by the integration of additional SPA services, such as Psychosocial Rehabilitation (PSR). For example, PSR can support CPST by providing the more targeted skill building activities needed for the child/youth to further objectives related to functioning within the community. CPST can also be provided in coordination with clinical treatment services, such as those within OLP, to address identified rehabilitative needs within a comprehensive treatment plan. Services are delivered in a trauma informed, culturally and linguistically competent manner.

Service Components

This service may include the following components:

1. **Intensive Interventions**
   Individual, family and relationship-based counseling, supportive counseling, solution-focused interventions, emotional and behavioral management, and problem behavior analysis with the individual, with the goal of developing and implementing social, interpersonal, self-care and independent living skills to restore stability, to support functional gains and to adapt to community living. These interventions engage the child/youth and family/caregiver in ways that support the everyday application of treatment methods as described in the child's/youth's treatment plan.

2. **Crisis Avoidance**
   Assisting the child/youth with effectively responding to or avoiding identified precursors or triggers that would risk their remaining in a natural community location, including assisting the child/youth and family members or other collaterals with identifying a potential psychiatric or personal crisis, developing a crisis management plan and/or, as appropriate, seeking other supports to restore stability and functioning. It is an intervention to assist the child and family in developing the capacity to prevent a crisis episode or the capacity to reduce the severity of a crisis episode should one occur.

3. **Intermediate Term Crisis Management** Assisting families following a crisis episode experienced by a child/family as stated in the crisis management plan. This component is intended to be stability-focused and relationship-based for existing children/youth receiving CPST services. It is also intended for children in need of longer-term crisis management services after having received a crisis intervention service such as, mobile crisis or ER. The purpose of this activity is to:
   a. Stabilize the child/youth in the home and natural environment
   b. Assist with goal setting to focus on the issues identified from mobile crisis or emergency room intervention, and other referral sources.

4. **Rehabilitative Psychoeducation**
   Educating the child/youth and family members or other collaterals to identify strategies or treatment options with the goal of minimizing the negative effects of symptoms, or emotional disturbances, substance use or associated environmental stressors which interfere with the child/youth's daily living, financial management,

housing, academic and/or employment progress, personal recovery or resilience, family and/or interpersonal relationships and community integration.

5. **Strengths Based Service Planning**
   Assisting the child/youth and family members or other collaterals with identifying strengths and needs, resources, natural supports and developing goals and objectives to utilize personal strengths, resources and natural supports to address functional deficits associated with their mental illness.

6. **Rehabilitative Supports**
   Restoration, rehabilitation, and support to minimize the negative effects of behavioral health symptoms or emotional disturbances that interfere with the child's/youth's daily functioning. This may include 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 or seek information from the appropriate provider to understand the purpose and possible side effects of medication prescribed for conditions.

Modality

- Individual
- Family
  - CPST service delivery may also include family contact *with or without the child/youth present*, as long as the contact is identified on and directly related to the child/youth's goals, in the treatment plan.
- Collateral
  - CPST service delivery may also include family and/or collateral contact *with or without the child/youth present*, as long as the contact is identified on and directly related to the child/youth's goals, in the treatment plan.
- Group may be delivered under Rehabilitative Supports and Rehabilitative Psychoeducation
  - Group limit refers to number of participants, regardless of payor. Groups cannot exceed 8 participants. Consideration should be given to smaller limit of members if participants are younger than 8 years of age.
  - Consideration for group limits, or, the inclusion of an additional group clinician/facilitator, should be based on, but not limited to: the purpose/nature of the group, the clinical characteristics of the participants, age of participants, developmental level and severity of needs of the participants, inclusion of

family and/or collaterals in group, and the experience and skill of the group clinician/facilitator

- Groups may include family/collaterals, *with or without the child/youth present*, as long as the contact is directly related to the child/youth's treatment plan goals, for the benefit of the child.

NOTE: The use of telehealth must be conducted in accordance with state-issued guidance. For OMH, agencies must secure required licensure/designation approval prior to telehealth utilization and adhere to 14 NYCRR 596 and Telehealth Services Guidance for OMH Providers. In addition, OASAS-certified providers must obtain OASAS certification to offer services via telehealth, in accordance with 4 NYCRR PART 830.5.

Setting

Services should be offered in the setting best suited for desired outcomes, including site-based, home or other community-based settings where the child/youth lives, works, attends school, engages in services, socializes.

Limitations/Exclusions

- A child with a developmental disability diagnosis without a co-occurring behavioral health condition is ineligible to receive this rehabilitative service.
- Rehabilitative services do not include and FFP (Federal Financial Participation) is not available for any of the following:
  - educational, vocational, and job training services,
  - room and board,
  - habilitation services such as financial management, supportive housing, supportive employment services, and basic skill acquisition services that are habilitative in nature,
  - services to inmates in public institutions
  - services to individuals residing in institutions for mental diseases
  - recreational, or custodial (i.e., for the purpose of assisting in the activities of daily living such as bathing, dressing, eating, and maintaining personal hygiene and safety; for maintaining the recipient's or anyone else's safety, and could be provided by persons without professional skills or training).
  - Services that must be covered under other Medicaid authorities (e.g. services within a hospital outpatient setting).

- Services also do not include services, supplies or procedures performed in a nonconventional setting including: resorts, spas, therapeutic programs, and camps.
- The provider agency will assess the child prior to developing a treatment plan for the child. Treatment services must be part of the treatment plan including goals and activities necessary to correct or ameliorate conditions discovered during the initial assessment visits.

Certification/Provider Qualifications

Provider Agency Qualifications:

- CPST practitioners above must operate within a child serving agency that is licensed, certified, designated and/ or approved by OCFS, OMH, OASAS or DOH or its designee, in settings permissible by that designation.
- Recognized Evidenced-based practice (EBP) models under the children's transformation require approval, designations and fidelity reviews on an ongoing basis as determined necessary by New York State. For more information see Appendix C.

Individual Practitioner Qualifications: Staff qualifications are categorized in accordance with CPST Service Components.

Qualifications required for service components 1-3 (Intensive Interventions; Crisis Avoidance; Intermediate Term Crisis Management):

- a Master's degree in social work, psychology, or in related human services, plus one year of applicable experience or who have been certified in an Evidenced Based Practice (in lieu of one-year experience requirement).
    - These practitioners may also include: Registered Professional Nurses with one year of behavioral health experience, Licensed Occupational Therapists, and Licensed Creative Arts Therapists (LCAT) to the extent they are operating under the scope of their license.

OR

- a Bachelor's degree and certification in an Evidenced Based Practice consistent with the CPST component being delivered.

OR

- a Bachelor's degree and three years applicable experience in children's mental health, addiction, and/or foster care/child welfare/juvenile justice or other related human services field and no certification in an Evidenced Based Practice

(Note: Individuals with the above qualifications may *also* provide components 4- 6)

Qualifications required for service components 4-6 (Rehabilitative Psychoeducation; Strengths Based Service Planning; Rehabilitative Supports):

- a Bachelor's degree and two years applicable experience in children's mental health, addiction, foster care/child welfare/juvenile justice, and/or a related human services field and no certification in an Evidenced Based Practice

(Note: Individuals with the above qualifications may *only* provide components 4- 6)

Supervisor Qualifications:

- The supervisor must provide regularly scheduled supervision and have the qualifications of at least a Licensed Clinical Social Worker (LCSW), Licensed Master Social Worker (LMSW), Licensed Mental Health Counselor (LMHC), Licensed Creative Arts Therapist (LCAT), Licensed Marriage and Family Therapist (LMFT), 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 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.

Training Requirements

Required Training: Mandated Reporter

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

PSYCHOSOCIAL REHABILITATION (PSR)

Definition:

Psychosocial Rehabilitation (PSR) services are designed to restore, rehabilitate, and support a child's/youth's developmentally appropriate functioning as necessary for the integration of the child/youth as an active and productive member of their family and community with the goal of achieving minimal on-going professional intervention. Services assist with implementing interventions on a treatment plan to compensate for, or eliminate, functional deficits and interpersonal and/or behavioral health barriers

associated with a child/youth's behavioral health needs. Activities are "hands on" and task oriented, intended to achieve the identified goals or objectives as set forth in the child/youth's individualized treatment plan.

These services must include assisting the child/youth to develop and apply skills in natural settings. PSR is intended to foster and promote the development of needed skills identified in assessment or through the ongoing treatment of a licensed practitioner. PSR services are to be recommended by a licensed practitioner and a part of a treatment plan. PSR activities are focused on addressing the rehabilitative needs of the child/youth as part of a treatment plan and can be provided in coordination with treatment interventions by a licensed practitioner (e.g., OLP) or provider of CPST. Services are delivered in a trauma informed, culturally and linguistically competent manner.

Service Components

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

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, rehabilitate and support:
  - Increasing community tenure and avoiding more restrictive treatment settings
  - Building and enhancing personal relationships
  - Establishing support networks including support to establish and maintain friendship/supportive social networks, improve interpersonal skills such as social etiquette and anger management.
  - Increasing community awareness
  - Developing coping strategies and effective functioning in the individual's social environment, including home, work, and school locations.
  - Learning to manage stress, unexpected daily events, and disruptions, behavioral health and physical health symptoms with confidence

- **Daily Living Skills**, with the goal to restore, rehabilitate and support the effect of the child's diagnosis and reestablish daily functioning skills:
    - 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 routines necessary to remain in the home, school, work and community.
    - Personal autonomy skills, such as:
        - Learning self-care
        - Developing and pursuing personal interests
        - Developing daily living skills specific to managing their own medications and treatment 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)
        - Learning about community resources and how to use them
        - Learning constructive and comfortable interactions with health care professionals
        - Learning relapse prevention strategies
        - Re-establishing good health routines and practices

- **Community Integration -** with the goal to restore, rehabilitate and support to reduce the effect of the child's diagnosis:
    - Reestablish social skills so that the person can remain in a natural community location and re-achieve developmentally appropriate functioning including using collaboration, partnerships and mutual supports to strengthen the child's community integration in areas of personal interests as well as other domains of community life including home, work and school.
    - Assisting the individual with generalizing coping strategies and social and interpersonal skills in community settings
    - Assisting the individual with effectively responding to or avoiding identified precursors or triggers that result in functional impairments.
    - Implementing learned skills (that may have been developed through a licensed practitioner providing treatment services) in the following areas
        - Social skills, such as:

- 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

▪ 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

▪ identifying resources where interests can be enhanced and shared with others in the community

▪ identifying and connecting to natural supports and resources, including family, community networks, and faith-based communities

Modality

- Individual
- Family
  - PSR service delivery may also include family contact *with or without the child/youth present*, as long as the contact is identified on and directly related to the child/youth's goals, in the treatment plan.
- Collateral
  - Collateral contact *with or without the child/youth and/or family present*, as long as the contact is identified on and directly related to the child/youth's goals and treatment plan. E.g., collateral contacts may include sharing techniques and information with a collateral(s) so they can better respond to the needs of the child.
- Group

- Group limit refers to number of child/youth participants, regardless of payor. Groups cannot exceed 8 children/youth.
- Consideration for group limits, or, the inclusion of an additional group clinician/facilitator, should be based on, but not limited to: the purpose/nature of the group, the clinical characteristics of the participants, age of participants, developmental level and severity of needs of the participants, inclusion of family and/or collaterals in group, and the experience and skill of the group clinician/facilitator
- Groups may include family/collaterals, *with the child/youth present*, as long as the contact is directly related to the child/youth's goals and treatment plan

NOTE: The use of telehealth must be conducted in accordance with state-issued guidance. For OMH, agencies must secure required licensure/designation approval prior to telehealth utilization and adhere to 14 NYCRR 596 and Telehealth Services Guidance for OMH Providers. In addition, OASAS-certified providers must obtain OASAS certification to offer services via telehealth, in accordance with 4 NYCRR PART 830.5.

Setting

PSR can occur in a variety of settings including community locations where the child/youth lives, works, attends school, engages in services, and/or socializes.

Limitations/Exclusions

- A child with a developmental disability diagnosis without a co-occurring behavioral health condition is ineligible to receive this rehabilitative service. The interventions delivered under PSR are rehabilitative in nature. If an individual requires or would benefit from habilitative supports, alternative or additional services must be sought.
- Rehabilitative services do not include and FFP (Federal Financial Participation) is not available for any of the following:
  - educational, vocational, and job training services,
  - room and board,
  - habilitation services such as financial management, supportive housing, supportive employment services, and basic skill acquisition services that are habilitative in nature,
  - services to inmates in public institutions
  - services to individuals residing in institutions for mental diseases

  - recreational, or custodial (i.e., for the purpose of assisting in the activities of daily living such as bathing, dressing, eating, and maintaining personal hygiene and safety; for maintaining the recipient's or anyone else's safety, and could be provided by persons without professional skills or training).
  - Services that must be covered under other Medicaid authorities (e.g. services within a hospital outpatient setting).
- Services also do not include services, supplies or procedures performed in a nonconventional setting including: resorts, spas, therapeutic programs, and camps.
- The provider agency will assess the child prior to developing a treatment plan for the child. Treatment services must be part of the treatment plan including goals and activities necessary to correct or ameliorate conditions discovered during the initial assessment visits.

Certification/Provider Qualifications

Provider Agency Qualifications:

- PSR practitioners must operate within a child serving agency that is licensed, certified, designated and/ or approved by OCFS, OMH, OASAS or DOH or its designee, in settings permissible by that designation.

Individual Staff Qualifications:

- At a minimum, staff must be 18 years old and have a high school diploma, high school equivalency preferred, or a State Education Commencement Credential with a minimum of two years' experience in children's mental health, addiction, foster care and/or a related human services field; or
  - a Bachelor's degree in social work, psychology, or in related human services; or
  - a Master's degree in social work, psychology, or in related human services
  - The practice of PSR by unlicensed individuals does not include those activities that are restricted under Title XIII.

Supervisor Qualifications:

- The PSR provider must receive regularly scheduled supervision from a Licensed Clinical Social Worker (LCSW), Licensed Master Social Worker (LMSW), Licensed Mental Health Counselor (LMHC), Licensed Creative Arts Therapist (LCAT), Licensed Marriage and Family Therapist (LMFT), 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

Required Training: Mandated Reporter

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

FAMILY PEER SUPPORT SERVICES (FPSS)

Definition:

Family Peer Support Services (FPSS) are an array of formal and informal activities and supports provided to families caring for/raising a child who is experiencing social, emotional, medical, developmental, 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. Services are delivered in a trauma informed, culturally and linguistically competent manner.

The need for FPSS must be recommended by a Licensed Practitioner of the Healing Arts and included within a treatment plan. Activities included must be intended to achieve the identified goals or objectives as set forth in the child's/youth's treatment plan.

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.

Service Components:

- **Engagement, Bridging, and Transition Support**

- Serving 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.
- Based on the strengths and needs of the youth and family, connecting them with appropriate services and supports. Accompanying the family when visiting programs.
- Facilitating meetings between families and service providers.
- Assisting the family to gather, organize and prepare documents needed for specific services.
- Addressing any concrete or subjective barriers that may prevent full participation in services
- Supporting and assisting families during stages of transition which may be unfamiliar (e.g. placements, in crisis, and between service systems etc.).
- Promoting continuity of engagement and supports as families' needs and services change.

- **Self-Advocacy, Self-Efficacy, and Empowerment**
  - Coach and model shared decision-making and skills that support collaboration, in addition to providing opportunities for families to self-advocate.
  - Supporting families to advocate on behalf of themselves to promote shared decision-making.
  - Ensuring that family members inform all planning and decision-making.
  - Modeling strengths-based interactions by accentuating the positive.
  - Supporting the families in discovering their strengths and concerns. Assist families to identify and set goals and short-term objectives.
  - Preparing families for meetings and accompany them when needed.
  - Empowering families to express their fears, expectations and anxieties to promote positive effective communication.
  - Assisting families to frame questions to ask providers.
  - Providing opportunities for families to connect to and support one another.
  - Supporting and encouraging family participation in community, regional, state, national activities to develop their leadership skills and expand their circles of support.
  - Providing leadership opportunities for families who are receiving Family Peer Support Services.
  - Empowering 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**
  - Supporting the efforts of families in caring for and strengthening their children's mental, and physical health, development and well-being of their children.
  - Helping the family learn and practice strategies to support their child's positive behavior.
  - Assisting the family to implement strategies recommended by clinicians.
  - Assisting families in talking with clinicians about their comfort with their treatment plans.
  - Providing emotional support for the family on their parenting journey to reduce isolation, feelings of stigma, blame and hopelessness.
  - Providing 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).
  - Supporting families as children transition from out of home placement.
  - Assisting families on how to access transportation.
  - Supporting 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**
  - Enhancing the quality of life by integration and supports for families in their own communities
  - Helping the family to rediscover and reconnect to natural supports already present in their lives.
  - Utilizing the families' knowledge of their community in developing new supportive relationships.
  - Helping the family identify and become involved in leisure and recreational activities in their community.

- In partnership with community leaders, encouraging families who express an interest to become more involved in faith or cultural organizations.
- Arranging support and training as needed to facilitate participation in community activities.
- Conducting groups with families to strengthen social skills, decrease isolation, provide emotional support and create opportunities for ongoing natural support.
- Working collaboratively with schools to promote family engagement.

Modality:

- Individual
  - FPSS is directed to the Family/Caregiver for the benefit of the child, as outlined in the child's goals and treatment plan
- Collateral
  - Collateral contact *with or without child/youth/family present*, as long as the contact is identified on and directly related to the child/youth's goals, in the treatment plan.
- Group
  - Group limit refers to number of participants, regardless of payor. Groups cannot exceed 12 individuals. Consideration should be given to group size when collaterals are included.
  - Consideration for group limits or the inclusion of an additional group facilitator should be based on, but not limited to: the purpose/nature of the group, inclusion of collaterals in group, and the experience and skill of the group facilitator
  - Groups may include family/collaterals, *with or without the child/youth present*, as long as the contact is directly related to the child/youth's goals and treatment plan goals, for the benefit of the child.

NOTE: The use of telehealth must be conducted in accordance with state-issued guidance. For OMH, agencies must secure required licensure/designation approval prior to telehealth utilization and adhere to 14 NYCRR 596 and Telehealth Services Guidance for OMH Providers. In addition, OASAS-certified providers must obtain OASAS certification to offer services via telehealth, in accordance with 4 NYCRR PART 830.5.

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, and/or socializes.

Limitations/Exclusions

- A child with a developmental disability diagnosis without a co-occurring behavioral health condition is ineligible to receive this rehabilitative service.

The following activities are not reimbursable for Medicaid family support programs:

- 12-step programs run by peers.
- General outreach and education including participation in health fairs, and other activities designed to increase the number of individuals served or the number of services received by individuals accessing services; community education services, such as health presentations to community groups, PTAs, etc.
- Contacts that are not medically necessary.
- Time spent doing, attending, or participating in recreational activities.
- Services provided to teach academic subjects or as a substitute for educational personnel such as, but not limited to, a teacher, teacher's aide, or an academic tutor.
- Time spent attending school (e.g., during a day treatment program) with the exception of attending school meetings with the parent/caregiver on behalf of the child.
- Habilitative services for the beneficiary (child) to acquire self-help, socialization, and adaptive skills necessary to reside successfully in community settings.
- Child care services or services provided as a substitute for the parent or other individuals responsible for providing care and supervision.
- Respite care.
- Transportation for the beneficiary or family.
- Services not identified on the beneficiary's authorized treatment plan.
- Services not in compliance with the service manual and not in compliance with State Medicaid standards.
- Services provided to children, spouse, parents, or siblings of the eligible beneficiary under treatment or others in the eligible beneficiary's life to address problems not directly related to the eligible beneficiary's issues and not listed on the eligible beneficiary's treatment plan.

- Any intervention or contact not documented or consistent with the approved treatment/recovery plan goals, objectives, and approved services will not be reimbursed.
- Rehabilitative services do not include and FFP (Federal Financial Participation) is not available for any of the following:
    - educational, vocational, and job training services,
    - room and board,
    - habilitation services such as financial management, supportive housing, supportive employment services, and basic skill acquisition services that are habilitative in nature,
    - services to inmates in public institutions
    - services to individuals residing in institutions for mental diseases
    - recreational, or custodial (i.e., for the purpose of assisting in the activities of daily living such as bathing, dressing, eating, and maintaining personal hygiene and safety; for maintaining the recipient's or anyone else's safety, and could be provided by persons without professional skills or training).
    - Services that must be covered under other Medicaid authorities (e.g. services within a hospital outpatient setting).
- Services also do not include services, supplies or procedures performed in a nonconventional setting including: resorts, spas, therapeutic programs, and camps.
- The provider agency will assess the child prior to developing a treatment plan for the child. Treatment services must be part of the treatment plan including goals and activities necessary to correct or ameliorate conditions discovered during the initial assessment visits.

Certification/Provider Qualifications

Provider Agency Qualifications:
Must operate within a child serving agency that is licensed, certified, designated and/ or approved by OCFS, OMH, OASAS or DOH or its designee, in settings permissible by that designation.

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.
- At a minimum, have a high school diploma, high school equivalency preferred or a State Education Commencement Credential. This educational requirement can be waived by the State if the person has demonstrated competencies and has relevant life experience sufficient for the peer credential.
- Complete Level One and Level Two of the Parent Empowerment Program Training for Family Peer Advocates 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 FPAs supervisor.
- Document 1000 hours of experience providing Family Peer Support Services.
- 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. This educational requirement can be waived by the State if the person has demonstrated competencies and has relevant life experience sufficient for the peer credential.
- Complete Level One of the Parent Empowerment Program Training for Family Peer Advocates or approved comparable training.
- Submit two letters of reference attesting to proficiency in and suitability for the role of a Family Peer Advocate (FPA).
- Agree to practice according to the Family Peer Advocate Code of Ethics.

An FPA with a Provisional Family Peer Advocate Credential must complete all other requirements of the Professional Family Peer Advocate credential within 18 months of commencing employment as a FPA.

OR

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

- Demonstrate lived experience as a primary caregiver of a youth who has participated in (or navigated) the addiction services system. They provide education, outreach, advocacy and recovery support services for families seeking and sustaining recovery on behalf of a child or youth.
- Have a high school diploma or General Equivalency Degree (GED) preferred or a State Education Commencement Credential.
- Complete a minimum of 46 hours of content specific training, covering the topics: advocacy, mentoring/education, recovery/wellness support and ethical responsibility
- Document 500 hours of related work or volunteer experience,
- Provide evidence of at least 25 hours of supervision in a peer role.
- Pass the NYCB/IC&RC Peer Advocate Exam or other exam by an OASAS designated certifying body
- Demonstrate a minimum of 20 hours in the area of Family Support (combined online and classroom training)
- Complete 24 hours recovery-specific continuing education; ***plus***, 4 hours peer ethics earned every three years and renews their certification every three years.

Supervisor Qualifications:

For a Credentialed Family Peer Advocate (FPA):

1. Individuals who have a minimum of three years' experience providing FPSS, at least one year of which is as a credentialed FPA with access to clinical consultation as needed. The clinical consultation may be provided by a staff member or through a contract

OR

2. A qualified behavioral health staff person:
    a. Who meets the criteria for a "qualified mental health staff person" found in 14 NYCRR 594 or 14 NYCRR 595 (refer to Appendices for criteria);
    b. with training in FPSS and the role of FPAs; and
    c. wherein efforts are made as the FPSS service gains maturity in NYS to transition to supervision by an experienced credentialed FPA within the organization.

For a Certified Recovery Peer Advocate with Family Specialty (CRPA-F):

1. A credentialed or licensed clinical staff member as defined in 14 NYCRR 800 that has training in FPS services and the role of the CRPA-F.

Additional Supervision Guidance:

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 for Credentialed Family Peer Advocates

Completion of Level One and Level Two of the Parent Empowerment Program Training For Family Peer Advocates or approved comparable training. Contact Families Together of NYS (www.FTNYS.org) or CTAC (www.ctacny.org) for detailed training requirements.

OR

Family Peer Support will be delivered by a Certified Recovery Peer Advocate (CRPA) with a Family Specialty. Complete a minimum of 46 hours of content specific training, covering the topics: advocacy, mentoring/education, recovery/wellness support and ethical responsibility. For more information on the CRPA-F: www.asapnys.org/ny-certification-board/

Other Required Training: Mandated Reporter

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

YOUTH PEER SUPPORT (YPS)

Definition:

Youth Peer Support (YPS) services are formal and informal services and supports provided to youth, who are experiencing social, medical, emotional, 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. Services are delivered in a trauma informed, culturally and linguistically competent manner.

The need for YPS must be determined by a licensed practitioner of the healing arts and included within a treatment plan. Youth Peer Support 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 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.

Service Components:

- **Skill Building:**
  - Developing skills for coping with and managing psychiatric symptoms, trauma, and substance use disorders
  - Developing skills for wellness, resiliency and recovery support
  - Developing skills to independently navigate the service system
  - Developing goal-setting skills
  - Building community living skills

- **Coaching:** Enhancing resiliency/recovery-oriented attitudes, i.e., hope, confidence, and self-efficacy
  - Promoting wellness through modeling.
  - Providing mutual support, hope, reassurance and advocacy that include sharing one's own "personal recovery/resiliency story" as the Youth Peer

Advocating (YPA) deems appropriate as beneficial to both the youth and themselves. YPA's may also share their recovery with parents to engage parents and help them "see" youth possibilities for future in a new light.

- **Engagement, Bridging, and Transition Support:**
  - Acting as a peer partner in transitioning to different levels of care and into adulthood; helping 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:**
  - Developing, linking, and facilitating the use of formal and informal services, including connection to peer support groups in the community
  - Serving as an advocate, mentor, or facilitator for resolution of issues
  - Assisting in navigating the service system including assisting with engagement and bridging during transitions in care
  - Helping youth develop self-advocacy skills (e.g., may attend a Committee on Special Education meeting with the youth and parent, coaching the youth to articulate his educational goals).
  - Assisting 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 guides the youth to effectively communicate their individual perspective to providers and families.
  - Assisting youth in developing skills to advocate for needed services and benefits and seeking to effectively resolve unmet needs.
  - Assisting youth in understanding their treatment plan and help to ensure the plan is person/family centered

- **Community Connections and Natural Supports:**
  - Connecting 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.
  - Helping 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.

- Facilitating or arranging youth peer resiliency/recovery support groups.

Modality:

- Individual
- Group
  - Group limit refers to number of child/youth participants, regardless of payor. Groups cannot exceed 8 children/youth.
  - Consideration for group limits or the inclusion of an additional group facilitator should be based on, but not limited to: the purpose/nature of the group, age of participants, developmental level and severity of needs of the participants, and the experience and skill of the group facilitator.

NOTE: The use of telehealth must be conducted in accordance with state-issued guidance. For OMH, agencies must secure required licensure/designation approval prior to telehealth utilization and adhere to 14 NYCRR 596 and Telehealth Services Guidance for OMH Providers. In addition, OASAS-certified providers must obtain OASAS certification to offer services via telehealth, in accordance with 4 NYCRR PART 830.5.

Setting:

YPS can occur in a variety of settings including community locations where the youth lives, works, attends school, engages in services, and/or socializes.

Limitations/Exclusions

- A youth with a developmental disability diagnosis without a co-occurring behavioral health condition is ineligible to receive this rehabilitative service.

The following activities are not reimbursable for Medicaid peer support programs:

- 12-step programs run by peers.
- General outreach and education including participation in health fairs, and other activities designed to increase the number of individuals served or the number of services received by individuals accessing services; community education services, such as health presentations to community groups, PTAs, etc.
- Contacts that are not medically necessary.
- Time spent doing, attending, or participating in recreational activities.
- Services provided to teach academic subjects or as a substitute for educational personnel such as, but not limited to, a teacher, teacher's aide, or an academic tutor.

- Time spent attending school (e.g., during a day treatment program), with the exception of attending meetings (e.g. CSE) with a Youth.
- Habilitative services for the beneficiary (youth) to acquire self-help, socialization, and adaptive skills necessary to reside successfully in community settings.
- Childcare services or services provided as a substitute for the parent or other individuals responsible for providing care and supervision.
- Respite care.
- Transportation for the beneficiary (youth) or family.
- Services not identified on the beneficiary's authorized treatment plan.
- Services not in compliance with the service manual and not in compliance with State Medicaid standards.
- Services provided to children, spouse, parents, or siblings of the eligible beneficiary under treatment or others in the eligible beneficiary's life to address problems not directly related to the eligible beneficiary's issues and not listed on the eligible beneficiary's treatment plan.
- Any intervention or contact not documented or consistent with the approved treatment/recovery plan goals, objectives, and approved services will not be reimbursed.
- Rehabilitative services do not include and FFP (Federal Financial Participation) is not available for any of the following:
    - educational, vocational, and job training services,
    - room and board,
    - habilitation services such as financial management, supportive housing, supportive employment services, and basic skill acquisition services that are habilitative in nature,
    - services to inmates in public institutions
    - services to individuals residing in institutions for mental diseases
    - recreational, or custodial (i.e., for the purpose of assisting in the activities of daily living such as bathing, dressing, eating, and maintaining personal hygiene and safety; for maintaining the recipient's or anyone else's safety, and could be provided by persons without professional skills or training).
    - Services that must be covered under other Medicaid authorities (e.g. services within a hospital outpatient setting).
    - Services also do not include services, supplies or procedures performed in a nonconventional setting including: resorts, spas, therapeutic programs, and camps.

- The provider agency will assess the child prior to developing a treatment plan for the child. Treatment services must be part of the treatment plan including goals and activities necessary to correct or ameliorate conditions discovered during the initial assessment visits.

Certification/Provider Qualifications

Provider Agency Qualifications:

Any child serving agency or agency with children's behavioral health and health experience that is licensed, certified, designated and/ or approved by OCFS, OMH, OASAS or DOH or its designee, to provide services outlined in the service definition.

Individual Qualifications:

YPS is delivered by a New York State Youth Peer Advocate Credential. To be eligible for the Youth Peer Advocate (YPA) Professional Credential, an individual must:

- Be an individual 18 to 30 years old who has self-identified as a person who has first-hand experience with, emotional (mental health), behavioral challenges, and/or co-occurring disorders
- Be able to use lived experience with a disability, mental illness, and involvement with juvenile justice, special education, substance use disorder, and/or foster care to assist in supporting youth in their resiliency/recovery and wellness
- At a minimum, have a high school diploma, high school equivalency or a State Education Commencement Credential. 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 component) and Level Two (online and in-person) training of State approved training for YPAs. 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
- Complete *20 hours* of continuing education and renew their credential *every 2 years*
- Demonstrate qualities of leadership, including:
    - Knowledge of advocacy
    - Group development and/or facilitation of peer-to-peer groups or activities

- Be supervised by a credentialed YPA with three years direct service experience or an individual who meets the criteria for a "qualified mental health staff person found in 14 NYCRR 591 or 14NYCRR 595.

A 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 old who has self-identified as a person who has first-hand experience with emotional (mental health), behavioral challenges, and/or co-occurring disorders
  - Be able to use lived experience with a disability, mental illness, juvenile justice, special education, substance use disorder, and/or foster care to assist in supporting youth in their resiliency/recovery and wellness
  - Has a high school diploma, high school equivalency or a State Education Commencement Credential. 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.
  - Has completed Level One of the Youth Peer Support Services Advisory Council recommended and State approved training for YPAs.
  - Submits two letters of reference attesting to proficiency in and suitability for the role of a YPA
  - Agrees to practice according to the Youth Peer Advocate Code of Ethics.
  - Demonstrates qualities of leadership, including:
    - Knowledge of advocacy
    - Group development and/or facilitation of peer-to-peer groups or activities
- Is supervised by a credentialed YPA or FPA with three years direct service experience OR an individual who meets the criteria for a "qualified mental health staff person found in 14 NYCRR 591 or 14NYCRR 595 (refer to Appendices for criteria).

A YPA with a provisional credential must complete all other requirements of the full credential within 18 months of employment as an YPA.

OR

Youth Peer Support will be delivered by a Certified Recovery Peer Advocate with a Youth Specialty (CRPA-Y). To be eligible as a CRPA-Youth, an individual must be 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
- Completed 46 hours of required training, covering topics of: advocacy, mentoring/education, recovery/wellness support and ethical responsibility
- Demonstrate a minimum of 20 hours in the area of Youth Support (combined online and classroom training)
- Completed at least 500 hours of related volunteer or work experience
- 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
- Complete 24 hours recovery-specific continuing education; ***plus***, 4 hours peer ethics earned every three years and renews their certification every three years.
- The youth requires education, support, coaching, and guidance in age-appropriate behaviors, interpersonal communication, problem-solving and conflict resolution, and relating appropriately to others to address daily living, social, and communication needs.

Supervisor Qualifications:

For Credentialed Youth Peer Advocates (YPA):

1) A credentialed YPA, with three years of direct YPS service experience with access to treatment plan consultation by a licensed practitioner as needed. The treatment plan supervision may be provided by a staff member or through a contract with another organization.
   OR
2) A credentialed FPA with three years of experience providing FPSS that has been trained in YPS services and the role of YPAs, and efforts are made as the YPST service gains maturity in NYS to transition to supervision by experienced credentialed YPAs within the organization.
   OR
3) A “qualified mental health staff person” found in 14 NYCRR 594 or 14 NYCRR 595 that has training in YPS services and the role of YPAs and efforts are made

as the YPS service gains maturity to transition to supervision by an experienced credentialed YPA within the organization.

For a Certified Recovery Peer Advocate with Youth Specialty (CRPA-Y):

1. A credentialed or licensed clinical staff member as defined in 14 NYCRR 800 that has training in YPS/FPS services and the role of the CRPA-Y/CRPA-F.

Additional Supervision Guidance:

- 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

Youth Peer Advocates (YPAs) must complete the Youth Peer Support Services Council recommended and State Approved Level One and Level Two YPA training or comparable training that has been approved by the Youth Peer Support Services Council and State.

OR

For the Credentialed Youth Peer Advocates: Complete a minimum of 46 hours of content specific training, covering the topics: advocacy, mentoring/education, recovery/wellness support and ethical responsibility and 20 hours in the area of Youth Peer Support.

Specific components of Level One and Level Two can be found on the Families Together in NYS web site (www.ftnys.org) or CTAC (www.ctacny.org)

Other Required Training: Mandated Reporter

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

IV. Guidelines for Medical Necessity Criteria

THE SIX NEW CHILDREN AND FAMILY SUPPORT AND TREATMENT SERVICES (CFTSS)

Guidelines for Medical Necessity Criteria

Other Licensed Practitioner (OLP): OLP service is delivered by a Non-physician licensed behavioral health practitioner (NP-LBHP) who is licensed in the state of New York operating within the scope of practice defined in State law and in any setting permissible under State practice law. OLP does not require a DSM diagnosis in order for the service to be delivered. NP-LBHPs include individuals licensed and able to practice independently as a:

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

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

- Licensed Master Social Worker (LMSW)

In addition to licensure, service providers that offer addiction services must demonstrate competency as defined by state law and regulations. Any practitioner above must operate within a child serving agency that is licensed, certified, designated and/or approved by OCFS, OMH, OASAS OR DOH or its designee, in settings permissible by that designation.

Please refer to the "Medicaid State Plan Children and FamilySupport and Treatment Services Provider Manual for Children's BH Early and Periodic Screening and Diagnostic Treatment (EPSDT) Services" for additional information regarding this service. This service is available for children from birth to 21 years of age.

Guidelines for Medical Necessity Criteria

Admission to OLP	Continued Stay	Discharge
Criteria 1 or 2 must be met: The child/youth is being assessed by the NP-LBHP to determine the need for treatment. The NP-LBHP develops a treatment plan for goals and activities necessary to correct or amorliorate conditions discovered during the initial assessment visits that: 1. Corrects or ameliorates conditions that are found through an EPSDT screening; OR 2. Addresses the prevention*, diagnosis, and/or treatment of health impairments; the ability to	**Criteria 1 OR 2 and 3, 4, 5, 6:** 1. The child/youth is making some progress but has not fully reached established service goals and there is expectation that if the child/youth continues to improve, then the service continues OR 2. Continuation of the service is needed to prevent the loss of functional skills already achieved AND 3. The child/youth continues to meet admission criteria AND	**Any one of criteria 1-6 must be met:** 1. The child/youth no longer meets continued stay criteria OR 2. The child/youth has successfully reached individual/family established service goals for discharge; OR 3. The child/youth or parent/caregiver(s) withdraws consent for services; OR

Other Licensed Practitioner (OLP): OLP service is delivered by a Non-physician licensed behavioral health practitioner (NP-LBHP) who is licensed in the state of New York operating within the scope of practice defined in State law and in any setting permissible under State practice law. OLP does not require a DSM diagnosis in order for the service to be delivered. NP-LBHPs include individuals licensed and able to practice independently as a:

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

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

- Licensed Master Social Worker (LMSW)

In addition to licensure, service providers that offer addiction services must demonstrate competency as defined by state law and regulations. Any practitioner above must operate within a child serving agency that is licensed, certified, designated and/or approved by OCFS, OMH, OASAS OR DOH or its designee, in settings permissible by that designation.

Please refer to the "Medicaid State Plan Children and FamilySupport and Treatment Services Provider Manual for Children's BH Early and Periodic Screening and Diagnostic Treatment (EPSDT) Services" for additional information regarding this service. This service is available for children from birth to 21 years of age.

Guidelines for Medical Necessity Criteria

Admission to OLP	Continued Stay	Discharge
achieve age-appropriate growth and development, and the ability to attain, maintain, or regain functional capacity.** * Prevention is focused on the promoton of protective factors, development of healthy behaviors and reduction of risk factors that can help prevent the onset of a diagnosable behavioral health disorder. ** In instances where behavioral health needs have been identified but a diagnosis is not yet known and/or not specified, providers can use an unspecified ICD-10 diagnosis code, such as R69 (illness, unspecified), F99 (mental disorder, not otherwise specified), or an appropriate Z-code. Throughout the course of the screening and assessment process, should another diagnosis or need outside of behavioral health be identified, then that child/youth should be referred to the appropriate service and/or resource for the condition identified (e.g., children/youth assessed as I/DD should be referred to OPWDD; children/youth assessed for Early Intervention). *See Appendix B for more information.*	4. The child/youth and/or family/caregiver(s) continue to be engaged in services AND 5. An alternative service(s) would not meet the child/youth needs AND 6. The treatment plan has been appropriately updated to establish or modify ongoing goals.	4. The child/youth is not making progress on established service goals, nor is there expectation of any progress with continued provision of services; OR 5. The child/youth is no longer engaged in the service, despite multiple attempts on the part of the provider to apply reasonable engagement strategies;OR 6. The child/youth and/or family/caregiver(s) no longer needs OLP as he/she is obtaining a similar benefit through other services and resources.

OLP Limits/Exclusions

Limits/Exclusions:

- Group limit refers to number of child/youth participants, regardless of payor. Groups should not exceed 8 children/youth.
- Consideration may be given to smaller limit of members if participants are younger than 8 years of age. Consideration should be given to group size when family/collaterals are included.
- Consideration for group limits, or, the inclusion of an additional group clinician/facilitator, should be based on, but not limited to: the purpose/nature of the group, the clinical characteristics of the participants, age of participants, developmental level and severity of needs of the participants, inclusion of family/collaterals in group; as well as the experience and skill of the group clinician/facilitator
- Inpatient hospital facilities are allowed for licensed professional 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 Visits and may not be billed separately.
- Visits to Intermediate Care Facilities for individuals with Mental Retardation (ICF-MR) are not covered.
- All NP-LBHP services provided while the person is a resident of an institution for Mental Disease, such a free standing psychiatric hospital or psychiatric residential treatment facility, are part of the institutional service and not otherwise 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.
- 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).
- Evidence based practices (EBP) require approval, designations, and fidelity reviews on an ongoing basis as determined necessary by New York State. Treatment services must be a part of a treatment plan including goals and activities necessary to correct or ameliorate conditions discovered during the initial assessment visits.

Crisis Intervention: Crisis Intervention (CI) Services are provided to children/youth who are identified as experiencing an 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. A child/youth in crisis may be referred by a family member or other collateral contact who has knowledge of the child/youth's capabilities and functioning.

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.

Please refer to "Medicaid State Plan Children and Family Support and Treatment Services Provider Manual for Children's BH Early and Periodic Screening and Diagnostic Treatment (EPSDT) Services" for additional information regarding this service. This service is available for children from birth to 21 years of age.

Guidelines for Medical Necessity Criteria

Admission to Crisis Intervention	Continued Stay	Discharge
All criteria must be met: • The child/youth experiencing 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; AND • The child/youth demonstrates at least one of the following:	**N/A**	**Any one of criteria 1-or 2 must be met:** 1. The child/youth no longer meets admission criteria (demonstrates symptom reduction, stabilization, and restoration, or developing the coping mechanisms to pre-crisis levels of

Crisis Intervention: Crisis Intervention (CI) Services are provided to children/youth who are identified as experiencing an 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. A child/youth in crisis may be referred by a family member or other collateral contact who has knowledge of the child/youth's capabilities and functioning.

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.

Please refer to "Medicaid State Plan Children and Family Support and Treatment Services Provider Manual for Children's BH Early and Periodic Screening and Diagnostic Treatment (EPSDT) Services" for additional information regarding this service. This service is available for children from birth to 21 years of age.

Guidelines for Medical Necessity Criteria

Admission to Crisis Intervention	Continued Stay	Discharge
○ Suicidal/assaultive/destructive ideas,threats, plans or actions that represent a risk to self or others; or ○ Impairment in mood/thought/behavior disruptive to home,school, or the community or ○ Behavior escalating to the extent that a higher intensity of services will likely be required; AND • The intervention is necessary to further evaluate, resolve, and/or stabilize the; AND • The services are recommended by the following Licensed Practictioners of the Healing Arts operating within the scope of their practice under State License: • Psychiatrist • Physician • Licensed Psychoanalyst • Registered Professional Nurse • Nurse Practitioner • Clinical Nurse Specialist • Licensed Clinical Social Worker • Licensed Marriage and Family Therapist • Addictionologist/Addiction Specialist • Physician Assistant • Licensed Master Social Worker (LMSW) • Licensed Mental Health Counselor or • Licensed Psychologist		functioning) and/or meets criteria for another level of care, either more or less intensive; OR 2. The child/youth or parent/caregiver(s) withdraws consent for services

Crisis Intervention: Crisis Intervention (CI) Services are provided to children/youth who are identified as experiencing an 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. A child/youth in crisis may be referred by a family member or other collateral contact who has knowledge of the child/youth's capabilities and functioning.

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.

Please refer to "Medicaid State Plan Children and Family Support and Treatment Services Provider Manual for Children's BH Early and Periodic Screening and Diagnostic Treatment (EPSDT) Services" for additional information regarding this service. This service is available for children from birth to 21 years of age.

Guidelines for Medical Necessity Criteria

Admission to Crisis Intervention	Continued Stay	Discharge

Crisis Intervention Limits/Exclusions

Limits/Exclusions:

- Within the 72 hour time-frame 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.
- Services may not be primarily educational, vocational, recreational, or custodial (i.e., for the purpose of assisting in the activities of daily living such as bathing, dressing, eating, and maintaining personal hygiene and safety; for maintaining the recipient's or anyone else's safety, and could be provided by persons without professional skills or training). Services also do not include services, supplies or procedures performed in a nonconventional setting including: resorts, spas, therapeutic programs, and camps. 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/youth's chart must reflect resolution of the crisis which marks the end of the episode. Warm handoff to follow up services with a developed plan should follow.

  Substance Use should be recognized and addressed in an integrated fashion as it may add to the risk and increase the need for engagement in care. Crisis services cannot be denied based upon substance use. Crisis Team members should be trained on screening for substance use disorders.

Community Psychiatric Supports and Treatment (CPST): CPST services are goal-directed supports and solution-focused interventions intended to address challenges associated with a behavioral health need and to achieve identified goals or objectives as set forth in the child/youth's treatment plan. This includes the implementation of interventions using evidenced-based techniques, drawn from cognitive-behavioral therapy and/or other evidenced-based psychotherapeutic interventions approved by New York State.
CPST includes the following components: Rehabilitative Psychoeducation, Intensive Interventions, Strengths Based Treatment Planning, Rehabilitative Supports, Crisis Avoidance, and Intermediate Term Crisis Management.
CPST is service designed for 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 settings including community locations where the member lives, works, attends school, engages in services (e.g. provider office sites), and/or socializes.

Please refer to "Medicaid State Plan Children and Family Support and Treatment Services Provider Manual for Children's BH Early and Periodic Screening and Diagnostic Treatment (EPSDT) Services" for additional information regarding this service. This service is available for children from birth to 21 years of age.

Guidelines for Medical Necessity

Admission to Community Psychiatric Supports and Treatment	Continued Stay	Discharge
All criteria must be met: 1. The child/youth has a behavioral health diagnosis that demonstrates symptoms consistent or corresponding with the DSM OR the child/youth is at risk of development of a behavioral health diagnosis*; AND 2. The child/youth is expected to achieve skill restoration in one of the following areas: a. participation in community activities and/or positive peer support networks b. personal relationships; c. personal safety and/or self-regulation d. independence/productivity; e. daily living skills f. symptom management g. coping strategies and effective functioning in the home, school, social or work environment; AND 3. The child/youth is likely to benefit from and respond to the service to prevent the onset or the worsening of symptoms, AND 4. The services are recommended by the following Licensed Practictioners of the Healing Arts operating within the scope of their practice under State License: • Licensed Master Social Worker	**All criteria must be met:** 1. The child/youth continues to meet admission criteria; AND 2. The child/youth shows evidence of engagement toward resolution of symptoms but has not fully reached established service goals and there is expectation that if the service continues, the child/youth will continue to improve; AND 3. The child/youth does not require an alternative and/or higher, more intensive level of care or treatment; AND 4. The child/youth is at risk of losing skills gained if the service is not continued;AND 5. Treatment planning includes family/caregiver(s) and/or other support systems, unless not clincally indicated or relevant	**Any one of criteria 1 -6 must be met:** 1. The child/youth no longer meets admission criteria and/or meets criteria for another level of care, either more or less intensive; OR 2. The child/youth has successfully met the specific goals outlined in the treatment plan for discharge; OR 3. The child/youth or parent/caregiver(s) withdraws consent for services; OR 4. The child/youth is not making progress on established service goals, nor is there expectation of any progress with continued provision of services; OR 5. The child/youth is no longer engaged in the service, despite multiple attempts on the part of

Community Psychiatric Supports and Treatment (CPST): CPST services are goal-directed supports and solution-focused interventions intended to address challenges associated with a behavioral health need and to achieve identified goals or objectives as set forth in the child/youth's treatment plan. This includes the implementation of interventions using evidenced-based techniques, drawn from cognitive-behavioral therapy and/or other evidenced-based psychotherapeutic interventions approved by New York State.
CPST includes the following components: Rehabilitative Psychoeducation, Intensive Interventions, Strengths Based Treatment Planning, Rehabilitative Supports, Crisis Avoidance, and Intermediate Term Crisis Management.
CPST is service designed for 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 settings including community locations where the member lives, works, attends school, engages in services (e.g. provider office sites), and/or socializes.

Please refer to "Medicaid State Plan Children and Family Support and Treatment Services Provider Manual for Children's BH Early and Periodic Screening and Diagnostic Treatment (EPSDT) Services" for additional information regarding this service. This service is available for children from birth to 21 years of age.

Guidelines for Medical Necessity

Admission to Community Psychiatric Supports and Treatment	Continued Stay	Discharge
• Licensed Clinical Social Worker • Licensed Mental Health Counselor • Licensed Creative Arts Therapist • Licensed Marriage and Family Therapist • Licensed Psychoanalyst • Licensed Psychologist • Physicians Assistant • Psychiatrist • Physician • Registered Professional Nurse or • Nurse Practitioner * In instances where behavioral health needs have been identified but a diagnosis is not yet known and/or not specified, providers can use an unspecified ICD-10 diagnosis code, such as R69 (illness, unspecified), F99 (mental disorder, not otherwise specified), or an appropriate Z-code. Throughout the course of the screening and assessment process, should another diagnosis or need outside of behavioral health be identified, then that child/youth should be referred to the appropriate service and/or resource for the condition identified (e.g., children/youth assessed as I/DD should be referred to OPWDD; children/youth assessed for Early Intervention). *See Appendix B for more information.*		the provider to apply reasonable engagement strategies;OR 6. The child/youth and/or family/caregiver(s) no longer needs this service as he/she is obtaining a similar benefit through other services and resources.

CPST Limits/Exclusions

Limits/Exclusions:

- The provider agency will assess the child prior to developing a treatment plan for the child.
- Treatment services must be part of the treatment plan including goals and activities necessary to correct or ameliorate conditions discovered during the initial assessment visits.
- A child with a developmental disability diagnosis without a co-occuring behavioral health condition is ineligible to receive this rehabilitative service.
- Group face-to-face may be delivered under Rehabilitative Supports and Rehabilitative Psychoeducation
- Group limit refers to number of child/youth participants, regardless of payor. Groups cannot exceed 8 children/youth.
- Consideration should be given to smaller limit of members if participants are younger than 8 years of age. Consideration should be given to group size when family/collaterals are included.
- Consideration for group limits, or, the inclusion of an additional group clinician/facilitator, should be based on, but not limited to: the purpose/nature of the group, the clinical characteristics of the participants, age of participants, developmental level and severity of needs of the participants, inclusion of family/collaterals in group; as well as the experience and skill of the group clinician/facilitator
- Evidence-Based Practices (EBP) require prior approval, designations, and fidelity reviews on an ongoing basis as determined necessary by New York State 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).1 o Implemented interventions using evidence-based techniques may ameliorate targeted symptoms and/or recover the person's capacity to cope with or prevent symptom manifestation.

Psychosocial Rehabilitation (PSR): Psychosocial Rehabilitation Services (PSR) are designed for children/youth and their families/caregivers to assist with implementing interventions outlined in the treatment plan to compensate for or eliminate functional deficits and interpersonal and/or behavioral health 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 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 intended to achieve the identified goals or objectives as set forth in the child/youth's individualized treatment plan.
Please refer to "Medicaid State Plan Children and Family Support and Treatment Services Provider Manual for Children's BH Early and Periodic Screening and Diagnostic Treatment (EPSDT) Services" for additional information regarding this service. This service is available for children from birth to 21 years of age.

Guidelines for Medical Necessity

Admission to Psychosocial Rehabilitation	Continued Stay	Discharge
All criteria must be met: 1. The child/youth has a behavioral health diagnosis that demonstrates symptoms consistent or corresponding with the DSM; AND 2. The child/youth is likely to benefit from and respond to the service to prevent the onset or the worsening of symptoms; AND 3. The service is needed to meet rehabilitative goals by restoring, rehabilitating, and/or supporting a child/youth's functional level to	**All criteria must be met:** 1. The child/youth continues to meet admission criteria; AND 2. The child/youth shows evidence of engagement toward resolution of symptoms but has not fully reached established service goals and there is expectation that if the service continues, the child/youth will continue to improve; AND	**Any one of criteria 1-6 must be met:** 1. The child/youth no longer meets admission criteria and/or meets criteria for another level of care, either more or less intensive; OR 2. The child/youth has successfully met the specific goals outlined in the treatment plan for discharge; OR

Psychosocial Rehabilitation (PSR): Psychosocial Rehabilitation Services (PSR) are designed for children/youth and their families/caregivers to assist with implementing interventions outlined in the treatment plan to compensate for or eliminate functional deficits and interpersonal and/or behavioral health 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 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 intended to achieve the identified goals or objectives as set forth in the child/youth's individualized treatment plan.
Please refer to "Medicaid State Plan Children and Family Support and Treatment Services Provider Manual for Children's BH Early and Periodic Screening and Diagnostic Treatment (EPSDT) Services" for additional information regarding this service. This service is available for children from birth to 21 years of age.

Guidelines for Medical Necessity

Admission to Psychosocial Rehabilitation	Continued Stay	Discharge
facilitate integration of the child/youth as participant of their community and family AND 4. The services are recommended by the following Licensed Practictioners of the Healing Arts operating within the scope of their practice under State License: • Licensed Master Social Worker • Licensed Clinical Social Worker • Licensed Mental Health Counselor • Licensed Creative Arts Therapist • Licensed Marriage and Family Therapist • Licensed Psychoanalyst • Licensed Psychologist • Physicians Assistant • Psychiatrist • Physician • Registered Professional Nurse or • Nurse Practitioner	3. The child/youth does not require an alternative and/or higher, more intensive level of care or treatment; AND 4. The child/youth is at risk of losing skills gained if the service is not continued; AND 5. Treatment planning includes family/caregiver(s) and/or other support systems, unless not clincially indicated or relevant.	3. The child/youth or parent/caregiver(s) withdraws consent for services; OR 4. The child/youth is not making progress on established service goals, nor is there expectation of any progress with continued provision of services; OR 5. The child/youth is no longer engaged in the service, despite multiple attempts on the part of the provider to apply reasonable engagement strategies;OR 6. The child/youth and/or family/caregiver(s) no longer needs this service as he/she is obtaining a similar benefit through other services and resources.

PSR Limits/Exclusions

Psychosocial Rehabilitation (PSR): Psychosocial Rehabilitation Services (PSR) are designed for children/youth and their families/caregivers to assist with implementing interventions outlined in the treatment plan to compensate for or eliminate functional deficits and interpersonal and/or behavioral health 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 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 intended to achieve the identified goals or objectives as set forth in the child/youth's individualized treatment plan.
Please refer to "Medicaid State Plan Children and Family Support and Treatment Services Provider Manual for Children's BH Early and Periodic Screening and Diagnostic Treatment (EPSDT) Services" for additional information regarding this service. This service is available for children from birth to 21 years of age.

Guidelines for Medical Necessity

Admission to Psychosocial Rehabilitation	Continued Stay	Discharge

Limits/Exclusions:

- The provider agency will assess the child prior to developing a treatment plan for the child., with the PSR worker implementing the intervention identified on the treatment plan.
- A child with a developmental disability diagnosis without a co-occurring behavioral health condition is ineligible to receive this rehabilitative service.
- Group limit refers to number of child/youth participants, regardless of payor. Groups cannot exceed 8 children/youth.
- Consideration for group limits, or, the inclusion of an additional group clinician/facilitator, should be based on, but not limited to: the purpose/nature of the group, the clinical characteristics of the participants, age of participants, developmental level and severity of needs of the participants, inclusion of family/collaterals in group; as well as the experience and skill of the group clinician/facilitator
- Treatment services must be a part of a treatment plan including goals and activities necessary to correct or ameliorate conditions discovered during the initial assessment visit

Family Peer Support Services (FPSS): Family Peer Support Services (FPSS) are an array of formal and informal activities and supports provided to families caring for/raising a child who is experiencing social, emotional, medical, developmental, 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.

This service is needed to achieve specific outcome(s), such as: strengthening the family unit, building skills within the family for the benefit of the child, promoting empowerment within the family, and strengthening overall supports in the child's environment

Please refer to "Medicaid State Plan Children and Family Support and Treatment Services Provider Manual for Children's BH Early and Periodic Screening and Diagnostic Treatment (EPSDT) Services" for additional information regarding this service. This service is available for children from birth to 21 years of age.

Guidelines for Medical Necessity

Admission to Family Peer Support Services	Continued Stay	Discharge
Criteria 1 OR 2, AND 3 AND 4 AND 5 must be met:	**All criteria must be met:**	**Any one of criteria 1-6 must be met:**

Family Peer Support Services (FPSS): Family Peer Support Services (FPSS) are an array of formal and informal activities and supports provided to families caring for/raising a child who is experiencing social, emotional, medical, developmental, 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.

This service is needed to achieve specific outcome(s), such as: strengthening the family unit, building skills within the family for the benefit of the child, promoting empowerment within the family, and strengthening overall supports in the child's environment

Please refer to "Medicaid State Plan Children and Family Support and Treatment Services Provider Manual for Children's BH Early and Periodic Screening and Diagnostic Treatment (EPSDT) Services" for additional information regarding this service. This service is available for children from birth to 21 years of age.

Guidelines for Medical Necessity

Admission to Family Peer Support Services	Continued Stay	Discharge
1. The child/youth has a behavioral health diagnosis that demonstrates symptoms consistent or corresponding with the DSM OR 2. The child/youth displays demonstrated evidence of skill(s) lost or undeveloped as a result of the impact of their physical health diagnosis; AND 3. The child/youth is likely to benefit from and respond to the service to prevent the onset or the worsening of symptoms; AND 4. The child/youth's family is available, receptive to and demonstrates need for improvement in the following areas such as but not limited to: a. strengthening the family unit b. building skills within the family for the benefit of the child c. promoting empowerment within the family d. strengthening overall supports in the child's environment; AND 5. The services are recommended by the following Licensed Practictioners of the Healing Arts operating within the scope of their practice under State License:	1. The child/youth continues to meet admission criteria; AND 2. The child/youth is making progress but has not fully reached established service goals and there is a reasonable expectation that continued services will increase the Child/youth meeting services goals; AND 3. Family/caregiver(s) participation in treatment is adequate to meaningfully contribute to the child/youth's progress in achieving servicegoals; AND 4. Additional psychoeducation or training to assist the family/caregiver understanding the child's progress and treatment or to care for the child would contribute to the child/youth's progress; AND 5. The child/youth does not require an alternative and/or higher, more intensive level of care or treatment; AND 6. The child/youth is at risk of losing skills gained if the service is not continue; AND 7. Treatment planning includes family/caregiver(s) and/or other support systems, unless not clinically indicated or relevant.	1. The child/youth and/or family no longer meets admission criteria OR 2. The child/youth has successfully met the specific goals outlined in the treatment plan for discharge; OR 3. The family withdraws consent for services; OR 4. The child/youth and/or family is not making progress on established service goals, nor is there expectation of any progress with continued provision of services; OR 5. The child/youth and/or family is no longer engaged in the service, despite multiple attempts on the part of the provider to apply reasonable engagement strategies;OR 6. The family/caregiver(s) no longer needs this service as they are

Family Peer Support Services (FPSS): Family Peer Support Services (FPSS) are an array of formal and informal activities and supports provided to families caring for/raising a child who is experiencing social, emotional, medical, developmental, 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.

This service is needed to achieve specific outcome(s), such as: strengthening the family unit, building skills within the family for the benefit of the child, promoting empowerment within the family, and strengthening overall supports in the child's environment

Please refer to "Medicaid State Plan Children and Family Support and Treatment Services Provider Manual for Children's BH Early and Periodic Screening and Diagnostic Treatment (EPSDT) Services" for additional information regarding this service. This service is available for children from birth to 21 years of age.

Guidelines for Medical Necessity

Admission to Family Peer Support Services	Continued Stay	Discharge
• Licensed Master Social Worker • Licensed Clinical Social Worker • Licensed Mental Health Counselor • Licensed Creative Arts Therapist • Licensed Marriage and Family Therapist • Licensed Psychoanalyst • Licensed Psychologist • Physicians Assistant • Psychiatrist • Physician • Registered Professional Nurse or • Nurse Practitioner		obtaining a similar benefit through other services and resources.

FPSS Limits/Exclusions

Limits/Exclusions:

- The provider agency will assess the child prior to developing the treatment plan for the child.
- Treatment services must be part of the treatment plan including goals and activities necessary to correct or ameliorate conditions discovered during the initial assessment visits.
- A child with a developmental disability diagnosis without a co-occurring behavioral health condition is ineligible to receive this rehabilitative service.
- A group cannot exceed more than 12 individuals in total.

Medicaid family support programs will not reimburse for the following:

- 12-step programs run by peers.
- General outreach and education including participation in health fairs, and other activities designed to increase the number of individuals served or the number of services received by individuals accessing services; community education services, such as health presentations to community groups, PTAs, etc.

- Contacts that are not medically necessary.
- Time spent doing, attending, or participating in recreational activities.
- Services provided to teach academic subjects or as a substitute for educational personnel such as, but not limited to, a teacher, teacher's aide, or an academic tutor.
- Time spent attending school (e.g., during a day treatment program).
- Habilitative services for the beneficiary (child) to acquire self-help, socialization, and adaptive skills necessary to reside successfully in community settings.
- Child Care services or services provided as a substitute for the parent or other individuals responsible for providing care and supervision.
- Respite care.
- Transportation for the beneficiary or family.
- Services not identified on the beneficiary's authorized treatment plan.
- Services not in compliance with the service manual and not in compliance with State Medicaid standards.
- Services provided to children, spouse, parents, or siblings of the eligible beneficiary under treatment or others in the eligible beneficiary's life to address problems not directly related to the eligible beneficiary's issues and not listed on the eligible beneficiary's treatment plan.
- Any intervention or contact not documented or consistent with the approved treatment/recovery plan goals, objectives, and approved services will not be reimbursed.

Youth Peer Support (YPS): Youth Peer Support (YPS) services are formal and informal services and supports provided to youth, who are experiencing social, medical, emotional, 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.

Youth Peer Support 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 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.

Please refer to "Medicaid State Plan Children and Family Support and Treatment Services Provider Manual for Children's BH Early and Periodic Screening and Diagnostic Treatment (EPSDT) Services" for additional information regarding this service. This service is available for children from birth to 21 years of age.

Guidelines for Medical Necessity

Admission to Youth Peer Support	**Continued Stay**	**Discharge**
Criteria 1 OR 2, AND 3, 4, 5, 6 must be met : 1. The youth has a behavioral health diagnosis that demonstrates symptoms consistent or corresponding with the DSM; OR 2. The youth displays demonstrated evidence of skill(s) lost or undeveloped as a result of the impact of their physical health diagnosis; AND	**All criteria must be met:** 1. The youth continues to meet admission criteria; AND 2. The youth shows evidence of engagement toward resolution of symptoms but has not fully reached established service goals and there is expectation that if the service continues, the youth will continue to improve; AND	**Any of criteria 1-6 must be met:** 1. The youth no longer meets admission criteria ; OR 2. The youth has successfully met the specific goals outlined in the treatment plan for discharge; OR

Youth Peer Support (YPS): Youth Peer Support (YPS) services are formal and informal services and supports provided to youth, who are experiencing social, medical, emotional, 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.

Youth Peer Support 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 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.

Please refer to "Medicaid State Plan Children and Family Support and Treatment Services Provider Manual for Children's BH Early and Periodic Screening and Diagnostic Treatment (EPSDT) Services" for additional information regarding this service. This service is available for children from birth to 21 years of age.

Guidelines for Medical Necessity

Admission to Youth Peer Support	Continued Stay	Discharge
3. The youth requires involvement of a Youth Peer Advocate to implement the intervention(s) outlined in the treatment plan, AND 4. The youth demonstrates a need for improvement in the following areas such as but not limited to: a) enhancing youth's abilities to effectively manage comprehensive health needs b) maintaining recovery c) strengthening resiliency, self-advocacy d) self-efficacy and empowerment e) developing competencecy to utilize resources and supports in the community f) transition into adulthood or participate in treatment; AND 5. The youth is involved in the admission process and helps determine service goals; AND 6. The youth is available and receptive to receiving this service; AND 7. The services are recommended by the following Licensed Practictioners of the Healing Arts operating within the scope of their practice under State License: • Licensed Master Social Worker • Licensed Clinical Social Worker • Licensed Mental Health Counselor	3. The youth does not require an alternative and/or higher, more intensive level of care or treatment; AND 4. The youth is at risk of losing skills gained if the service is not continued.; AND 5. Treatment planning includes family/caregiver(s) and/or other support systems, unless not clinically indicated.	3. The youth or parent/caregiver withdraws consent for services; OR 4. The youth is not making progress on established service goals, nor is there expectation of any progress with continued provision of services; OR 5. The youth is no longer engaged in the service, despite multiple attempts on the part of the provider to apply reasonable engagement strategies;OR 6. The youth no longer needs this service as they are obtaining a similar benefit through other services and resources.

Youth Peer Support (YPS): Youth Peer Support (YPS) services are formal and informal services and supports provided to youth, who are experiencing social, medical, emotional, 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.

Youth Peer Support 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 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.

Please refer to "Medicaid State Plan Children and Family Support and Treatment Services Provider Manual for Children's BH Early and Periodic Screening and Diagnostic Treatment (EPSDT) Services" for additional information regarding this service. This service is available for children from birth to 21 years of age.

Guidelines for Medical Necessity

Admission to Youth Peer Support	Continued Stay	Discharge
• Licensed Creative Arts Therapist • Licensed Marriage and Family Therapist • Licensed Psychoanalyst • Licensed Psychologist • Physicians Assistant • Psychiatrist • Physician • Registered Professional Nurse or • Nurse Practitioner		

YPS Limits/Exclusions

Limits/Exclusions:

- The provider agency will assess the child prior to developing the treatment plan for the child.
- Treatment services must be part of the treatment plan including goals and activities necessary to correct or ameliorate conditions discovered during the initial assessment visits.
- A youth with a developmental disability diagnosis without a co-occuring behavioral health condition is ineligible to receive this rehabilitative service.
- Group limit refers to number of child/youth participants, regardless of payor. Groups cannot exceed 8 children/youth.
- Consideration for group limits, or, the inclusion of an additional group clinician/facilitator, should be based on, but not limited to: the purpose/nature of the group, the clinical characteristics of the participants, age of participants, developmental level and severity of needs of the participants, inclusion of family/collaterals in group; as well as the experience and skill of the group clinician/facilitator.

Medicaid family support programs will not reimburse for the following:

- 12-step programs run by peers.
- General outreach and education including participation in health fairs, and other activities designed to increase the number of individuals served or the number of services received by individuals accessing services; community education services, such as health presentations to community groups, PTAs, etc.
- Contacts that are not medically necessary.
- Time spent doing, attending, or participating in recreational activities.
- Services provided to teach academic subjects or as a substitute for educational personnel such as, but not limited to, a teacher, teacher's aide, or an academic tutor.
- Time spent attending school (e.g., during a day treatment program).
- Habilitative services for the beneficiary (child) to acquire self-help, socialization, and adaptive skills necessary to reside successfully in community settings.
- Child Care services or services provided as a substitute for the parent or other individuals responsible for providing care and supervision.
- Respite care.
- Transportation for the beneficiary or family.
- Services not identified on the beneficiary's authorized treatment plan.
- Services not in compliance with the service manual and not in compliance with State Medicaid standards.
- Services provided to children, spouse, parents, or siblings of the eligible beneficiary under treatment or others in the eligible beneficiary's life to address problems not directly related to the eligible beneficiary's issues and not listed on the eligible beneficiary's treatment plan
- Any intervention or contact not documented or consistent with the approved treatment/recovery plan goals, objectives, and approved services will not be reimbursed.

State Assurances

The state assures that rehabilitative services do not include and FFP is not available for any of the following in accordance with section 1905(a0(13) of the Act.

- Educational, vocational and job training services;
- Room and board
- Habilitation services
- Services to inmates in public institutions as defined in 42 CFR 435.1010;
- Services to individuals residing in institutions for mental disease as described in 42 CFR 435.1010
- Recreational and social activities
- Services that must be covered elsewhere in the state Medicaid plan

V. Utilization Management Guidelines for Children's State Plan for Medicaid Managed Care Plans

Note: Below are guidelines, Plans may opt not to conduct Authorization activities. Provider agencies should coordinate with Plans to determine requirements and workflows.

Service	Prior Authorization	Concurrent Authorization	Additional Guidance
Other Licensed Practitioner (OLP)	No	Yes	As indicated in the SPA all treatment plans* must have authorization from DOH or its designee, in this case that designee is MMCP. Therefore, the MMCP will review the treatment plan, inclusive of the provider assessment, at least before the 4th visit to evaluate medical necessity for authorization prior to receipt of further services. Where the MMCP has determined continued services are medically necessary, the authorization period following the initial 3 visits must be inclusive of at least 30 service visits. The MMCP will review services at reasonable intervals thereafter as determined by the MMCP and consistent with the child's treatment plan and/or Health Home plan of care. The MMCP must ensure that prior and concurrent review activities do not violate parity law. Note: the 30-visit count should not include: a) FFS visits or visits paid by another MMCP; or b) psychiatric assessment and medication management visits. Multiple services received on the same day shall count as a single visit. * Treatment plan in this context indicates the needed clinical or functional information the MMCO needs from the treating provider in order to evaluate medical necessity for each service in the applicable MMCO benefit package.
Crisis Intervention	No	No	None
Community Psychiatric Supports and Treatment (CPST)	No	Yes	As indicated in the SPA all treatment plans* must have authorization from DOH or its designee, in this case that designee is MMCP. Therefore, the MMCP will review the treatment plan, inclusive of the provider assessment, at least before the 4th visit to evaluate medical necessity for authorization prior to receipt of further services. Where the MMCP has determined continued services are medically necessary, the authorization period following the initial 3 visits must be inclusive of at least 30 service visits. The MMCP will review services at reasonable intervals thereafter as determined by the MMCP and consistent with the child's treatment plan

Service	Prior Authorization	Concurrent Authorization	Additional Guidance
			and/or Health Home plan of care. The MMCP must ensure that prior and concurrent review activities do not violate parity law. Note: the 30-visit count should not include: a) FFS visits or visits paid by another MMCP; or b) psychiatric assessment and medication management visits. Multiple services received on the same day shall count as a single visit. * Treatment plan in this context indicates the needed clinical or functional information the MMCO needs from the treating provider in order to evaluate medical necessity for each service in the applicable MMCO benefit package.
Psychosocial Rehabilitation (PSR)	No	Yes	As indicated in the SPA all treatment plans* must have authorization from DOH or its designee, in this case that designee is MMCP. Therefore, the MMCP will review the treatment plan, inclusive of the provider assessment, at least before the 4th visit to evaluate medical necessity for authorization prior to receipt of further services. Where the MMCP has determined continued services are medically necessary, the authorization period following the initial 3 visits must be inclusive of at least 30 service visits. The MMCP will review services at reasonable intervals thereafter as determined by the MMCP and consistent with the child's treatment plan and/or Health Home plan of care. The MMCP must ensure that prior and concurrent review activities do not violate parity law. Note: the 30-visit count should not include: a) FFS visits or visits paid by another MMCP; or b) psychiatric assessment and medication management visits. Multiple services received on the same day shall count as a single visit. * Treatment plan in this context indicates the needed clinical or functional information the MMCO needs from the treating provider in order to evaluate medical necessity for each service in the applicable MMCO benefit package.
Family Peer Supports and Services (FPSS)	No	Yes	As indicated in the SPA all treatment plans* must have authorization from DOH or its designee, in this case that designee is MMCP. Therefore, the MMCP will review the treatment plan, inclusive of the provider assessment, at least before the 4th visit to evaluate medical necessity for authorization prior to receipt of further services. Where the MMCP has determined continued services are medically necessary, the authorization period following the initial 3 visits

Service	Prior Authorization	Concurrent Authorization	Additional Guidance
			must be inclusive of at least 30 service visits. The MMCP will review services at reasonable intervals thereafter as determined by the MMCP and consistent with the child's treatment plan and/or Health Home plan of care. The MMCP must ensure that prior and concurrent review activities do not violate parity law. Note: the 30-visit count should not include: a) FFS visits or visits paid by another MMCP; or b) psychiatric assessment and medication management visits. Multiple services received on the same day shall count as a single visit. * Treatment plan in this context indicates the needed clinical or functional information the MMCO needs from the treating provider in order to evaluate medical necessity for each service in the applicable MMCO benefit package.
Youth Peer Support (YPS)	No	Yes	As indicated in the SPA all treatment plans* must have authorization from DOH or its designee, in this case that designee is MMCP. Therefore, the MMCP will review the treatment plan, inclusive of the provider assessment, at least before the 4th visit to evaluate medical necessity for authorization prior to receipt of further services. Where the MMCP has determined continued services are medically necessary, the authorization period following the initial 3 visits must be inclusive of at least 30 service visits. The MMCP will review services at reasonable intervals thereafter as determined by the MMCP and consistent with the child's treatment plan and/or Health Home plan of care. The MMCP must ensure that prior and concurrent review activities do not violate parity law. Note: the 30-visit count should not include: a) FFS visits or visits paid by another MMCP; or b) psychiatric assessment and medication management visits. Multiple services received on the same day shall count as a single visit. * Treatment plan in this context indicates the needed clinical or functional information the MMCO needs from the treating provider in order to evaluate medical necessity for each service in the applicable MMCO benefit package.

VI. EPSDT State Plan Services for Children: Standards of Care (Authorized Under Children's Behavioral Health and Health Services 18 NYCRR 505.38)

Administrative Standards

These Standards of Care are applicable to the following Children and Family Treatment and Support Services (CFTSS):

- **Other Licensed Practitioner (OLP)**
- **Community Psychiatric Supports and Treatment (CPST)**
- **Psychosocial Rehabilitation (PSR)**
- **Family Peer Support Services (FPSS)**
- **Youth Peer Support (YPS)**
- **Crisis Intervention (CI)**

I. Agency Administration of Services:

Principle – Services are outcome focused and delivered by qualified staff in accordance with appropriate policies, procedures and guidelines to ensure child/youth's needs are met in a responsive, effective, integrated, and culturally competent, trauma informed manner.

Standard	Expected Practice
A. Agency Assurances: Provider has written Policies and Procedures to ensure compliance with regulatory and quality of care standards and to provide a reference for all aspects of operation.	1. Policies and procedures include, at a minimum, standards related to Administrative Compliance; Service Operations; Records Management; Employee/Staffing; Orientation and Training of Staff; Quality Management; and Health and Safety, Fiscal Compliance. 2. Policies and procedures are made available in written format to all staff (employees, contractors, volunteers and student interns) to access as needed and are a source for ongoing notification, training and orientation to ensure adherence.
B. Administrative Compliance: Policies and procedures are developed, reviewed and	1. Policies and Procedures are modified as significant operational changes are implemented, as new services and programs are put into effect, and/or as changes in requirements occur.

Standard	Expected Practice
revised to reflect up-to-date regulatory compliance and service operations.	2. Policies and procedures include a written up-to-date description of the services offered by the agency and ensure that services implemented are consistent with services described. 3. Policies and procedures include a written staffing plan that addresses the types, roles and numbers of staff available to provide the services offered and coverage plan for staff absences or vacancies.
C. Service Operations: Policies and Procedures support the availability and delivery of services that uphold the child/youth's rights, are culturally and linguistically responsive and adhere to clinical quality standards.	1. Policies and procedures ensure that services are delivered within the scope of practice as per service designation. 2. Policies and procedures ensure clear protocols are in place that support child/youth's rights and protections, as a mandatory component of all services provided by provider staff. Provider has protocols in accordance with the requirements of the oversight agency(ies) that has licensed, certified, authorized, or designated the provider and ensures: a. consent to receive services is obtained b. orientation to service information is provided c. individual's rights are explained (including the right to file grievances)[2] 3. Policies and procedures in place to help improve meaningful access to care for people of diverse backgrounds that include: a. Recruiting and assigning multicultural and/or multilingual clinicians and staff to match child/youth's cultural groups whenever possible. b. Providing services in a culturally competent manner for all children, youth and families 4. Policies and procedures ensure that language interpretation/translation services are available for verbal and written correspondence to serve families with Limited English Proficiency (LEP) or with language-based disabilities, and takes reasonable steps to provide meaningful access to agency services[3] This also includes specialized information/access to youth who are sight/visually impaired, deaf or hard of hearing.

[2] OMH website: Rights of Outpatients OMH Bureau of Policy, Regulation and Legislation https://www.omh.ny.gov/omhweb/patientrights/outpatient.htm https://www.oasas.ny.gov/regs/documents/815.pdf

[3] *Section 527.4 of 14 NYCRR: 527.4 Communication needs; Title VI of the Civil Rights Act of 1964 (42 USC 2000d)*

Standard	Expected Practice
	5. Policies and procedures are developed that define how services will be delivered, documented and reflect clinical quality of care standards. 6. Policies and procedures describe the process for, and support the importance of, information sharing in a timely manner in order to provide coordinated services for child/youth and integrated services among child serving systems. 7. Policies and procedures define and address prompt intervention in the event of a crisis or a behavioral, medical, or psychiatric emergency when it occurs.
D. Records Management: Policies and Procedures describe the requirements for establishing a legal record for, service documentation and billing, and meet standards and regulatory requirements related to proper storage and management of case records. This includes Electronic Health Records (EHR).	1. Provider's policies ensure all understand and adhere to the requirements of Health Insurance Portability and Accountability Act (HIPAA) (Pub. L. No. 104-191, 110 Stat. 1936 (1996)), 42 CFR Part 2. This includes employees, contractors, students, interpreters/translators. 2. Provider defines, by policy, all records it maintains that address an individual's care and treatment and what each record contains, and implements a system of documentation that supports appropriate service planning, coordination, and accountability. 3. Policies and procedures include a records management policy that describes confidentiality, accessibility, security, and retention and destruction of paper and electronic records pertaining to individuals, consistent with applicable state and federal laws and regulations.[4]
E. Employee/Staffing: Provider maintains documentation of administrative oversight to include: hiring, retention, and supervision of qualified staff.	1. Provider maintains an Organizational Chart that provides a visual description outlining the organizational relationships in the agency. The chart clearly identifies the line of authority and is distributed to all staff (employees, contractors, volunteers and student interns). 2. Each position has a written job description. As employees are hired, they are provided with a detailed job description and clearly defined expectations of the position are communicated. 3. Agency Management clearly communicates with new staff the policies and procedures of the agency. The employee manual contains the materials that staff will refer to throughout their

[4] 42 CFR Part 2 Confidentiality of Alcohol and Drug Abuse records; The Health Insurance Portability and Accountability Act (Public Law 104-191); regulations (45 CFR Parts 160, 162, 164); 42 USC 290dd – United States Code; The Public Health and Welfare; Public Health Service; Substance Abuse and Mental Health Services Administration; Confidentiality of records) NY State Mental Hygiene Law Section 33.13

Standard	Expected Practice
	employment. Staff signs written attestation acknowledging review and understanding of contents and policies via employee manual. All staff are kept informed of policy changes that affect performance of duties and the provider has a written process to advise them of policy changes. 4. Provider maintains documentation that staff have current NYS licensure, certification, or registration, as appropriate, and are appropriately qualified to deliver CFTSS services within the scope of their practice. 5. Provider provides that staffing is adequate to meet the needs of the population served and assigns cases based on presenting needs, acuity, preferences and staff expertise; caseload size and supervision ratios are monitored. 6. Provider maintains policies and procedures for conducting background checks in accordance with the requirements of the oversight agency(ies) that has licensed, certified, authorized, or designated the provider for all staff (employees, contractors, volunteers and student interns) who has regular and substantial contact with child/youth, family/caregiver.[5]
F. Orientation and Training of Staff: Provider has a training and orientation plan in place for all staff.	1. Provider has written policies and procedures that describe staff orientation, mandatory training and other offered trainings for staff. 2. Provider maintains a record of staff's completion of trainings to demonstrate agency requirements being met. 3. Provider ensures that staff have the required experience and training to provide care that is trauma informed, culturally competent, and appropriate to the developmental level of the population served and in accordance with ethical standards per scope of practice. 4. Provider has written protocols to address personal safety of staff and provides appropriate training in de-escalation techniques.

[5] NYS Social Service Law 424-a

Standard	Expected Practice
G. Health and Safety: Policies and procedures that address clinical/client emergencies, crisis events or disasters, prevention of abuse and/or neglect and incident reporting.	1. Provider has written protocol for delivery of services in a manner which protects the health and safety of the child/youth. 2. Provider has policies and procedural requirements regarding management, reporting, and response to client related incidents and other client complaints, which include allegations of suspected client abuse, neglect, and exploitation.[6] 3. Provider has policy and procedural requirements regarding the management, reporting, documentation, and response to clinical/medical emergencies and incidents of elevated client risk as determined by the requirements of the lead provider that has licensed, certified, authorized, or designated the provider. 4. Provider has written emergency preparedness and response plan for all of its services and locations that includes responses to environmental and natural disasters.
H. Quality Management: Policy and procedures are in place to monitor the quality and evaluate the effectiveness of services on a systematic basis, and to implement quality improvements when indicated.	1. Provider has policies and procedures that clearly describes a quality management plan, and implementation processes for that plan. This includes clear documentation of indicators and monitoring processes for those indicators. 2. Provider implements methods to monitor quality and assess outcome of services by gathering, tracking, and analyzing data on the following: a. service performance b. participant feedback c. disparities in care across cultural groups d. clinical supervision e. grievances and complaints f. critical incidents 3. Provider implements quality improvement measures when indicated by:

[6] Reference for mandated reporting: http://public.leginfo.state.ny.us/lawssrch.cgi?NVLWO:

Standard	Expected Practice
	Linking outcome/analysis data to determine needed actions and initiatives related to effectiveness, timeliness, person centeredness, cultural and linguistic competence, safety or any other aspect of quality of care standards to improve services. 4. The provider monitors the time from first call for appointment to first service appointment and utilizes this process data as part of a quality improvement plan.
I. Fiscal Compliance: Provider has written policies and procedures regarding billing and compliance with all applicable funding sources.	1. Provider has written procedures for billing practices including timely billing, reconciliation, and denial procedures. 2. Provider has the ability to verify the source of payment and bill accordingly. 3. Provider is legally and fiscally sound and capable of maintaining a system of operations to deliver services.

Clinical Standards

II. Initial Contact and Engagement:

The child/youth and family/caregiver are provided with person-centered, trauma informed, culturally and linguistically appropriate care upon initial contact and barriers are identified and addressed to enhance connectedness.

Standard	Expected Practice
A. Service is initiated in a timely manner to meet the needs of the child/youth and family/caregiver and collaterals.	1. Outreach is made to child/youth and family/caregiver to establish initial contact and engage in scheduling appointment. 2. An appointment is made in the established time per service and per service type, in accordance with agency standards and/or MCO requirements. 3. Contact is maintained and continued engagement efforts are made with the child/youth and family/caregiver until the appointment occurs. 4. To meet the needs of child/youth, family/caregiver and collaterals, flexibility in scheduling an initial appointment is demonstrated. This includes identifying barriers and problem solving toward removing barriers to treatment, e.g., childcare, transportation, etc.

Standard	Expected Practice
	See additional guidance in Provider Manual for Crisis Intervention
B. The child/youth and family/caregiver are oriented to services and provided with the necessary information and documentation regarding the scope of services, confidentiality and information sharing protocols.	1. The scope of services to be rendered and service guidelines are clearly described to the child/youth and family/caregiver. This information is provided verbally and in writing in a language/format that is understandable to the child/youth and family/caregiver. 2. The child/youth and family/caregiver are clearly informed when/how information is shared within the agency, with outside agencies/providers, and other collateral sources (consent to share information) and circumstances when consent to share information is not required. 3. All orientation procedures are demonstrated through appropriate documentation completed and maintained in child/youth's record.
C. An integrated approach to service delivery is demonstrated by the coordination of care and collaboration among the multidisciplinary team (service providers, child/youth, family/caregiver and collaterals) to achieve safe and effective care	1. The child/youth, family/caregiver and collaterals are provided with the information necessary to contact the appropriate service provider for both routine follow-up and immediate access in times of crisis. **2.** The purpose of a multidisciplinary team is clearly explained to the child/youth and family/caregiver including their role as active participants. The multidisciplinary team works together to coordinate the medical, psychosocial, emotional, therapeutic, and recovery support needs of the child/youth and family/caregiver, both within and outside the provider agency. 3. Appropriate releases are obtained and information is shared in a timely manner in order to provide safe, appropriate, and effective care; the child/youth's and family/caregiver's needs and preferences related to sharing information are elicited ahead of time. 4. All communication with referral sources, family/caregivers, the multidisciplinary team and other collaterals is HIPAA compliant and documented in the child/youth's case record.
D. The child/youth and family/caregiver are provided care that reflects the awareness	1. Provider has an understanding of the cultural perspectives of the child/youth and family/caregiver and seeks out/includes individuals and/or information to enhance the understanding and responsiveness to cultural perspectives. 2. Provider's assessment and interventions acknowledge, respect and integrate the child/youth's and family/caregiver's beliefs, cultural values and practices.

Standard	Expected Practice
and responsiveness of cultural differences and diversity.[7]	3. Provider has awareness and understanding of social diversity with respect to race, ethnicity, sex, sexual orientation, gender identity or expression, religion, immigration status and its impact on engagement, experience with the service system and satisfaction with care. 4. Provider utilizes competent interpretation/translation services as needed to ensure the child/youth, parent/caregiver with limited English proficiency or language-based disabilities can participate meaningfully in services.

III. Assessment:

An assessment is conducted with the child/youth and family/caregiver to identify the strengths, needs and preferences that inform the delivery of the services.

Standard	Expected Practice
A. A service specific assessment is done based on the needs of the child/youth	1. The assessment is relevant to the child/youth's age/developmental stage. 2. Information is gathered to assess the strengths, needs and preferences of the child/youth related to the delivery of the CFTSS. 3. Safety issues for the child/youth are identified through the assessment and provider protocols are followed if indicators of risk arise. 4. Linkage to appropriate service is expedited if indicated by clinical presentation. 5. The supporting documentation (including frequency, scope and duration) that substantiates the need for the specific service is maintained in the child/youth's record.

IV. Care and Retention:

The child/youth and family/caregiver are engaged throughout the service process to maintain involvement and promote successful outcomes for the child/youth and family/caregiver.

[7] National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care, US Dept. of Health and Human Services, EPDST: A Guide for States

Standard	Expected Practice
A. Services are provided and engagement is maintained with the child/youth and family/caregiver in the most appropriate setting(s) for desired outcomes, as identified in the treatment plan.	1. Services are provided in home and community settings, as appropriate, making full use of natural environments and supports, such as community, school, family, and friends. 2. The determination of the appropriate setting by the multidisciplinary team includes the child/youth and family/caregiver's preferences and addresses issues of safety, accessibility. The setting is conducive to the provision of services in meeting treatment goals/objectives. 3. Use of appropriate setting(s) is clearly documented throughout service process. 4. To effectively maintain engagement, re-assessment of the appropriate setting is conducted throughout the service process as the child/youth and family/caregiver's needs and situation change.
B. Consistent and personalized follow-up is provided and concrete steps taken to encourage ongoing participation in services.	1. Confirmation contacts prior to appointments and/or use of other effective methods to reduce "no-shows" and offer the child/youth alternatives and choices and consistent follow-up is made on missed appointments. 2. Scheduling is flexible so that services are accommodating and accessible to children and families and must include evenings and weekends. 3. Barriers to participation in services are identified and addressed with child/youth and family/caregiver.
C. A trauma informed approach to care is utilized; the impact of trauma is understood, signs and symptoms of trauma are recognized and the knowledge about trauma is integrated into policies, procedures and practices.[8]	1. Services incorporate principles of safety, trustworthiness/transparency, collaboration, empowerment, and respect for cultural and gender differences. 2. Provider has an understanding of the interconnection between cultural factors and the experience of trauma and trauma reactions 3. Provider uses culturally responsive assessment and treatment approaches and/or makes appropriate resources available for the child/youth and family/caregiver on trauma exposure, its impact, treatment for traumatic stress and associated behavioral health symptoms.

[8] http://www.nctsn.org/The National Child Traumatic Stress Network; and SAMSHA

Standard	Expected Practice
	4. Provider engages in efforts to strengthen the resilience and protective factors for child/youth and family/caregiver. 5. Provider emphasizes continuity of care and collaboration across child serving systems and the prevention of re-traumatization. 6. Provider maintains environment for staff that addresses secondary trauma and increases staff resilience.

V. Child/Youth-and Family-Centered Services:

Services emphasize shared decision-making approaches that empower families, provide choice, maximize strengths and are attuned to the relationship between family/caregiver and child, relevant to the child's development stage. This is reflected through treatment/service planning best practice approaches to service delivery and documentation.

Standard	Expected Practice
A. Every child/youth has an individualized, strength based, culturally competent, developmentally appropriate treatment/service plan.	1. The plan is individualized to the circumstances and preferences of the child/youth and family/caregiver and identifies/includes: a. The desired goals and outcomes. b. Scope, frequency and duration of service c. Criteria to indicate the child/youth's readiness for discharge. d. Signatures of child/youth and/or family/caregiver to ensure their participation and demonstrate agreement. 2. Services are delivered in accordance with best practice principles and approaches, are child and family centered and appropriate to the child's presenting needs and stage of development. a. Family/caretaker or other natural supports significant to the child/youth's care and recovery, are involved in the treatment/service as identified and agreed upon by the child/youth and legal guardian. b. The treatment/service plan is reviewed, approved and signed by a licensed practitioner to ensure quality and appropriateness of care. ***See Health Record Documentation Guidance for specific information related to CFTSS treatment planning.***

Standard	Expected Practice
B. Services are provided in accordance with the treatment/service plan and documented in the child/youth's record using a child/youth and family centered approach.	1. Services are provided as identified in the plan and reflected in contemporaneous or collaborative progress notes. 2. Notes are directly linked to goals and objectives at a minimum, by summarizing the services provided, interventions utilized, the child/youth and family caregiver's response, and evidence of progress made toward goals. 3. Notes include any significant information impacting services, including child/youth and family caregivers' preferences, coordination with the multidisciplinary team, and consideration of the need for changes to the plan.
C. Treatment/service planning is an active process that engages the child/youth, family/caregiver and collaterals in ongoing review of progress toward goals and objectives	1. Ongoing coordination with the multidisciplinary team and active participation in the plan review occurs with the family, to reflect progress of the child/youth toward goals/objectives. 2. Shared decision making occurs related to changes in goals, objectives and continuing service needs relevant to progress being made, the child/youth and family/caregiver preferences, and/or readiness for discharge
D. Treatment/service planning includes the development of a safety plan for all at-risk child/youth (with moderate to high risk factors) that incorporates strengths and preferences of the child/youth and family/caregiver	1. Child/youth and family/caregiver are assisted in implementing a written, individualized safety/crisis plan that contains at least the following elements: identification of triggers, warning signs of increased symptoms, management techniques of self-regulation, contact information for supportive persons and plan to get emergency help as needed; a copy is provided. 2. Awareness is maintained regarding changes or updates to the safety/crisis plan made by the multidisciplinary team and recommendations are provided for needed changes to reflect child/youth or family/caregiver's preferences 3. Education is routinely provided to the child/youth and family/caregiver about available community supports and crisis services. ***See additional guidance regarding the safety plan for Crisis Intervention (to be issued).***
E. Discharge planning is a dynamic process throughout the course of	1. The discharge plan is part of the treatment/service plan and is developed at the start of service delivery and is regularly reviewed and amended as needed.

Standard	Expected Practice
service delivery and includes the participation of child/youth, family/caregiver and collaterals.	2. Discharge plan considers the child/youth and family/caregiver's circumstances and preferences. 3. Shared decision making occurs with the child/youth, family/caregiver and collaterals regarding readiness for discharge and needed follow up services. Linkage to services is facilitated (e.g., identification of alternative providers, assistance with obtaining appointments, contact names and numbers provided, etc.). 4. Discharge summaries are completed that identify services provided, the child/youth's response, progress toward goals, circumstances of discharge and efforts to re-engage if the discharge was not planned.

VII. BILLING AND CODING FOR CFTSS

A. Overview

This section outlines the claiming requirements necessary to ensure proper claim submission for CFTSS and is intended for use by Medicaid Managed Care Plans (MMCP) and CFTSS providers.

This section provides billing guidance only. It does not supersede applicable regulatory requirements or procedures for admission to a program, record keeping, service documentation, initial and on-going treatment planning and reviews, etc.

Appendix A includes listing of rate codes, procedure codes and modifiers to be used for each service.

B. Fundamental Requirements

Provider Designation to Deliver Services

Providers are required to receive a designation from NYS to provide and be reimbursed for CFTSS. CFTSS may require additional licensure, certification or approvals from State agencies based on population(s) served.

For more information on how to apply to become a Designated Provider of CFTSS, refer to the Children's CFTSS and HCBS Provider Designation webpage.

Medicaid-Enrolled Provider

CFTSS agencies must enroll as a Medicaid provider agency. In addition, to be paid for delivering a Medicaid service, all providers eligible to enroll in Medicaid are required to enroll in Medicaid as an Ordering, Prescribing, Referring, or Attending (ORPA) non-billing practitioner. Information on how to become a Medicaid provider is available on the eMedNY website: https://www.emedny.org. These requirements are outlined in more detail at: https://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health/children/docs/provider_enrollment_npi_memo.pdf[9]

[9] This memo is only effective until such time provider types that currently cannot enroll in Medicaid are able to enroll in Medicaid. Please refer to the eMedNY site for updates and information on Medicaid enrollable provider types. Link: eMedNY: Provider Enrollment & Maintenance

Additional information specific to Medicaid provider enrollment for children/youth's services is available at the following MCTAC webinar: [Training - Medicaid Provider Enrollment for New Children's SPA and HCBS Providers | CTACNY]

Medicaid Managed Care Plan Contracting

To be paid for services delivered to a child/youth enrolled in a Medicaid Managed Care Plan, a provider must be contracted and credentialed with that MMCP for the service rendered (i.e. in the MMCP's network).

A Medicaid Managed Care Plan has discretion to deny a claim from an out of network provider.

Single Case Agreements (SCA) may be executed between a MMCP and a provider when an out of network provider has been approved by a MMCP to deliver specific services to a specific MMCP enrollee. Medicaid Managed Care Plans must execute SCAs with non-participating providers to meet clinical needs of children/youth when in-network services are not available. The MMCP must pay at least the NYS government rates for 24 months from the service implementation date.

Medicaid Managed Care Plans are held to specific network requirements for services described in this manual. NYS monitors MMCP contracting regularly to ensure network requirements are met.

C. Rates

Child Health Plus

As of January 1, 2023, CFTSS became a covered benefit under Child Health Plus (CHP). CHP Plans are required to pay 100% of the Medicaid fee-for-service (FFS) rate (also known as, "government rates"). For questions specific to CHP, providers should contact their contracted Plans or email chplus@health.ny.gov.

Government Rates

NYS law requires that Medicaid Managed Care Plans pay government rates (otherwise known as Medicaid fee-for-service rates) for certain services administered by a MMCP. MMCPs will be required to pay government rates for CFTSS until March 31, 2027, or as long as governed by State law.

Please refer to the "Rate" section in following link for the latest reimbursement rates for CFTSS: Children and Family Treatment and Support Services (ny.gov)

Regions

Regions are assigned to providers based upon the geographic location of the provider's headquarters, and are defined by the Department of Health as follows:

- Downstate: 5 boroughs of New York City, counties of Nassau, Suffolk, Westchester, Rockland, Putnam, Orange, Dutchess, Sullivan and Ulster
  Upstate: all other counties

D. Claims Information

General Claim Requirements[10]

Electronic claims will be submitted using the 837i claim form to both Medicaid FFS and Medicaid Managed Care. Paper claims (UB-04) and web-based claiming will also be accepted by MMCPs.

Each service has a unique rate code. If a child/youth receives multiple services in the same day with the same CPT code, but separate rate codes and modifiers, all services would be payable.

CFTSS is paid based on the county in which services were provided. Providers must include the Federal Information Processing Standards (FIPS) code (and if submitting electronically) or proxy locator county code (if submitting on paper) on all claims. The list of applicable codes and further information is located under the CFTSS Rates tab on the DOH website (Children and Family Treatment and Support Services (ny.gov)) located here and included in the table in Appendix A

Enrollment Status

[10] Note: NYS will be reviewing claim and encounter data periodically and annually, or upon information that there has been fraud or abuse, to determine if inappropriate CFTSS combinations were provided/allowed. In instances where such combinations are discovered, NYS will make the appropriate recoveries and referrals for judicial action.

Before delivering services to a child/youth, providers are responsible for checking the Electronic Provider Assisted Claim Entry System (ePaces)[11] to verify the child/youth's:

- Medicaid enrollment status,
- Medicaid Managed Care Plan enrollment status

Providers should ensure child/youth enrollment with Medicaid, and appropriate MMCP, through the NYS system. Claims will not be paid if a claim is submitted for a child/youth who is not enrolled with Medicaid or the claim was submitted to an incorrect MMCP.

Providers should always verify that claims are submitted to the correct MMCP.

Medicaid Fee-For-Service Claiming (eMedNY)

Claims for services delivered to a child/youth in receipt of fee-for-service Medicaid are submitted by providers to eMedNY. See https://www.emedny.org for training on use of the eMedNY system. Claim submissions need to adhere to the 90-day timely filing rules for Medicaid FFS.

Managed Care Plan Claiming

MMCPs and providers must adhere to the rules in this billing and coding manual. The MMCP must support both paper and electronic submission of claims for all claim types. The MMCP must offer its providers an electronic payment option including a web-based claim submission system. MMCPs rely on CPT codes and modifiers when processing claims. Therefore, all MMCPs will require claims to be submitted with the CPT code and modifier (if applicable), in addition to the NYS assigned rate code.

Providers will enter the rate code in the header of the claim as a value code. This is done in the value code field by first typing in "24" followed immediately with the appropriate four-digit rate code. This is the standard mechanism historically and currently used in Medicaid FFS billing.

Billing requirements depend on the type of service provided; however, every claim submitted will require at least the following:

[11] ePaces is a web-based application which will allow Providers to create/submit claims and other transactions in HIPAA format.

- Use of the 837i (electronic) or UB-04 (paper) claim format,
- Medicaid fee-for-service rate code,
- Valid CPT code(s),
- CPT code modifiers (as needed),
- Units of service, and
- Revenue codes

Sample institutional claim form can be found through MCTAC/CTAC: http://billing.ctacny.org/
MMCPs will not pay claims if submitted without the applicable rate code, CPT code, and modifiers. If an individual service has multiple modifiers listed, they must all be included on the claim submission.

Providers must adhere to timely filing guidelines as outlined in their contract with the MMCP. When a clean claim is received by the MMCP they must adjudicate per prompt pay regulations.
If a provider does not have a contract or a Single Case Agreement in place with the MMCP, the claim can be denied.

Multiple Services Provided on the Same Date to the Same Child/Youth

In some cases, a child/youth can receive multiple services on the same day. This can include multiple services within the same program type (e.g., an evaluation and a family counseling session or an individual session and group session), or services provided by separate programs (e.g., OLP and Family Peer Support). If these services are allowed per the service combination grid in Section E below, they would both be reimbursable when billed using the appropriate rate code and CPT code.

Services Provided While in Transit

Services that are delivered in transit are allowable and may be billed within the daily limits of the service.

For example, a Family Peer Advocate escorts a family to a destination where the family will implement a strategy supported by the Family Peer Advocate; while in route, the Family Peer Advocate talks through the plan to help prepare the family. The time spent

in transit would be considered part of the billable service. Transportation is not reimbursable.

Submitting Claims for Services When the Child/Youth is Not Present

Services delivered on behalf of a child/youth to collateral contacts (family members, caregivers, and other stakeholders identified on the child/youth's plan of care) without the child/youth present, are allowable and may be billed in accordance with service contact allowances.

Such services may include sharing techniques and information so the collateral can better respond to the needs of the child/youth, meetings with employers or prospective employers regarding the child/youth's needs, or education and training for family members/caregivers.

For example, a child/youth receives therapy via OLP on Mondays at 5pm. During the OLP session, the PSR provider conducts a 30-minute session with the child/youth's parent/caregiver to review skills already practiced in the community with the child/youth to reinforce appropriate application in the home. The service provider may bill for PSR services for the 30-minute session with the parent/caregiver, even though the child/youth was not present when the service was delivered and even though the child/youth was receiving another service (OLP) at the time that PSR was delivered on the child/youth's behalf; this is not considered double billing because the child/youth is receiving two separate services.

Services Delivered by Multiple Staff Members

If two practitioners are required to deliver a service to a child/youth and family on the same date and at the same time, the provider must delineate what service and what goals each practitioner is addressing directly with the child/youth and on behalf of the child/youth in the child/youth's progress notes. The claim should reflect the total time spent for each practitioner in a single claim.

For Example: Practitioner A meets with the child/youth directly to deliver CPST from 10:00 am to 10:30 am and Practitioner B meets with a family member to also deliver CPST addressing a need on the behalf of the child/youth from 10:00 am to 10:30 am. The combined claim would reflect the 60-minute combined duration of the service.

Submitting Claims for Non-Sequential Time for the Same Service, on the Same Day

If the same service is delivered to the same child/youth on the same day but at non-sequential times, the total time spent on the service may be submitted as a combined claim.

For example, from 10:00am to 10:15am, a PSR service is provided to the child/youth. If, later in the same day, another PSR session is conducted with the child/youth from 1:15 pm to 1:45 pm, the service provider would document the multiple services provided during the day and bill for a combined time of 90 minutes (6 units).

Timed Units per Encounter of Service

Timed Units per Encounter of Service		
Range of Minutes per Face-to-Face Encounter	**Billable Minutes**	**Billable Units (15 Minutes per Unit)**
Under 8 minutes	1-7 minutes	Not billable
8-22 minutes	15 minutes	1 unit
23-37 minutes	30 minutes	2 units
38-52 minutes	45 minutes	3 units
53-67 minutes	60 minutes	4 units
68-82 minutes	75 minutes	5 units
83-97 minutes	90 minutes	6 units
98-112 minutes	105 minutes	7 units
113-127 minutes	120 minutes	8 units

Submitting Claims for Daily Billed Services

Services that are billed on a daily basis should be submitted on separate claims.

Claims Coding Table

Appendix A show the rate code, CPT code, and modifier code combinations that are required under Medicaid Managed Care. Providers will use these coding combinations to indicate to the MMCP that the claim is for a children/youth's service and is to be paid at the government rate. The procedure and modifier code combinations must be adhered to by both provider and MMCP to ensure appropriate rate payment.

In acknowledgement of the need for checks against fraud and abuse, but to ensure a child/youth 's access to services, service utilization in excess of the "soft" unit (i.e. annual, daily, dollar amount) limits must be based on medical necessity. Documentation of the medical necessity for extended durations must be kept on file in the child/youth 's record. In addition to concurrent utilization review and authorization as per this Manual, and any subsequent edits, the MMCP may conduct post-payment administrative reviews to ensure services were provided appropriately.

Please refer to Section V. Utilization Management Guidelines for Children's State Plan and Demonstration Services for Medicaid Managed Care Plans for details on annual and daily limits.

Provider Assistance

MMCPs are required to develop and implement provider training and support programs for network providers. This training and support will allow network providers to gain the appropriate knowledge, skills, and expertise, and receive technical assistance to comply with the MMCPs' requirements. Training and technical assistance shall be provided to network providers on billing/claims submission, coding, data interface, documentation requirements, and UM requirements.

Network providers shall be informed in writing regarding the information requirements for UM decision making, procedure coding and submitting claims. MMCPs will provide technical assistance in other areas such as claim submission as indicated by provider performance identified through the quality management and provider profiling programs put in place by the MMCP. MMCPs will ensure providers receive prompt resolution to their inquiries.

Where to Submit Questions and Complaints

Questions and complaints related to billing, payment, or claims should be directed as follows:
Specific to Medicaid Managed Care and for behavioral health providers and services: NYSDOH.BCS.Behavioral.Health.Complaints@health.ny.gov
Specific to a mental health provider/service: OMH-Managed-Care@omh.ny.gov
Specific to a substance use disorder provider/service: PICM@oasas.ny.gov

E. Service Combinations:

To promote greater flexibility and service access, co-enrollment in multiple programs is permitted for individuals enrolled in CFTSS. Co-enrollment is expected to be informed and guided by individual choice; be clinically indicated with distinct and separate
objectives; and, inclusive of coordination and collaboration between service providers.

At the onset of program admission and throughout the treatment episode, information should be collected to understand what, if any, additional programs or services the individual/family are enrolled in. Coordination of care and consultation are critical aspects of co-enrollment not just with other CFTSS providers, but with additional programming as well. Documentation should reflect occurrences of co-enrollment including, the agency(ies) and program(s) in which the individual is enrolled, the goals and objectives of the co-enrolled program treatment plan, and record of coordination between program staff. Monitoring instances of co-enrollment aid with
avoiding service duplication and maximizing program outcomes through a coordinated approach to care.

When determining which service should be utilized, MMCPs, providers, families, and care managers should discuss which services best meet the individual needs of the child/youth.

Co-Enrollment between CFTSS and other Program Types

For programs with limited co-enrollment allowances, review the program specific information for more detail.

Program/Service Type	**Service Combinations with CFTSS (OLP, CPST, PSR, FPS, YPS)**	**Program Considerations**
OMH Programs		

Assertive Community Treatment (ACT)	Youth ACT – Not Allowable Adult ACT – Limited Allowance	Adult ACT- Individuals cannot be co-enrolled in Adult ACT and receive CPST or PSR. Note: Adult ACT services available to youth age 18 and older
Children's Community Residence	Limited Allowance	All services for the exception of PSR are allowable for co-enrollment, see the CFTSS Provisions in Community Residence memo for more information.
Continuing Day Treatment	Limited Allowance	Individuals cannot be co-enrolled in CDT and receive OLP, CPST, or PSR. Note: These services available to youth age 18 and older
Crisis Residence	Yes	
Children's Day Treatment	Limited Allowance	CFTSS and Day Treatment co-enrollment is permissible however, CFTSS providers must render services outside of Day Treatment hours. The exception to this is for services that allow for provision with the parent/caregiver and/or collateral without the child present. For instance, an FPS provider can meet with the parent/caregiver while the child is receiving services through Day Treatment programming.
MHOTRS/Clinic	Limited Allowance	An individual may simultaneously receive CFTSS Family Peer Support or Youth Peer Support and MHOTRS pre-admission Peer Support. However, once the individual is admitted to a MHOTRS program, they can no longer continue to receive the same service from both programs. Please Note: In MHOTRS Programs, "Peer Support Services" is an umbrella term to encompass the various types of peer services

		including, youth peer, family peer and adult/older adult peer support services. It is possible for an individual to receive one type of peer service via a MHOTRS program while receiving a different type through CFTSS. It is important that providers identify the type of Peer Support Service rendered via a MHOTRS Program to ensure duplication of service does not occur.
Partial Hospital Program	Yes	
Personalized Recovery Oriented Services (PROS)	Limited Allowance	Individuals cannot be co-enrolled in PROS and receive OLP, CPST, or PSR. Care Managers and others who are coordinating care should be aware that there are two types of PROS Programs: PROS with Clinic and PROS without Clinic. Some individuals attend a PROS with Clinic and choose not to participate in the clinic treatment component. To verify whether an individual is enrolled in Clinic Treatment at a PROS, you can check their Medicaid RRE Codes in eMedNY/ePaces; RE Code 84 indicates that an individual is enrolled in Clinic Treatment in PROS. Note: These services are available to individuals 18 years and older.
Residential Treatment Facility (RTF)	Not Allowable	
Inpatient Hospital; Psychiatric Center	Not Allowable	
OASAS Programs		
Clinic	Yes	

OASAS Outpatient Rehab	Yes	
Opioid Treatment Program	Yes	
OCFS Programs		
Core Limited Health Related Services (CLHRS)	Yes	
29-I Other Limited Health Related Services (OLHRS)	Yes	
DOH Programs		
Children's Home and Community Based Services (HCBS) Waiver	Yes	

F. CFTSS Billing:

CFTSS Off-Site

The off-site rate compensates provider agencies for staff travel costs directly related to service provision. The off-site rate must only be used when services are delivered off-site (community location; the off-site rate cannot be used when services are delivered at an agency designated/licensed site) and can only be reimbursed in conjunction with a completed CFTSS service claim. Only one off-site rate can be billed per service, per claim.

The off-site rate cannot be reimbursed for situations when providers travel off-site but a service was not delivered. If multiple staff travel to provide different services by each staff, the off-site rate can be reimbursed per service. When multiple service sessions occur at the same community location (e.g., school, library, community center, etc.) for multiple children/families, the off-site rate should only be billed for one session/identified child unless sessions where it's separated by travel.

Telehealth

The use of telehealth must be conducted in accordance with state-issued guidance. For OMH, agencies must secure required licensure/designation approval prior to telehealth utilization and adhere to 14 NYCRR 596 and Telehealth Services Guidance for OMH Providers. In addition, OASAS-certified providers must obtain OASAS certification to offer services via telehealth, in accordance with 4 NYCRR PART 830.5.

Billing Limitations

There are no daily or annual claim limits associated with any of the CFTSS listed below. All determinations of scope, frequency and duration must be in accordance with medical necessity and an individualized treatment plan.

Other Licensed Practitioner (OLP)

When submitting claims for any of the OLP services the following rules apply:

OLP – Licensed Evaluation

Licensed Evaluation (Assessment) is the process of identifying a child/youth's strengths and weaknesses, problems and service needs, through a comprehensive evaluation of the child/youth's current mental, physical and behavioral condition and history. The assessment is the basis for establishing a behavioral health diagnosis where needed, and treatment plan, and is conducted within the context of the child/youth self-identified needs, goals, and ethnic, religious and cultural identities. In instances where a diagnosis is not yet known and/or not specified, providers can use an unspecified ICD-10 diagnosis code, such as R69 (illness, unspecified), F99 (mental disorder, not otherwise specified), or an appropriate Z-code. Appendix B contains a listing of z-codes that may be appropriate to use in such instances; please note that note that this list is not intended to be exhaustive of all z-codes that could potentially be used.

- Claims for OLP initial evaluation are defined using a distinct rate code (see Appendix A)
- Off-site services will be billed with one claim for the service rate code and a second claim for the off-site rate code. These would both have the same procedure code and different modifiers (as described in Appendix A),
- Claims are billed daily, in 15-minute units
- Assessments may be provided on-site or off-site (Off-site delivered in a community-based location other than the agency's designated address),
- Each claim must include the appropriate procedure code and modifier as noted in the rate table
- Off-site is billed daily in 15-minute units

<u>OLP – Counseling</u>

Psychotherapy (Counseling) is the therapeutic communication and interaction for the purpose of alleviating symptoms or functional limitations associated with a child/youth's behavioral health needs, reversing or changing maladaptive patterns of behavior, encouraging personal growth and development, and supporting the child/youth's capacity to achieve age–appropriate developmental milestones.

OLP - Individual and/or Family Counseling

- Claims for OLP individual and/or family counseling services are defined using a distinct rate code. This service may be provided to the child/youth and/or to the child/youth's family (with or without the child/youth present). See Appendix A for the list of rate codes and descriptions,

- Claims are billed daily, in 15-minute units. If a child/youth counseling service and family counseling service are provided on the same day, each service must be listed on the claim using the appropriate CPT/modifier combination,
- Each counseling claim must include the CPT code,
- Counseling claims must also include the appropriate modifier(s) in addition to CPT code,
- A separate claim is submitted for off-site,
- Off-site is billed daily, in 15-minute units.

Note: When submitting a fee-for-service claim for both child/youth and family counseling occurring on the same day, the provider must include both services on one claim line with all appropriate modifiers and combined service units (e.g., rate code 7901, CPT code – H0004, modifiers EP, HS, 8 units – indicates a child/youth counseling session AND a family counseling session without the child/youth, for combined total units of 8). Medicaid managed care claims for Individual and Family Counseling will continue to be submitted using two separate claim lines.

OLP – Evidence Based Practice (EBP)
To bill the EBP rate, authorized EBP providers must: 1) meet the required OLP qualifications; 2) obtain NYS EBP authorization; 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 rates are billed and paid.
Authorized programs may begin billing the enhanced Medicaid rate upon completion of initial EBP training. Providers should not bill the standard OLP rates for services provided via EBPs and should instead only bill the appropriate combinations listed in Appendix A: CFTSS Rate Code Descriptions.
All billing rules as outlined under OLP – Individual and/or Family Counseling (above) apply, in alignment and accordance with fidelity requirements.

OLP – Group Counseling

- OLP group services are claimed using a distinct rate code. See Appendix A for the list of rate codes and descriptions,
- Group sessions are billed daily, with a separate claim for each member in the group, in 15-minute units
- Each group counseling claim must include the CPT code and modifier(s),
- Group size may not exceed more than eight members,
- Group sessions may be provided on-site or off-site,

- When group sessions are provided off-site, each member of the group bills using two claims: the first using the service rate code and the second using the off-site group add-on rate code, and
- Off-site is billed daily in 15-minute units.

Crisis Under OLP

Note: The three crisis services described below are NOT part of the separate Crisis Intervention. Any child/youth receiving this service must have already been evaluated and under the care of the practitioner delivering the OLP (counseling and evaluated) prior to using the crisis components.

Crisis under OLP is used if the child/youth experiences psychiatric, behavioral, or situational distress in which the Non-Physician Licensed Behavioral Health Practitioner (NP-LBHP) is contacted as the treatment provider. The reimbursement categories- Crisis Triage (By telephone), Crisis Off-Site (In-person) and Crisis Complex Care (Follow up) allow the NB-LBHP to provide the necessary interventions in crisis circumstances.

OLP - Crisis Off-site

- Claims are billed daily, in 15-minute units.
- Each crisis claim must include the appropriate CPT code and modifier(s),
- May only be provided off-site, and
- Only one claim is submitted for OLP Crisis; a separate off-site claim is not permissible

OLP - Crisis Triage (by telephone)

- Claims are billed daily, in 15-minute units, and
- Each crisis claim must include the appropriate CPT code and modifier(s)

OLP - Crisis Complex Care (follow-up to Crisis)

- Claims are billed daily, in five-minute units,
- Each Crisis Complex Care claim must include the appropriate CPT code and modifier(s), and
- Crisis Complex Care is provided by telephone

Crisis Intervention

Crisis Intervention components and distinct rate code descriptions:

- Mobile Crisis
  - One Person Response: Licensed,
  - Two Person Response: Licensed/Unlicensed/Certified Peer,
  - Two Person Response: Both Licensed (up to 90 minutes),
  - Two Person Response: Both Licensed (90-180 minutes),
  - Two Person Response: Both Licensed (over 180 minutes),
  - Two Person Response: Licensed/Unlicensed/Certified Peer (90-180 minutes), and
  - Two Person Response: Licensed/Unlicensed/Certified Peer (over 180 minutes)
- Mobile and Telephonic Follow up
  - One Person Face-to-Face Follow-Up: Licensed,
  - One Person Face-to-Face Follow-Up: Unlicensed/Certified Peer,
  - One Person Face-to-Face Follow-Up: Licensed/Unlicensed/Certified Peer
  - Telephonic Follow-Up: Licensed, and
  - Telephonic Follow-Up: Unlicensed/Certified Peer

Claims for Crisis Intervention services are defined using distinct rate codes. See Appendix A for the list of rate codes and descriptions.

When submitting claims for Crisis Intervention services the following rules apply:

<u>Crisis Intervention</u>

One Licensed:

- Crisis Intervention one licensed claims requires the use of the appropriate rate code (see Appendix A),
- Services are billed daily, in 15-minute units,
- Each service must include the CPT code and modifier(s), and
- This service is provided off-site; a separate off-site claim is not permissible

Two Person Response: Licensed and Unlicensed/Certified Peer

- Crisis Intervention with two clinicians, including one licensed requires the use of the appropriate rate code (see Appendix A),
- Services are billed daily, in 15-minute units,
- Each service must include the CPT code and modifier(s), and
- This service is provided off-site; a separate off-site claim is not permissible

Two Person Response: Both Licensed (up to 90 minutes)

- Crisis Intervention two licensed providers claims require the use of the appropriate rate code (see Appendix A),
- Services are billed daily, in 15-minute units,
- Each service must include the CPT code and modifier(s), and
- This service is provided off-site; a separate off-site claim is not permissible

Two Person Response: Both Licensed (90-180 minutes)

- Crisis Intervention exceeds 90 minutes and less than 180 minutes with two clinicians, both licensed, requires the use of the appropriate rate code (see Appendix A),
- Services are billed per diem,
- Each service must include the CPT code and modifier(s),
- Services are billed daily, and
- This service is provided off-site; a separate off-site claim is not permissible

Two Person Response: Both Licensed (over 180 minutes)

- Crisis Intervention Per Diem over 180 minutes, two clinicians, both licensed, requires the use of the appropriate rate code (see Appendix A),
- Services are billed per diem,
- Each service must include the CPT code and modifier(s),
- Services are billed daily, and
- This service is provided off-site; a separate off-site claim is not permissible

Two Person Response: Licensed and Unlicensed/Certified Peer (90-180 minutes)

- Crisis Intervention over90 minutes and less than 180 minutes with two clinicians, including one licensed requires the use of the appropriate rate code (see Appendix A),
- Services are billed per diem,
- Each service must include the CPT code and modifier(s),
- Services are billed daily, and
- This service is provided off-site; a separate off-site claim is not permissible

Two Person Response: Licensed and Unlicensed/Certified Peer (over 3 hours)

- Crisis Intervention Per Diem, over 180 minutes, two clinicians, including one licensed, requires the use of the appropriate rate code (see Appendix A),

- Services are billed per diem,
- Each service must include the CPT code and modifier(s),
- Services are billed daily, and
- This service is provided off-site; a separate off-site claim is not permissible

Crisis Intervention Mobile and Telephonic Follow up

- Services are billed daily, in 15-minute units,
- Each service must include the CPT code and modifier(s),
- Mobile Follow-up is provided off site; a separate off-site claim is not permissible,
- Mobile/Telephonic can be delivered with distinct rate code descriptions for the following (found in Appendix A):
    - One Person Face-to-Face Follow-Up: Licensed,
    - One Person Face-to-Face Follow-Up: Unlicensed/Certified Peer,
    - One Person Face-to-Face Follow-Up: Licensed and Unlicensed/Certified Peer,
    - Telephonic Follow-Up: Licensed, and
    - Telephonic Follow-Up: Unlicensed/Certified Peer

Community Psychiatric Support and Treatment (CPST)

Claims for CPST services are defined based on child/youth and/or family and collateral (with or without the child/youth present) or group and where the service is provided (i.e., on-site or off-site). See Appendix A for the list of rate codes and descriptions.

When submitting claims for CPST services the following rules apply:

CPST - Service Professional

Individual and/or Family

- CPST claims require the use of the appropriate rate code (see Appendix A),
- CPST services are billed daily, in 15-minute units. If a child/youth CPST service and family CPST service are provided on the same day, each service must be listed on the claim using the appropriate CPT/modifier combination,
- Each CPST claim must include the CPT code and modifier(s),
- CPST may be provided on-site or off-site,
- Off-site CPST claims will be billed with one claim for the service rate code and a second claim for the off-site rate code, and

- Off-site CPST is billed daily in 15-minute units.

Group

- Requires the use of the appropriate rate code (see Appendix A),
- CPST group services are billed daily, in 15-minute units,
- Each CPST group claim must include the CPT code and modifier(s),
- Group size may not exceed more than eight members,
- CPST group sessions may be provided on-site or off-site,
- When group sessions are provided off-site, each member of the group bills using two claims: the first using the service rate code and the second using the off-site group add-on rate code, and
- Off-site CPST is billed daily in 15-minute units.

CPST – EBP

To bill the EBP rate, authorized EBP providers must: 1) meet the required CPST qualifications; 2) obtain NYS EBP authorization; 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 rates are billed and paid.
Authorized programs may begin billing the enhanced Medicaid rate upon completion of initial EBP training. Providers should not bill the standard CPST rates for services provided via EBPs and should instead only bill the appropriate combinations listed in Appendix: CFTSS Rate Code Descriptions.
All billing rules as outlined under CPST – Service Professional (above) apply, in alignment and accordance with fidelity requirements.

Psychosocial Rehabilitation (PSR)

PSR is divided into two different types of sessions: Individual and Group. Claims for PSR services are defined using distinct rate codes based on the type of service provided (i.e., individual or group). See Appendix A for the list of rate codes and descriptions.
When submitting claims for PSR services the following rules apply:

PSR - Service Professional

Individual

- Requires the use of the appropriate rate code (see Appendix A),

- PSR individual services are billed daily in 15-minute units,
- Each PSR claim must include the appropriate CPT code and modifier(s),
- PSR may be provided on-site or off-site,
- Off-site PSR is billed using two claims: the first using the service rate code and the second using the off-site add-on rate code. Both will include the same procedure code and different modifiers (see Appendix A), and
- Off-site PSR is billed daily in 15-minute units.

Group

- PSR Group services are billed daily, in 15-minute units,
- Each PSR Group claim must include the CPT code and modifier(s),
- Group size may not exceed more than eight members,
- PSR Group sessions may be provided on-site or off-site,
- When group sessions are provided off-site, each member of the group bills using two claims: the first using the service rate code and the second using the off-site group add-on rate code, and
- Off-site PSR is billed daily in 15-minute units

Family Peer Support Services (FPSS)

FPSS is divided into two different types of sessions: Individual and Group. Services can be provided on-site or off-site. See Appendix A for the list of rate codes and descriptions.
When submitting claims for FPSS services the following rules apply:

FPSS Service Professional

Individual

- Requires the use of the appropriate rate code (see Appendix A),
- FPSS services are billed daily, in 15-minute units,
- Each FPSS claim must include the CPT code and modifier(s),
- FPSS may be provided on-site or off-site,
- Off-site FPSS billed using two claims: the first using the service rate code and the second using the off-site add-on rate code, and
- Off-site FPSS is billed daily in 15-minute units

Group

- Requires the use of the appropriate rate code (see Appendix A),
- FPSS group services are billed daily, in 15-minute units,
- Each FPSS group claim must include the CPT code and modifier(s),
- Group size may not exceed more than 12 members,
- FPSS group sessions may be provided on-site or off-site,
- When group sessions are provided off-site, each member of the group bills using two claims: the first using the service rate code and the second using the off-site group add-on rate code, and
- Off-site FPSS is billed daily in 15-minute units

Youth Peer Support (YPS)

YPS is divided into two different types of sessions: Individual and Group. Claims for YPS services are defined using distinct rate codes based on the type of service provided (i.e., individual or group.). See Appendix A for the list of rate codes and descriptions.
When submitting claims for YPS services the following rules apply:

<u>YPS Service Professional</u>

Individual

- YPS claims require the use of the appropriate rate code (see Appendix A),
- YPS services are billed daily, in 15-minute units,
- Each YPS claim must include the CPT code and modifier(s),
- Services provided by a bachelor's level practitioner must include the modifier
- YPS may be provided on-site or off-site,
- Off-site YPS billed using two claims: the first using the service rate code and the second using the off-site add-on rate code, and
- Off-site is billed daily in 15-minute units

Group

- YPS claims require the use of the appropriate rate code (see Appendix A),
- YPS group services are billed daily, in 15-minute units,
- Each YPS group claim must include the CPT code and modifier(s),
- Group size may not exceed more than eight members,
- YPS group sessions may be provided on-site or off-site,

- When group sessions are provided off-site, each member of the group bills using two claims: the first using the service rate code and the second using the off-site group add-on rate code, and
- Off-site is billed daily in 15-minute units

VIII. APPENDICES

A. CFTSS Rate Code Descriptions:

Appendix A shows the rate code, CPT code, and modifier code combinations that will be required under Medicaid Managed Care. Providers will use these coding combinations to indicate to the MMCP that the claim is for a children/youth's service and is to be paid at the government rate. The procedure and modifier code combinations must be adhered to by both provider and MMCP to ensure appropriate rate payment.

In acknowledgement of the need for checks against fraud and abuse, but to ensure a child/youth's access to services is, service utilization in excess of the "soft" unit (i.e. annual, daily, dollar amount) limits must be based on medical necessity. Documentation of the medical necessity for extended durations must be kept on file in the child/youth's record. In addition to concurrent utilization review and authorization as per the Medicaid State Plan Children and Family Treatment and Support Services Provider Manual for Children's Behavioral Health Early and Periodic Screening and Diagnostic Treatment (EPSDT) Services January 9, 2019 and any subsequent edits, the MMCP may conduct post-payment administrative reviews to ensure services were provided appropriately.

Note: There are no soft unit (i.e., annual, daily, dollar amount) limits for CFTSS. All determinations of scope, frequency and duration must be in accordance with medical necessity and an individualized treatment plan.

Other Licensed Practitioner

Service	Rate Code	Procedure Code	Modifier	Unit Measure	Unit Limit
OLP Licensed Evaluation	7900	90791	EP	15 Minutes	N/A

Service	Rate Code	Procedure Code	Modifier	Unit Measure	Unit Limit
OLP Counseling – Individual OLP Counseling – Family (with or without the child/youth present)	7901	H0004	EP HR – Family with child/youth HS – Family without child/youth	15 Minutes	N/A
Other Licensed Practitioner (OLP) EBP, FFT[12]	7981	H004	U1, UA	15 Minutes	N/A
Other Licensed Practitioner (OLP) Counseling, EBP, PCIT[13]	7982	H0004	U1, UB	15 Minutes	N/A
OLP Crisis -Offsite (In-person only)	7902	H2011	EP, ET	15 Minutes	N/A
OLP Crisis Triage -- Telephone	7903	H2011	EP, GT	15 Minutes	N/A

[12] eMedNY Naming Convention:

OLP FFT: OTH LLC PRACT CNSL INDIVL: EBP, FFT

[13] eMedNY Naming Convention:

OLP PCIT: OTH LIC PRACT CNSL INDIVL: EBP, PCIT

Service	Rate Code	Procedure Code	Modifier	Unit Measure	Unit Limit
OLP Crisis Complex Care (Follow up)	7904	90882	EP, TS	5 Minutes	N/A
OLP Counseling - Group	7905	H0004	HQ, EP	15 Minutes	N/A
Offsite – OLP Evaluation Individual or Family with child/youth present Family without child/youth present	7920	90791 or H0004 depending on service provided	90791- EP, SC - Evaluation H0004 -SC - Individual H0004 – HR, SC – Family with child/youth H0004 – HS, SC – Family without child/youth	15 Minutes	N/A
Offsite – OLP Counseling Group	7927	H0004	EP, HQ, SC	15 Minutes	N/A

* Providers are able to provide EBP services beginning November 1, 2023. Plans have 90 days after November 1, 2023 to make internal system changes to accommodate billing for EBPs. This includes adding rate codes, procedure codes, modifiers, and units for billing measure. Providers must wait to begin billing for EBPs until plans have their systems fully configured and upon Centers for Medicare and Medicaid Services (CMS) approval. Please refer to the *Notification Regarding Enhanced Rates for EBPs Within CFTSS* for further details.

OLP Counseling (Family and Individual) Fee-for-Service billing Only

OLP Counseling if **Family AND Individual are provided on same day,** combine both services on one claim line and submit.

Service	Rate Code	Unit Measure	Unit Limit
Fee-for-Service Only - OLP Counseling – Two Services – Family AND Individual provided on same day – combine both services on one claim line	7901	15 Minutes	N/A

Crisis Intervention

Mobile Crisis					
Service	**Rate Code**	**Procedure Code**	**Modifier**	**Unit Measure**	**Unit Limit**
One-Person Response: Licensed	7906	H2011	EP, HO	15 Minutes	N/A
Two-Person Response: Licensed/ Unlicensed/Certified Peer	7907	H2011	EP, HT	15 Minutes	N/A
Two-Person Response: Both Licensed (up to 90 minutes)	7908	H2011	EP	15 Minutes	N/A
Two-Person Response: Both Licensed (90-180 minutes)	7936	S9484	EP, HO	Per diem (90-180 minutes)	N/A
Two-Person Response: Both Licensed (over 180 minutes)	7937	S9485	EP, HO	Per diem greater than 180 minutes	N/A

Two-Person Response: Licensed/ Unlicensed/Certified Peer (90-180 minutes)	7909	S9484	EP	Per diem (90-180 minutes)	N/A
Two-Person Response: Licensed/ Unlicensed/Certified Peer (over 180 minutes)	7910	S9485	EP	Per diem greater than 180 minutes	N/A

Mobile Follow Up Services

Service	Rate Code	Procedure Code	Modifier	Unit Measure	Unit Limit
One-Person Face-to-Face Follow-Up: Licensed	7938	H2011	TS, HO	15 minutes	N/A
One-Person Face-to-Face Follow-Up: Unlicensed/Certified Peer	7939	H2011	TS, HM, HA	15 minutes	N/A
One-Person Face-to-Face Follow-Up: Licensed/Unlicensed/Certified Peer	7940	H2011	TS, HT	15 minutes	N/A

Telephonic Follow Up Services

Service	Rate Code	Procedure Code	Modifier	Unit Measure	Unit Limit
Telephonic Follow-Up: Licensed	7941	H2011	TS, HO, GT	15 minutes	N/A
Telephonic Follow- Up Unlicensed/Certified Peer	7942	H2011	TS, HM, GT	15 minutes	N/A

Community Psychiatric Support and Treatment

Service	Rate Code	Procedure Code	Modifier	Unit Measure	Unit Limit
CPST Service Professional –	7911	H0036	EP	15 Minutes	N/A

Service	Rate Code	Procedure Code	Modifier	Unit Measure	Unit Limit
Individual and/or Family (with or without the child/youth)					
Community Psychiatric Support and Treatment (CPST) Service Professional, EBP, FFT[14]	7983	H0036	U1, UA	15 Minutes	N/A
Offsite Community Psychiatric Support and Treatment (CPST) Service Professional, Individual and/or Family	7921	H0039	EP, SC	15 Minutes	N/A
CPST Service Professional - Group	7912	H0036	EP, HQ	15 Minutes	N/A
Offsite - CPST Individual and/or Family (with or without the child/youth)	7921	H0036	EP, SC	15 Minutes	N/A
Offsite – CPST Group	7928	H0036	EP, HQ, SC	15 Minutes	N/A

Psychosocial Rehabilitation

Service	Rate Code	Procedure Code	Modifier	Unit Measure	Unit Limit
PSR Service Professional	7913	H2017	EP	15 Minutes	N/A
PSR Service Professional - Group	7914	H2017	EP, HQ	15 Minutes	N/A
Offsite - PSR Individual	7922	H2017	EP, SC	15 Minutes	N/A
Offsite – PSR Group	7929	H2017	EP, HQ, SC	15 Minutes	N/A

Family Peer Support

Service	Rate Code	Procedure Code	Modifier	Unit Measure	Unit Limit
FPS Service Professional	7915	H0038	EP, UK	15 Minutes	N/A

[14] eMedNY Naming Convention:

CPST FFT: COMM PSYCH SUPP TRTMNT SRVC PROF: EBP, FFT

Service	Rate Code	Procedure Code	Modifier	Unit Measure	Unit Limit
FPS Service Professional - Group	7916	H0038	EP, UK, HQ	15 Minutes	N/A
Offsite – FPS Individual	7923	H0038	EP, UK, SC	15 Minutes	N/A
Offsite – FPS Group	7930	H0038	EP, HQ, SC, UK	15 Minutes	N/A

Youth Peer Supports

Service	Rate Code	Procedure Code	Modifier	Unit Measure	Unit Limit
YPS Service Professional	7917	H0038	EP	15 Minutes	N/A
YPS Service Professional - Group	7918	H0038	EP, HQ	15 Minutes	N/A
Offsite - YPS Individual	7923	H0038	EP, SC	15 Minutes	N/A
Offsite –YPS Group	7930	H0038	EP, HQ, SC	15 Minutes	N/A

B. List of Potential Z-Codes:

Z-Codes (used in the ICD-10), also known as Other Conditions That May Be a Focus of Clinical Attention, are codes used to identify issues that are a focus of clinical attention or affect the diagnosis, course, prognosis, or treatment of an individual's behavioral health disorder. However, these codes are not a diagnosis.

When an individual is presenting with significant impairment, Z-codes must be reflected in a child/youth's case record when there is no evidence of a diagnosis. Rationale for use of Z-codes should be directly tied to a clinical assessment.

The following list of Z-codes may be used in instances where a diagnosis is not yet known and/or not specified; please note that this list is not intended to be exhaustive of all Z-codes that could potentially be used.

Code Category	ICD-10 Code	ICD-10 Code Description
Problems Related to Upbringing	Z62.21	Child in welfare custody (in care of non-parental family member, in foster care)
Problems Related to Upbringing	Z62.810	Personal history of physical and sexual abuse in childhood [Excludes current physical or sexual abuse
Problems Related to Upbringing	Z62.811	Personal history of psychological abuse in childhood [Excludes current psychological abuse in childhood
Problems Related to Upbringing	Z62.812	Personal history of neglect in childhood [Excludes current neglect]
Problems Related to Upbringing	Z62.820	Parent-biological child conflict (parent-child problem)
Problems Related to Upbringing	Z62.821	Parent-adopted child conflict
Problems Related to Upbringing	Z62.822	Parent-foster child conflict
Problems Related to Primary Support Group, including Family Circumstances	Z63.4	Disappearance and death of family member
Problems Related to Primary Support Group, including Family Circumstances	Z63.5	Disruption of family by separation and divorce
Problems Related to Primary Support Group, including Family Circumstances	Z63.72	Alcoholism and drug addiction in family
Problems Related to Primary Support Group, including Family Circumstances	Z63.8	Other specified problems related to primary support group (family discord, estrangement, high expressed emotional level within family, inadequate family support, inadequate or distorted communicated within family)

Code Category	ICD-10 Code	ICD-10 Code Description
Problems Related to other Psychosocial Circumstances	Z65.4	Victim of crime and terrorism (victim of torture)
Problems Related to other Psychosocial Circumstances	Z65.5	Exposure to disaster, war, and other hostilities
Problems Related to Employment and Unemployment	Z59.5	Extreme poverty
Problems Related to Housing and Economic Circumstances	Z59.9	Problem related to housing and economic circumstances, unspecified
Problems Related to other Psychosocial Circumstances	Z65.9	Problem related to unspecified psychosocial circumstances
Problems Related to certain Psychosocial Circumstances	Z64.0	Problems related to unwanted pregnancy
Problems Related to Upbringing	Z62.898	Other specified problems related to upbring
Problems Related to Employment and Unemployment	Z56.0	Unemployment, unspecified
Problems Related to Housing and Economic Circumstances	Z69.6	Low income
Problems Related to Housing and Economic Circumstances	Z59.7	Insufficient social insurance /welfare support
Problems related to education and literacy	Z55.0	Illiteracy and low level literacy
Problems Related to Housing and Economic Circumstances	Z59.0	Homelessness
Problems Related to Housing and Economic Circumstances	Z59.1	Inadequate housing
Problems Related to Housing and Economic Circumstances	Z59.4	Lack of adequate food and safe drinking water

Code Category	ICD-10 Code	ICD-10 Code Description
Problems related to social environment	Z60.3	Acculturation difficulty (problem with migration, problems with social transplantation
Problems Related to Upbringing	Z62.0	Inadequate parental supervision and control
Problems Related to Upbringing	Z62.22	Institutional upbringing
Persons encountering health services in other circumstances	Z69.010	Encounter for mental health services for victim of parental child abuse
Persons encountering health services in other circumstances	Z69.020	Encounter for mental health services for victim of non-parental child abuse
Other problems related to primary support group	Z63.31	Absence of family member due to military deployment
Screening	Z13.40	Developmental delay screening
Screening	Z13.41	Autism screening
Screening	Z13.9	Health risk assessment screening
Screening	Z13.89	Screenings, other (social emotional)
Screening	Z13.32	Encounter for maternal depression screening

C. Evidence Based Practices (EBPs):

I. BACKGROUND

An integral design element of Children and Family Treatment and Supports (CFTSS) is the allowance for state endorsed Evidence Based Practices (EBPs) for specific interventions and services. New York State (NYS) is committed to the promotion and support of EBP models under the Children's Medicaid Redesign by implementing a process for agencies to apply and be approved for the provision of recognized EBPs under the Early and Periodic Screening and Diagnostic Treatment (EPSDT) CFTSS State Plan services.

In a cross-agency effort comprised of the Office of Mental Health (OMH), Office of Addiction Services and Supports (OASAS), Office of Children and Family Services (OCFS), and the Department of Health (DOH), NYS identified a list of allowable EBPs and mechanisms to guide and inform implementation within CFTSS programming. The use of EBPs within CFTSS is intended to improve quality of care, outcomes, reduce length of stay, and enhance practitioner competencies. This effort was informed by peer-reviewed research, stakeholder feedback, and consultation with proprietary organizations and other states with EBP implementation.

EBPs in CFTSS will be conducted via a phased implementation. NYS is committed to continually researching and monitoring EBP outcomes and as appropriate, expanding the type of EBPs in CFTSS.

II. INTRODUCTION

Through the implementation of the CFTSS array of services, NYS intended to offer providers greater capacity to individualize care to children and families at the right time, in the right way and in the right amounts. To further assist providers in offering specialized care, NYS is creating greater flexibilities, by enabling agencies to augment CFTSS through the provision of targeted EBP approaches for children and their families. This allows clinicians to apply evidence-based strategies in ways that best meet the client's needs and preferences.

CFTSS designated agencies that provide Other Licensed Practitioner (OLP) and Community Psychiatric Supports and Treatment (CPST) will be able to provide EBP options through an application process, offering a wider range of treatment approaches to meet the needs of children/youth and families. CFTSS provider agencies have the flexibility to consider a child/youth and family's unique and individualized needs within the context of the overall service array, as not every child/youth and family either needs or will benefit from a specific EBP. Therefore, enrollment in CFTSS is not contingent upon appropriateness for an EBP; instead, by embedding EBPs within the CFTSS construct, families may remain enrolled within a service before needing the EBP and/or after completing the EBP short term intervention.

III. NYS Endorsed EBPs in CFTSS

What are EBPs?

The term ‘evidenced-based practice’ is commonly used in a variety of settings and contexts. For the purpose of NYS-endorsed EBPs for CFTSS, the term refers to a specific list of NYS identified practices and programs supported by credible research evidenced as effective. While regulations, guidance, and standards of care may reference ‘best practice’, select EBPs require substantial training, consultation, and other associated activities to meet fidelity measures. These rigorous standards warrant additional resources and compensation to support agency efforts to comply with fidelity and program requirements. Because of this, EBPs are identified as practice models that are recognized as achieving the highest standard of research evidence; require specialized training and credentialling; and maintain a structure to enable outcome replication in alignment with fidelity.

In alignment with the definition of evidenced-based care by The American Psychological Association, NYS-endorsed EBPs for CFTSS considers available research with clinical expertise in the context of patient characteristics, culture, and preferences (APA, 2006). EBPs are intended to be applied flexibly, within model fidelity, to accommodate client culture and preferences, as informed by training organizations, supervisors, cultural diversity consultants, and clinicians’ informed judgment. This approach assumes that clinicians are conducting treatment in a manner conducive to therapeutic rapport, client-directed care, and cultural humility.

Becoming a NYS Endorsed CFTSS EBP Provider

Getting Started

Provider Qualifications: To promote flexible service and intervention options for children/youth and families, EBP authorization is only available to provider agencies with existing OLP and CPST designation. In addition, eligible EBP CFTSS applicants are required to have fully implemented the full range of OLP and CPST service components and demonstrate active provision at the time of application submittal. Not all children/youth and families eligible for CFTSS will be appropriate for treatment via EBP; therefore, agencies must have the ability to offer services in a manner that adapts to the needs and preferences of the population(s) served. Agencies must be able to deliver CFTSS both with and without the EBP; OLP and CPST via EBP cannot be the only option available to CFTSS enrolled children/youth and families.

Given EBPs will be delivered via OLP and CPST, it is critical that provider agencies not only have existing designation authorization but also demonstrate adherence to service standards, requirements, and positive quality of care measures.

NOTE: Depending upon the authorizing state agency, specific criteria to verify a provider agency's compliance to verify "good standing" may apply.

NYS Endorsed EBPs

Evidence Based Practice	NYS Contracted Proprietary Organization	NYS Recognized Credentialling Organizations	Staff Qualifications
Functional Family Therapy (FFT)	FFT, LLC	FFT Partners	OLP: All current service staff qualifications allowable CPST: a Master's degree in social work, psychology, or in related human services, plus one year of applicable experience
Parent-Child Interaction Therapy (PCIT)	PCIT International		OLP: All current OLP licensed practitioner types allowable

How to Apply

CFTSS provider agencies seeking to provide a state endorsed EBP must apply and receive authorization. Authorization is population and site specific.

Prior to applying, agencies are encouraged to complete a self-assessment to understand if the necessary structures are in place to support EBP implementation and determine if the needs of the children/youth and families served via the program aligns with allowable EBPs. It is critical that agencies are aware of the credentialing obligations, fidelity measures, and other billing and program requirements prior to beginning the application process.

Application Process:

Applicants must email Provider Designation (OMH-Childrens-Designation@omh.ny.gov) to request an application for EBP Authorization. The following information must be provided in the email request:

- Program Name
- Number of sites and addresses (how many sites will be providing the EBP?)
- Type of EBP

Based on the information provided in the email request, NYS will provide the applicant with the necessary forms to apply. All forms must be filled out completely and submitted to Provider Designation (OMH-Childrens-Designation@omh.ny.gov) by the identified deadline. Incomplete or missing forms may result in an applicant not being authorized for a specific cohort but may reapply for future cohorts.

Requests for EBP authorization will be evaluated by the New York State EBP Review Team. The NYS EBP Review team is comprised of representatives from four state agencies (DOH, OMH, OASAS, and OCFS); however, NYS reserves the right to seek input and advice from other experts through the application review process.

The State will make a determination following the review of all required documentation. It is NYS' 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. Authorization will be awarded dependent upon a variety of factors including, the content of the application, community need, provider agency standing and/or functioning of current CFTSS programming, EBP readiness, and regional distribution to support statewide access.

Any existing EBP provider that was operational before the issuance of this guidance will need to apply for authorization if the provider wishes to be considered for enhanced Medicaid reimbursement. Agencies must submit applications, and be approved by NYS, to be reimbursed for the EBP under CFTSS.

EBP Authorization

NYS has partnered with specific proprietary organizations to administer EBP training. Given that training availability is limited, EBP authorization will be administered in phases or cohorts. If an application is not accepted within a cohort, it will be waitlisted until the next available cohort for review. Agencies will be notified in the event their application is reserved for future cohorts.

NOTE: Applicants may be limited by the number of staff they can include in a specific cohort.

Authorization Agencies

Agencies whose applications have been approved and accepted into a training cohort will received EBP authorization to enable them to initiate training and bill the enhanced Medicaid rates after training begins. Once authorized, NYS will issue an updated CFTSS Designation Letter indicating approval by EBP and site/location. Agencies are required to update all applicable documentation including policies and procedures, as applicable, to reflect EBP requirements and associated processes in accordance with this guidance.
Authorized provider agencies are able to use the title of "NYS-authorized" and "NYS-endorsed" as relevant to EBPs in alignment with CFTSS Designation.

EBP authorization will be reflected on public-facing lists and will be communicated to the NYS Center for Workforce Excellence (see section Phase II for more information) and Medicaid Managed Care Organizations.

Waitlist for EBP Authorization

EBP training space is limited; therefore, NYS will be authorizing CFTSS agencies in phases or by cohorts. Applications will be reviewed in the order received; however, priority may be granted to agencies depending upon identified need or geographic location. In the event a cohort is filled, approved applications will be 'waitlisted' until the next available cohort. Waitlisted agencies will be notified, and their application will be reserved with priority. Upon the opening of another cohort, for each identified EBP, NYS or its designee will inform waitlisted applicants and welcome them to update their previously submitted application, as needed.

Denial of EBP Authorization

Regardless of outcome, agencies will be notified of the EBP application determination. If an applicant is not authorized, they will be notified, in writing, of the state's determination with rationale. There is no appeal process, and all NYS EBP Review Team decisions are final. However, applicants may resubmit/reapply an application with missing information or new evidence in a future cohort.

Denial of EBP authorization will not impact existing licensure or designation.

Credentialing Process

Center for Workforce Excellence

NYS has partnered with the Center for Workforce Excellence (CWE) to not only support the implementation of EBPs in CFTSS but also, further penetration of EBPs across the child-serving system. As a result, authorized EBP providers are required to collaborate with the CWE to facilitate staff trainings, provide requested data and other EBP-related

information, and to ensure access to supportive technical assistance and associated resources. The CWE will serve as the conduit between NYS, EBP proprietary organizations, and provider agencies.

In the event an authorized provider agency has staff with existing credentialing or prefers to partner with a proprietary organization different than those partnered with NYS, connection with the CWE is still required to maintain EBP authorization under CFTSS. Data and information collected through the CWE will help to inform and guide future efforts to expand EBP endorsement across the lifespan and meet the needs of specialized populations. This information will inform and guide the State on future EBP efforts and modalities.

Training

As part of the application process, CFTSS provider agencies will attest to their ability to meet the training and consultation requirements for EBP credentialling. Changes to information included in the agency's application should be communicated to the CWE when impacting training attendance and program adherence. Similarly, for agencies that opt to partner with a proprietary organization other than those contracted with NYS, ongoing communication with the CWE to track training and compliance is still required.

Ongoing Authorization

Although individual practitioners or teams will be credentialed in an EBP, NYS will only issue authorization to agencies with OLP and CPST designation. Authorization will not be granted to individuals or groups. EBP authorization identifies provider agencies currently delivering an EBP to model fidelity or are in the process of pursuing certification to deliver an EBP. It is the responsibility of the EBP authorized agency to ensure they maintain competent staff to uphold the model, delivering the intervention to fidelity, and certification renewal of the EBP. It is understood that staff turnover, attrition, and other factors may impact an agency's temporary ability to maintain model fidelity. In these cases, EBP authorization may be maintained pending agency efforts to come into compliance with EBP requirements. This may include hiring for staff vacancies and enrolling in needed training for credentialing. During the period in which fidelity is not met, billing the enhanced rate is not permitted. Agencies are required to update the CWE with information specific to changes in staffing and ability to maintain fidelity.

Suspension or Termination of Authorization

EBP authorization is contingent upon an agency's OLP and CPST designation and ongoing provision of these services when not delivered via the EBP. Agencies must maintain CFTSS licensing/designation in compliance with related state-issued regulations, guidance, or other requirements. Authorization may be impacted in circumstances in which an agency's CFTSS program in placed under Enhanced

Monitoring or other corrective action. Agencies are required to disclose any program or fiscal changes impacting CFTSS operations and quality of care to NYS. In addition, continued EBP authorization is dependent upon a program's adherence to EBP fidelity measures - with certain exceptions such as staff turnover based on model allowances. For circumstances in which a program is unable to meet training requirements or other required model expectations, EBP authorization may be revoked. If OLP and/or CPST licensing/designation is terminated or voluntarily withdrawn for any reason, EBP authorization will subsequently be revoked.

IV. PROGRAM IMPLEMENTATION

Eligibility

The intent of any endorsed EBP should be to target children and youth under 21 years of age, who are Medicaid or Child Health Plus eligible and have needs in alignment with CFTSS Medical Necessity, in accordance with the identified service, and meet the target criteria of the authorized EBP.

Appropriateness

In addition to Medical Necessity, appropriateness for an EBP must also be considered. The below elements should be used to inform if a child/youth and family may match with a specific EBP in alignment with clinical need.

Functional Family Therapy	
Ages	Youth 11-18 years of age
Presenting Needs	- At risk or have been referred for behavioral or emotional problems including, violence, drug abuse/use, emotional and behavioral concerns, gang involvement, family/relationship conflict
Interventions	- status/diversion youth/at risk for outplacement or further penetration into care systems - moderate and serious system-involved youth
Time Commitment	- Short-term, family-based/relational program - 12-16 sessions for moderate cases, 26-30 for more serious cases spread over 3 to 5 months
Location(s)	- Conducted in home and office settings (preference for home) - Cannot be conducted via telehealth
Parent-Child Interaction Therapy	
Ages	Children 2.5 – 6 years 11 months

Presenting Needs	Children with DBDs / disruptive behaviors / pathogenic parenting including, - Aggression that is not typical to the developmental stage of the child - Behaviors exhibited frequently for extended periods of time that are not related to any obvious stressors - Behaviors are interfering with the child or caregiver(s)'s life
Intervention	Transdiagnostic behavioral family intervention including, Using play to facilitate healthy interaction between caregiver(s) and child(ren)
Time Commitment	12-20 sessions
Location(s)	Can be delivered via telehealth or in a community-based setting Recommended modality is to deliver PCIT in an office-based setting for some of the sessions
Contraindications	- Parents in active substance misuse/disorder - Perpetrators of sexual abuse

Documentation

EBPs will be administered via select CFTSS as such, documentation must reflect the use of EBPs within the child's case record. Any EBP program required documentation should be maintained with CFTSS program documentation. CFTSS treatment plans and progress notes must identify when interventions are administered via EBP. Documentation must clearly identify how the needs and priorities of the child/youth and family is appropriate for an EBP.
All CFTSS documentation must remain adherent to applicable program requirements. For more information specific to CFTSS documentation see CFTSS Health Record Documentation Guidance.

CFTSS Operational Considerations

Child/youth and families cannot be concurrently enrolled in the same EBP across multiple programs or services.

Commonly, agencies employ credentialed staff that work in a variety of programs and settings. If agencies opt to utilize currently employed EBP credentialed staff to deliver services in CFTSS and the staff works in a different program such as an Article 31 Mental Health Outpatient Treatment and Rehabilitative Services (MHOTRS)/clinic or

locally funded program, they must be appropriately cost-allocated to reflect time worked in each program type.

Admission prioritization and service access must align with agency policies and procedures in accordance with level of risk, need, and severity of condition. Any admission processes should consider equitable and timely access for all eligible and appropriate youth for admission to CFTSS.

D. Glossary of Terms:

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.

Authorization: the approval by the managed care plan for the provision of service to enable the provider to bill Medicaid for services rendered.

Child/Youth: Individual under age 21

Collateral: means a person who is a member of the recipient's family or household, or other individual who regularly interacts with the recipient and is directly affected by or has the capability of affecting his or her condition, and is identified in the treatment plan as having a role in treatment and/or is necessary for participation in the evaluation and assessment of the recipient prior to admission. A group composed of collaterals of more than one recipient may be gathered together for purposes of goal-oriented problem solving, assessment of treatment strategies and provision of practical skills for assisting the recipient in the management of his or her illness.

Crisis Episode: All acute psychological/emotional change an individual 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.

Crisis Plan: A tool utilized by providers for children/youth 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: Attributes of a healthcare organization that describe the set of congruent behaviors, attitudes, skills, policies, and procedures that are promoted and endorsed to enable caregivers at all levels of the organization to work effectively and efficiently with persons and communities of all cultural backgrounds.
An important element of cultural competence is the capacity to overcome structural barriers in healthcare delivery that sustain health and healthcare disparities across cultural groups.

Culture: The shared values, traditions, arts, history, folklore, and institutions of a group of people that are united by race, ethnicity, nationality, language, religious, spirituality, socioeconomic status, social class, sexual orientation, politics, gender, gender identity, age, disability, or any other cohesive group variable.

Designated Mental Illness (DMI): A disruption of cognitive, emotional, or behavioral functioning, which can be classified and diagnosed using the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM), or the International Classification of Diseases (ICD), other than:

- substance use disorders in the absence of other mental health conditions defined in the DSM or ICD;
- Neurodevelopmental disorders in the absence of other mental health conditions defined in the DSM or ICD except Attention-Deficit/Hyperactivity Disorder and Tic Disorders;
- major neurocognitive disorder, traumatic brain injury, or mental disorders due to another medical condition

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 intellectual disability, cerebral palsy, epilepsy, neurological impairment, familial dysautonomia, Prader-Willi syndrome or autism; (2) Is attributable to any other condition of a person found to be closely related to 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.

Early and Periodic Screening and Diagnostic Treatment (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. NYS 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: Is defined as the primary caregiving unit and is inclusive of the wide diversity of primary caregiving units. 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.

Federal Financial Participation (FFP): A percentage of state expenditures to be reimbursed by the federal government for the administrative and program costs of the Medicaid program. FFP is calculated as a percentage based on the per capita income of the state compared to the nation. The minimum level of participation is 50 percent.

Home 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 or nursing facility, such as an 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.

Human Services Field: A wide range of fields of education and degrees that may qualify an individual to provide one or more of the Children and Family Treatment and Support Services. Such field may include, child and family studies, community mental health, counseling, education, nursing, occupational therapy, physical therapy, psychology, recreation therapy, rehabilitation, social work, sociology, or speech and language pathology, human services, human development, criminal justice or other related degrees. For a reference list to fields that may be appropriate, please go to: https://oasas.ny.gov/system/files/documents/2019/11/approved-human-services-degrees.pdf

Licensed Practitioner of the Healing Arts (LPHA): 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, Licensed Creative Arts Therapist, 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. Approved LPHAs who can refer and recommend may vary for each service are defined in the service description.

Medical Necessity: New York law defines “medically necessary medical, dental, and remedial care, services, and supplies” in the Medicaid program as those “necessary to prevent, diagnose, correct, or cure conditions in the person that cause acute suffering, endanger life, result in illness or infirmity, interfere with such person's capacity for normal activity, or threaten some significant handicap and which are furnished an eligible person in accordance with state law” (N.Y. Soc. Serv. Law, § 365-a).

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.

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

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

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, and Licensed Nurse Practitioners are also licensed, but services by these practitioners authorized for Medicaid reimbursement reside under another authority in the Medicaid State Plan.

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

- The child/youth'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/youth's life

Recommendation: when a treating Licensed Practitioner of the Healing Arts (LPHA) identifies a particular need in a child/youth based on a completed assessment and documents the medical necessity for a specific service.

NOTE: For access to the rehabilitative services, the child/youth must have a behavioral health diagnosis. If the child is not yet diagnosed, the LPHA must first make a referral to a Licensed Practitioner who has the ability to diagnose in the scope of his/her practice (e.g., OLP).

Referral: when an individual or service provider identifies a need in a child/youth and/or their family and makes a linkage/connection to a service provider for the provision of a service that can meet that need.

NOTE: For access to the rehabilitative services, the child/youth must have a behavioral health diagnosis. If the child is not yet diagnosed, a referral must first be made to a Licensed Practitioner who has the ability to diagnose in the scope of his/her practice (e.g., OLP)

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 child/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.

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). Cultural difference exists in the perception and interpretation of the trauma; the meaning given to the traumatic event; and the beliefs about control over the event.

Treatment Plan: A treatment plan describes the child/youth'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 and linguistically 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.

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

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
- Treatment planning and Implementation

- Psychotherapeutic Interventions (e.g. Cognitive Behavioral Therapy; Trauma-Focused CBT; Dialectical Behavior Therapy; Child-Parent Psychotherapy, etc.)
- Therapeutic Use of Self-Disclosure

F. Staffing Guidelines:

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 and health experience that is licensed, certified, designated, and/or approved 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 CPRA-Family, the individual must be at least 18 years of age and have the following:

- Demonstrated lived experience as a primary caregiver of a youth who has participated in (or navigated) the addiction services system. They provide education, outreach, advocacy and recovery support services for families seeking and sustaining recovery on behalf of a child or youth
- Have a high school diploma or General Equivalency Degree (GED) preferred or a State Education Commencement Credential.
- Completed a minimum of 46 hours of content specific training, covering the topics: advocacy, mentoring/education, recovery/wellness support and ethical responsibility
- Documented 500 hours of related work or volunteer experience,
- Provided evidence of at least 25 hours of supervision in a peer role.
- Passed the NYCB/IC&RC Peer Advocate Exam or other exam by an OASAS designated certifying body
- Demonstrated a minimum of 20 hours in the area of Family Support (combined online and classroom training)

- Complete 24 hours of continuing education plus 4 hours peer ethics earned every three years.

d. ***Certified Recovery Peer Advocate (CRPA) with a Youth Specialty:*** To be certified as a CRPA-Youth, an individual must be 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 500 hours of related work or volunteer experience.
- Provided evidence of at least 25 hours of supervision in a peer role, 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
- Demonstrated a minimum of 20 hours specifically related to Youth Peer Support (combined online and classroom training)
- Completed 24 hours of continuing education plus 4 hours peer ethics earned every three years

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).

f. ***Community Psychiatric Support and Treatment (CPST) Provider***

<u>Components 1-3:</u>

- Master's degree 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 in lieu of the one year experience requirement OR
- a Bachelor's degree who have been certified in an Evidenced Based Practice consistent with the CPST component being delivered
    - These practitioners may also 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. OR
- Bachelor's degree with a minimum of three years of applicable experience in children's mental health, addiction, and/or foster care/child welfare/juvenile justice or other related human services field and no certification in an Evidenced Based Practice

<u>Components 4-6:</u>

- Bachelor's degree with a minimum of two years of applicable experience in children's mental health, addiction, foster care/child welfare/juvenile justice and/or a related human services field and no certification in an Evidenced Based Practice
    - Practitioners with a bachelor's degree and the required applicable experience but no certification in an Evidenced Based Practice may only perform limited CPST activities.

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:

- 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. 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 credential.

- Complete Level One and Level Two of the Parent Empowerment Program (PEP) Training for Family Peer Advocates or approved comparable training.
- Submit three letters of reference attesting to proficiency in and suitability for the role of a FPA including one from the FPA's supervisor.
- Document 1000 hours of experience providing Family Peer Support Services.
- Agree to practice according to the Family Peer Advocate Code of Ethics.
- 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:

- 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. This educational requirement can be waived by the State if the person has demonstrated competencies and has relevant life experience sufficient for the peer credential.
- Completed Level One of the Parent Empowerment Training for Family Peer Advocates 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 Family Peer Advocate Credential must complete all other requirements of the Professional Family Peer Advocate Credential within 18 months of commencing 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

- 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
- 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
    - 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. Credentialed or Licensed clinical staff member" found in 14 NYCRR 800

a. *Credentialed or Licensed clinical staff member* means:

i. a credentialed alcoholism and substance abuse counselor (CASAC) who has a current valid credential issued by the Office, or a comparable credential, certificate or license from another recognized certifying body as determined by the Office;

ii. a counselor certified by and currently registered as such with the National Board for Certified Counselors;

iii. a rehabilitation counselor certified by the Commission of Rehabilitation Counselor Certification;

iv. a therapeutic recreation therapist certified by the National Council on Therapeutic Recreation or the American Therapeutic Recreation Association; or a person who holds a baccalaureate degree in a field allied to therapeutic recreation and, either before or after receiving such degree, has five years of full-time, paid work experience in an activities program in a health care setting;

v. a professional licensed and currently registered as such by the New York State Education Department to include:

1. a physician who has received the doctor of medicine (M.D.) or doctor of osteopathy (D.O.) degree;
2. a physician's assistant (PA);

3. a certified nurse practitioner;
4. a registered professional nurse (RN);
5. a psychologist;
6. an occupational therapist;
7. a social worker (LMSW; LCSW), including an individual with a Limited Permit Licensed Master Social Worker (LP-LMSW) only if such person has a permit which designates the OASAS-certified program as the employer and is under the general supervision of a LMSW or a LCSW; and
8. a mental health practitioner including: a licensed mental health counselor (LMHC), a marriage and family therapist (LMFT), a creative arts therapist (LCAT), and licensed psychoanalyst; and any mental health practitioner with a Limited Permit.

u. ***Registered Professional Nurse*** is an individual who is licensed and currently registered as a registered professional nurse by the New York State Education Department

v. ***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.

G. Cultural Competency and Language Access:

Cultural Competency is defined as attributes of a healthcare organization that describe the set of congruent behaviors, attitudes, skills, policies, and procedures that are promoted and endorsed to enable caregivers at all levels of the organization to work effectively and efficiently with persons and communities of all cultural backgrounds. An important element of cultural competence is the capacity to overcome structural barriers in healthcare delivery that sustain health and healthcare disparities across cultural groups.

All Medicaid-participating health care providers should be culturally competent. This means they need to recognize and understand the cultural beliefs and health practices of the families and children they serve, and use that knowledge to implement policies and inform practices that support quality interventions and good health outcomes for children. Given changing demographics, this process is ongoing.

Medicaid-enrolled children may live in families where English is not spoken at home. State Medicaid agencies and Medicaid managed care plans, as recipients of federal funds, also have responsibilities to assure that covered services are delivered to children without a language barrier. They are required take “reasonable steps” to assure that individuals who are limited English proficient have meaningful access to Medicaid services.

Though interpreter services are not classified as mandatory 1905(a) services, all providers who receive federal funds from HHS for the provision of Medicaid services are obligated, under Title VI of the Civil Rights Act, to make language services available to those with limited English proficiency. The HHS Office for Civil Rights and the Department of Justice have provided guidance for recipients of federal funds on expectations of how to provide language services (U.S. Department of Justice, Executive Order 13166.)

Providers of New York State Plan Amendment Services are expected to deliver effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs. The *Standards of Care Appendix* incorporates the standards and specific practices that support this expectation.

For further guidance on providing culturally and linguistically appropriate services, *The DHHS Office of Minority Health* offers numerous resources, including: Center for Linguistic and Cultural Competence in Health Care; Think Cultural Health; A Physician’s Practical Guide to Culturally Competent Care; The National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (the National CLAS Standards); and The National CLAS Standards’ implementation guide, A Blueprint for Advancing and Sustaining CLAS Policy and Practice.