



To: NYS Children and Family Treatment and Support Services (CFTSS) Service
Providers

Re: Updated CFTSS Provider Manual

Date: September 14, 2020

As a result of recent SPA submissions and changes to CFTSS, New York State (NYS) is reissuing an updated version of the Provider Manual to reflect the most current information for each service. For ease of review, we have outlined the major edits below.

Edits Made to the CFTSS Manual:

(1) For All Services:

- The manual was updated to reflect changes in staff qualifications across all CFTSS outlined in the memo below issued in April 2020
 - Effective Changes to the Children's Waiver of Home and Community Based Services (HCBS) and Children and Family Treatment and Support Services (CFTSS) - ([Web](#)) - ([PDF](#))
- Under Modality: Clarifying language was added to specify who can receive services and how services can be provided for billing purposes

(2) Under Other Licensed Practitioner (OLP):

- As per the memo above, Licensed Creative Arts Therapists were added as allowable licensed practitioners
- In accordance with the memo below, language was added to reflect NP-LBHPs with a provisional or limited license can provide Other Licensed Practitioner services under required supervision.
 - Guidance for Providers Regarding Student Interns and Limited Permits for CFTSS and HCBS - ([Web](#)) - ([PDF](#)) - June 2019

(3) Under Crisis Intervention (CI):

- Additional practitioners and telephonic follow-up were added, in accordance with the approved SPA, to align children's mobile crisis intervention with adult 1115 Waiver crisis intervention services and billable activities.



(4) Under Family Peer Support Services (FPSS):

- Under Limitations and Exclusions: The following sentence was deleted, “Services provided in the car are considered transportation and time may not be billed under rehabilitation.” Transportation alone is not billable under FPSS; however, the sentence was removed to clarify that services provided while in transit in a car to a service location where additional services will be provided is allowable and billable time.
- Edits were made to the Certified Recovery Peer Advocate with Family Specialty (CRPA-F) staff and supervisor qualification in accordance with board certification requirements.

(5) Under Youth Peer Support:

- The service “Youth Peer Support and Training (YPST)” has been edited throughout to reflect the new service title “Youth Peer Support,” as per the SPA.
- Under Limitations and Exclusions: The following sentence was deleted, “Services provided in the car are considered transportation and time may not be billed under rehabilitation.” Transportation alone is not billable under YPS; however, the sentence was removed to clarify that services provided while in transit in a car to a service location where additional services will be provided is allowable and billable time.
- Edits were made to the Certified Recovery Peer Advocate with Youth Specialty (CRPA-Y) staff and supervisor qualification in accordance with board certification requirements.

If you are a designated provider and have any service-related questions, please feel free to contact the lead agency as outlined in your designation letter.

To find out how to be approved provide services, you may submit any inquiries to the provider designation mailbox at: OMH-Childrens-Designation@omh.ny.gov.

For general Children’s Behavioral Health Transition questions please submit to: BH.Transition@health.ny.gov

Thank you,
The NYS State Interagency Team



Children's Health and Behavioral Health Services Transformation

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

September 2020

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



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I. BACKGROUND

New York State (NYS) is pleased to release the Children and Family Treatment and Support Services Provider Manual as a guide for the six children's health and behavioral health Medicaid State Plan services. 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 who meets relevant medical necessity criteria:

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

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*”.

NOTE: An integral part of the Children’s Medicaid Redesign has been the intent to include the authority for and provision of State recognized Evidenced Based Practice (EBP) models. NYS continues to be committed to the promotion of support of EBP models under the children’s transformation and plans to develop a process for agencies to apply and be approved for the provision of recognized EBPs under the EPSDT Children and Family Treatment and Support Services State Plan services, specifically through the services of Other Licensed Practitioner and Community Psychiatric Supports and Treatment. This process is still under development by the State and will be issued at a later date. More information will be forthcoming.

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 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.

Generally speaking, a child in need can be referred for “Other Licensed Practitioner” services and “Crisis Intervention,” at which time a licensed practitioner will make a determination for the provision of the service. For the remaining four rehabilitative services, which includes Community Psychiatric Supports & Treatment, Psychosocial Rehabilitation Services, Family Peer Support Services, and Youth Peer Support, each must be *recommended* (see Glossary) by a Licensed Practitioner of the Healing Arts (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-LBHP’s”)*. NP-LBHP’s authorized under OLP include the following:

- Licensed Psychoanalysts
- Licensed Clinical Social Workers
- Licensed Marriage and Family Therapists
- Licensed Mental Health Counselors
- Licensed Masters Social Workers when under the supervision of licensed clinical social workers (LCSWs), licensed psychologists, or psychiatrists
- Licensed Creative Arts Therapist

NP-LBHP’s are licensed clinicians able to practice independently for which reimbursement is authorized under Other Licensed Practitioner within the Medicaid State Plan. This OLP “billing authority” allows services provided by NP-LBHP’s to be reimbursable when delivered in nontraditional settings, including the home and/or community, or other site-based settings when appropriate, as permissible under State practice law. Services must be within the practitioner’s scope of practice, as defined in NY State law. The delivery of services by NP-LBHP’s 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 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. 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-LBHP's 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 SPA services.

All NP-LBHP have the capacity to conduct a comprehensive assessment within the scope of their practice. NP-LBHP who have the ability to diagnose within his or her scope of practice under state law includes a Licensed Clinical Social Worker (LCSW). Licensed Master Social Workers (LMSWs) are required to work under the supervision of a Licensed Clinical Social Worker (LCSW), licensed psychologist, or psychiatrist to conduct a diagnostic evaluation.

- **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.

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 present, as long as the contact is identified on and directly related to the child/youth's goals, in the treatment plan.
- Collateral (Allowable under Crisis Complex Care)
- Group
 - 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 and/or 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 and/or collaterals in group; as well as the experience and skill of the group clinician/facilitator.
 - Groups may include family/collaterals, with the child present, as long as the contact is directly related to the child/youth's goals and treatment plan

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, 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.
- 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).
- 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 Qualification:

- 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.
- 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 psychoanalysts;
 - (2) licensed clinical social workers (LCSWs);
 - (3) licensed marriage and family therapists (LMFT);
 - (4) licensed creative arts therapists; (LCAT); and
 - (5) licensed mental health counselors (LMHC).
 - (6) 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.
- 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.

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).

NOTE: Psychiatrists, Licensed Physician Assistants, Licensed Physicians, Psychologists, and Licensed Nurse Practitioners are authorized to provide services that are Medicaid reimbursable under a different authority within the State Plan.

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 a face-to-face 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. 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 face-to-face 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. Face-to-face 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 face-to-face 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 face-to-face intervention to the child and/or family.
- Follow-up may be conducted in person or by phone.

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 correct or ameliorate conditions discovered during the initial assessment visits. CPST is a face-to-face 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.

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 complimented 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 (Counseling)

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 (Counseling)

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 (Counseling)

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
- Collateral

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

- 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 and/or 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 and/or collaterals in group; as well as the experience and skill of the group clinician/facilitator
 - Groups may include family/collaterals, with the child present, as long as the contact is directly related to the child/youth's goals and treatment plan

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. Authorization of the treatment plan is required by the DOH or its designee. 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.

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
 - 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

- It also includes support to establish and maintain friendship/supportive social networks, improve interpersonal skills such as social etiquette and anger management.
- **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
- Collateral

PSR may include family and/or collateral contact with the child present, as long as the contact is directly related to the child/youth's goals and treatment plan

- 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; as well as the experience and skill of the group clinician/facilitator
- Groups may include family/collaterals, with the child present, as long as the contact is directly related to the child/youth's goals and treatment plan

Setting

PSR can occur in a variety of settings including community locations where the child/youth lives, works, attends school, engages in services, 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.
- 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. Authorization of the treatment plan is required by the DOH or its designee. 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
- 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 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 collaterals in group; as well as the experience and skill of the group clinician/facilitator

- Groups may include family/collaterals, with the child present, as long as the contact is directly related to the child/youth's goals and treatment plan

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. Authorization of the treatment plan is required by the DOH or its designee. 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 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 Preschool or 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 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.

- Groups may include family/collaterals, with the child present, as long as the contact is directly related to the child/youth's goals and treatment plan

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.
- 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 (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. Authorization of the treatment plan is required by the DOH or its designee. 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 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 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 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 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 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 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 OLP	Continued Stay	Discharge
<p>Criteria 1 or 2 must be met:</p> <p>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 ameliorate conditions discovered during the initial assessment visits that:</p> <ol style="list-style-type: none"> 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 achieve age-appropriate growth and development, and the ability to attain, maintain, or regain functional capacity. 	<p>Criteria 1 OR 2 and 3, 4, 5, 6:</p> <ol style="list-style-type: none"> 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 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 	<p>Any one of criteria 1-6 must be met:</p> <ol style="list-style-type: none"> 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 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



	<p>6. The treatment plan has been appropriately updated to establish or modify ongoing goals.</p>	<p>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</p> <p>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.</p>
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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
<p>All criteria must be met:</p> <ul style="list-style-type: none"> • 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: <ul style="list-style-type: none"> ○ 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 Practitioners of the Healing Arts operating within the scope of their practice under State License: <ul style="list-style-type: none"> • 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 	<p>N/A</p>	<p>Any one of criteria 1-or 2 must be met:</p> <ol style="list-style-type: none"> 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 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
<ul style="list-style-type: none"> Licensed Psychologist 		

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 designed to provide community-based services to children and families who may have difficulty engaging in formal office settings, but can benefit from community based rehabilitative services. CPST allows for delivery of services within a variety of permissible 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
<p>All criteria must be met:</p> <ol style="list-style-type: none"> 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: <ol style="list-style-type: none"> 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 Practitioners of the Healing Arts operating within the scope of their practice under State License: <ul style="list-style-type: none"> • Licensed Master Social Worker • Licensed Clinical Social Worker • Licensed Mental Health Counselor 	<p>All criteria must be met:</p> <ol style="list-style-type: none"> 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 clinically indicated or relevant 	<p>Any one of criteria 1 -6 must be met:</p> <ol style="list-style-type: none"> 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 the provider to apply reasonable engagement strategies;OR



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 designed to provide community-based services to children and families who may have difficulty engaging in formal office settings, but can benefit from community based rehabilitative services. CPST allows for delivery of services within a variety of permissible 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
<ul style="list-style-type: none"> • Licensed Creative Arts Therapist • Licensed Marriage and Family Therapist • Licensed Psychoanalyst • Licensed Psychologist • Physicians Assistant • Psychiatrist • Physician • Registered Professional Nurse or • Nurse Practitioner 		<p>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.</p>

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-occurring 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
<p>All criteria must be met:</p> <ol style="list-style-type: none"> The child/youth has a behavioral health diagnosis that demonstrates symptoms consistent or corresponding with the DSM; AND The child/youth is likely to benefit from and respond to the service to prevent the onset or the worsening of symptoms; AND The service is needed to meet rehabilitative goals by restoring, rehabilitating, and/or supporting a child/youth’s functional level to facilitate integration of the child/youth as participant of their community and family AND The services are recommended by the following Licensed Practitioners of the Healing Arts operating within the scope of their practice under State License: <ul style="list-style-type: none"> Licensed Master Social Worker Licensed Clinical Social Worker Licensed Mental Health Counselor Licensed Creative Arts Therapist 	<p>All criteria must be met:</p> <ol style="list-style-type: none"> The child/youth continues to meet admission criteria; AND 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 The child/youth does not require an alternative and/or higher, more intensive level of care or treatment; AND The child/youth is at risk of losing skills gained if the service is not continued; AND Treatment planning includes family/caregiver(s) and/or other support systems, unless not clinically indicated or relevant. 	<p>Any one of criteria 1-6 must be met:</p> <ol style="list-style-type: none"> The child/youth no longer meets admission criteria and/or meets criteria for another level of care, either more or less intensive; OR The child/youth has successfully met the specific goals outlined in the treatment plan for discharge; OR The child/youth or parent/caregiver(s) withdraws consent for services; OR The child/youth is not making progress on established service goals, nor is there expectation of any progress with continued provision of services; OR The child/youth is no longer engaged in the service, despite multiple attempts on the part



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
<ul style="list-style-type: none"> • Licensed Marriage and Family Therapist • Licensed Psychoanalyst • Licensed Psychologist • Physicians Assistant • Psychiatrist • Physician • Registered Professional Nurse or • Nurse Practitioner 		<p>of the provider to apply reasonable engagement strategies;OR</p> <p>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.</p>

PSR Limits/Exclusions

- 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
<p>Criteria 1 OR 2, AND 3 AND 4 AND 5 must be met:</p> <ol style="list-style-type: none"> 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: <ol style="list-style-type: none"> 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 Practitioners of the Healing Arts operating within the scope of their practice under State License: <ul style="list-style-type: none"> • Licensed Master Social Worker 	<p>All criteria must be met:</p> <ol style="list-style-type: none"> 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. 	<p>Any one of criteria 1-6 must be met:</p> <ol style="list-style-type: none"> 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
<ul style="list-style-type: none"> • 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 		<p>obtaining a similar benefit through other services and resources.</p>

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
<p>Criteria 1 OR 2, AND 3, 4, 5, 6 must be met :</p> <ol style="list-style-type: none"> 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 3. The youth requires involvement of a Youth Peer Advocate to implement the intervention(s) outlined in the treatment plan, AND 	<p>All criteria must be met:</p> <ol style="list-style-type: none"> 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 3. The youth does not require an alternative and/or higher, more intensive level of care or treatment; AND 	<p>Any of criteria 1-6 must be met:</p> <ol style="list-style-type: none"> 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
<p>4. The youth demonstrates a need for improvement in the following areas such as but not limited to:</p> <ul style="list-style-type: none"> a) enhancing youth’s abilities to effectively manage comprehensive health needs b) maintaining recovery <ul style="list-style-type: none"> c) strengthening resiliency, self-advocacy d) self-efficacy and empowerment e) developing competency to utilize resources and supports in the community f) transition into adulthood or participate in treatment; AND <p>5. The youth is involved in the admission process and helps determine service goals; AND</p> <p>6. The youth is available and receptive to receiving this service; AND</p> <p>7. The services are recommended by the following Licensed Practitioners of the Healing Arts operating within the scope of their practice under State License:</p> <ul style="list-style-type: none"> • 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 	<p>4. The youth is at risk of losing skills gained if the service is not continued.; AND</p> <p>5. Treatment planning includes family/caregiver(s) and/or other support systems, unless not clinically indicated.</p>	<p>3. The youth or parent/caregiver withdraws consent for services; OR</p> <p>4. The youth is not making progress on established service goals, nor is there expectation of any progress with continued provision of services; OR</p> <p>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</p> <p>6. The youth no longer needs this service as they are obtaining a similar benefit through other services and resources.</p>



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
<ul style="list-style-type: none"> Physicians Assistant Psychiatrist Physician Registered Professional Nurse or Nurse Practitioner 		

YPS Limits/Exclusions
<p>Limits/Exclusions:</p> <ul style="list-style-type: none"> 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-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. <p>Medicaid family support programs will not reimburse for the following:</p> <ul style="list-style-type: none"> 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(a)(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 and Demonstration Services for Medicaid Managed Care Plans

Service	Prior Authorization	Concurrent Authorization	Additional Guidance
Outpatient Clinic: Services including initial assessment; psychosocial assessment; and individual, family/collateral, group psychotherapy, and Licensed Behavioral Practitioner (LBHP).	No	Yes	MMCOs/HARPs must pay for at least 30 visits per calendar year without requiring authorization. MMCOs/HARPs must ensure that concurrent review activities do not violate parity law. Note: the 30-visit count should not include: a) FFS visits or visits paid by another MMCO/HARP; or b) psychiatric assessment and medication management visits. Multiple services received on the same day shall count as a single visit (and must be delivered consistent with OMH clinic restructuring regulations).
Mental Health Clinic Services: Psychiatric Assessment; Medication Treatment	No	No	MH clinic visits exclusively for Medication Management or Psychiatric Assessment will not count towards the 30 visits per calendar year.
Psychological or neuropsychological testing	Yes	N/A	
Mental Health Partial Hospitalization	Yes	Yes	
Mental Health Continuing Day Treatment (CDT)	Yes	Yes	
Personalized Recovery Oriented Services (PROS) Pre-Admission Status	No	No	Begins with initial visit and ends when Initial Service Recommendation (ISR) is submitted to Plan. Providers bill the monthly Pre-Admission rate but add-ons are not allowed. Pre-Admission is open-ended with no time limit
PROS Admission: Individualized Recovery Planning	Yes	No	Admission begins when Individual Service Recommendation (ISR) is approved by Plan. Initial Individualized Recovery Plan (IRP) must be developed within 60 days of the admission date. Upon admission, providers may offer additional services and bill add-on rates accordingly for: <ul style="list-style-type: none"> • Clinical Treatment; • Intensive Rehabilitation (IR); or • Ongoing Rehabilitation and Supports (ORS). Prior authorization will ensure that individuals are not receiving duplicate services from other clinical or BH HCBS providers.



Service	Prior Authorization	Concurrent Authorization	Additional Guidance
PROS Active Rehabilitation	Yes	Yes	
Assertive Community Treatment (ACT)	Yes	Yes	<p>Plans will collaborate with SPOA agencies around determinations of eligibility and appropriateness for ACT following NYS guidelines. New ACT referrals must be made through local Single Point Of Access (SPOA) agencies.</p> <p>Plans will collaborate with SPOA to facilitate referrals.</p> <p>In NYC, the referring provider contacts MMCO/HARP to request ACT referral. Provider and MMCO/HARP care manager review whether the member meets ACT level of care admission criteria. The MMCO/HARP notifies the referring provider a level of service determination (LOSD) to the referring provider that a level of service determination for ACT admission has been made. The provider sends the referral and LOSD to SPOA.</p> <p>In ROS, the referring provider makes a SPOA referral and contacts MMCO/HARP to request an ACT level of service determination. The referring provider and MMCO/HARP care manager review whether the member meets ACT level of care admission criteria. Simultaneously, SPOA reviews the referral and assesses for capacity/availability of ACT slot. The MMCO/HARP notifies the referring provider and LGU/SPOA that a level of service determination for ACT admission has been made.</p>
OASAS outpatient rehabilitation programs	No	Yes	
OASAS outpatient and opioid treatment program (OTP) services	No	Yes	
Outpatient and Residential Addiction services	No	Yes	
Residential Supports and Services	No	Yes	

Service	Prior Authorization	Concurrent Authorization	Additional Guidance
Other Licensed Practitioner (OLP)	No	Yes	<p>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.</p> <p>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.</p> <p>* 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.</p>
Crisis Intervention	No	No	None
Community Psychiatric Supports and Treatment (CPST)	No	Yes	<p>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</p>



Service	Prior Authorization	Concurrent Authorization	Additional Guidance
			<p>treatment plan and/or Health Home plan of care. The MMCP must ensure that prior and concurrent review activities do not violate parity law.</p> <p>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.</p> <p>* 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.</p>
<p>Psychosocial Rehabilitation (PSR)</p>	<p>No</p>	<p>Yes</p>	<p>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.</p> <p>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.</p> <p>* 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.</p>
<p>Family Peer Supports and Services (FPSS)</p>	<p>No</p>	<p>Yes</p>	



Service	Prior Authorization	Concurrent Authorization	Additional Guidance
			<p>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.</p> <p>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.</p> <p>* 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.</p>
Youth Peer Support (YPS)	No	Yes	<p>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.</p>



Service	Prior Authorization	Concurrent Authorization	Additional Guidance
			<p>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.</p> <p>* 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.</p>



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.	<ol style="list-style-type: none"> 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 revised to reflect up-to-date	<ol style="list-style-type: none"> 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. 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.



<p>regulatory compliance and service operations.</p>	<p>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.</p>
<p>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.</p>	<p>1. Policies and procedures ensure that services are delivered within the scope of practice as per service designation.</p> <p>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 lead agency that has licensed, certified, authorized, or designated the provider and ensures:</p> <ul style="list-style-type: none"> a. consent to receive services is obtained b. orientation to service information is provided c. freedom of choice is offered d. individual’s rights are explained (including the right to file grievances)¹ <p>3. Policies and procedures in place to help improve meaningful access to care for people of diverse backgrounds that include:</p> <ul style="list-style-type: none"> a. Recruiting and assigning multicultural and/or multilingual clinicians to match child/youth’s cultural groups whenever possible. b. Providing services in a culturally competent manner for all children, youth and families <p>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 services² This also includes specialized information/access to youth who are sight/visually impaired, deaf or hard of hearing.</p> <p>5. Policies and procedures are developed that define how services will be delivered, documented and reflect clinical quality of care standards.</p> <p>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.</p>

¹ 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>

² Section 527.4 of 14 NYCRR: 527.4 Communication needs; Title VI of the Civil Rights Act of 1964 (42 USC 2000d)



	<p>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.</p>
<p>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).</p>	<ol style="list-style-type: none"> 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.³
<p>E. Employee/Staffing: Provider maintains documentation of administrative oversight to include: hiring, retention, and supervision of qualified staff.</p>	<ol style="list-style-type: none"> 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 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.

³ 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



	<ol style="list-style-type: none"> 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 lead agency 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.⁴
<p>F. Orientation and Training of Staff: Provider has a training and orientation plan in place for all staff.</p>	<ol style="list-style-type: none"> 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.
<p>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.</p>	<ol style="list-style-type: none"> 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.⁵ 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 NYS Social Service Law 424-a

⁵ Reference for mandated reporting: [http://public.leginfo.state.ny.us/lawssrch.cgi?NVLWO:](http://public.leginfo.state.ny.us/lawssrch.cgi?NVLWO)



	<ol style="list-style-type: none"> 4. Provider has written emergency preparedness and response plan for all of its services and locations that includes responses to environmental and natural disasters. 5. Provider has written policy and procedures addressing the safe administration, handling, storage, and disposal of medications, to include protocol for client incidents where providers are asked to handle any type of client medication, prescribed or Over the Counter. Policy addresses the administration of medication only by persons who are authorized to do so by state law.
<p>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.</p>	<ol style="list-style-type: none"> 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: <ol style="list-style-type: none"> 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: 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.
<p>I. Fiscal Compliance: Provider has written policies and procedures regarding billing and compliance with all applicable funding sources.</p>	<ol style="list-style-type: none"> 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 has a policy regarding reimbursable services (e.g., transportation expenses and per diems) and where possible to work within the federal and state guidelines. 4. 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
<p>A. Service is initiated in a timely manner to meet the needs of the child/youth and family/caregiver and collaterals.</p>	<ol style="list-style-type: none"> 1. Outreach is made to child/youth and family/caregiver to establish initial contact and engage in scheduling face to face 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 face to face appointment is demonstrated. This includes identifying barriers and problem solving toward removing barriers to treatment, e.g., childcare, transportation, etc. <p><i>See additional guidance in Provider Manual for Crisis Intervention</i></p>
<p>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.</p>	<ol style="list-style-type: none"> 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.
<p>C. An integrated approach to service delivery is demonstrated by the coordination of care and collaboration among the multidisciplinary team (service providers, child/youth,</p>	<ol style="list-style-type: none"> 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



<p>family/caregiver and collaterals) to achieve safe and effective care</p>	<p>the medical, psychosocial, emotional, therapeutic, and recovery support needs of the child/youth and family/caregiver, both within and outside the provider agency.</p> <ol style="list-style-type: none"> 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. 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.
<p>D. The child/youth and family/caregiver are provided care that reflects the awareness and responsiveness of cultural differences and diversity.⁶</p>	<ol style="list-style-type: none"> 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. Provider’s assessment and interventions acknowledge, respect and integrate the child/youth’s and family/caregiver’s beliefs, cultural values and practices. 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. 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
<p>A. A service specific assessment is done based on the needs of the child/youth</p>	<ol style="list-style-type: none"> The assessment is relevant to the child’s age/developmental stage. Information is gathered to assess the strengths, needs and preferences of the child/youth related to the delivery of the CFTSS. Safety issues for the child/youth are identified through the assessment and provider protocols are followed if indicators of risk arise.

⁶ 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



	<p>4. Linkage to appropriate service is expedited if indicated by clinical presentation and/or need for medication and/or medical intervention.</p> <p>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.</p> <p><i>See additional guidance for the comprehensive assessment conducted by a licensed practitioner (to be issued).</i></p>
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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.

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.	<ol style="list-style-type: none"> 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.	<ol style="list-style-type: none"> 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	<ol style="list-style-type: none"> 1. Services incorporate principles of safety, trustworthiness/transparency, collaboration, empowerment, and respect for cultural and gender differences.



<p>trauma is understood, signs and symptoms of trauma are recognized and the knowledge about trauma is integrated into policies, procedures and practices.⁷</p>	<ol style="list-style-type: none"> 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. 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.
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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
<p>A. Every child/youth has an individualized, strength based, culturally competent, developmentally appropriate treatment/service plan.</p>	<ol style="list-style-type: none"> 1. The plan is individualized to the circumstances and preferences of the child/youth and family/caregiver and identifies/includes: <ol style="list-style-type: none"> 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.

⁷ <http://www.nctsn.org/The> National Child Traumatic Stress Network; and SAMSHA



	<ul style="list-style-type: none"> 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. <p><i>See additional guidance for specific guidance on the treatment plan (to be issued).</i></p>
<p>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.</p>	<ul style="list-style-type: none"> 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.
<p>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</p>	<ul style="list-style-type: none"> 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
<p>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</p>	<ul style="list-style-type: none"> 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.



<i>See additional guidance regarding the safety plan for Crisis Intervention (to be issued).</i>	
E. Discharge planning is a dynamic process throughout the course of service delivery and includes the participation of child/youth, family/caregiver and collaterals.	<ol style="list-style-type: none">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.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. APPENDICES

A. 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/Adolescent/Youth: Individual under age 21

Collateral: An individual who regularly interacts with the child/youth, other than the “family” (see definition), 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 child/youth.

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.

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 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, Psychologists, 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.

B. Knowledge Base/Skills Recommendations:

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

Knowledge Base

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

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

C. 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:

- CASAC:** Staff person who holds a credential by the NYS OASAS as a Credentialed Alcohol and Substance Abuse Counselor
- CASAC-T:** A CASAC Trainee who meets specific eligibility requirements and passes the Alcohol and Drug Counselor (ADC) examination
- 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.crc certification.com).
- f. ***Community Psychiatric Support and Treatment (CPST) Provider***

Components 1-3:

- 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

Components 4-6:

- 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.

- Licensed Occupational Therapist*** is an individual who is licensed and currently registered as an Occupational Therapist by the New York State Education Department
- 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
- Licensed Psychoanalyst*** is an individual who is currently licensed and currently registered as a psychoanalyst by the New York State Education Department

- i. 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;

- 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.

D. 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.