Part 511-2 Children's Mental Health Rehabilitation Services (CMHRS) Program

Comprehensive PAR (CPAR) Provider Application Guide

Note: The use of this document, although encouraged, is not required. This guide is intended to inform CPAR content to streamline the application process; the use of this guide does not guarantee application approval. Additional information, beyond the elements included in this guide, may be requested by OMH during the review process.

All providers required to complete a CPAR application must have a completed Provider Designation Application indicating the agency's intent to serve the mental health population and the pursuit of CMHRS Program licensure. The below criteria are intended to provide programmatic information for CPAR applicants to support the licensure application process.

Note: The 'designation process' is authorized via Part 511 Early and Periodic Screening, Diagnostic and Treatment Services for Children; Sub-Part 511-2 is the Children's Mental Health Rehabilitation Services Program. Part 511 requires provider agencies to be approved via the Designation Process prior to service delivery.

How to Use this Document:

This guide serves two purposes: 1) to provide context and references for specific requirements and/or standards to inform application content; and, 2) outlines specific information that must be included in the application in addition to or in expansion of existing CPAR application questions.

To assist the applicant with navigating the guide, two resources have been incorporated:

- The arrow symbol will point the applicant to sections in the guide that outline specific topics that must be addressed or *actionable* elements.
- **Tip Boxes**. These boxes offer tips to further guide the applicant.

INTRODUCTION

Vision:

The development of the Children's Mental Health Rehabilitation Services (CMHRS) Program is intended to license two Children and Family Treatment and Support Services (CFTSS): Other Licensed Practitioner (OLP) and Community Psychiatric Supports and Treatment (CPST). In addition, the CMHRS Program intends to promote equitable and timely service access by requiring three additional CFTS services: Psychosocial Rehabilitation (PSR), Youth Peer Support and Training (YPST) and Family Peer Support Services (FPSS) be provided either

directly by the CMHRS Program or via formal agreement with an agency designated to provide these services (these three services will remain *unlicensed*). This is intended to assure coordination of care amongst service providers and integration of care and treatment across services.

In general, CFTSS 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 introducing CMHRS Programs, children and families/caregivers can more readily access the full-service array (all five services listed in Part 511-2) regardless of what CMHRS Program agency they may have entered or service they may have started receiving. Furthermore, with assured access to all services, children's treatment plans can be better individualized to their needs; increasing types of services when needs are more complex to better support families in crisis.

The CFTSS that comprise CMHRS Programs 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:

- Child-centered
- Family-focused
- Community-based
- Multi-system
- Culturally competent
- Least restrictive/least intrusive

Further, CFTSS under the CMHRS Program should be planned and delivered in partnership with the provider, the child/youth, family/caregiver, and significant others involved in the child's treatment. Providers should be guided by the CASSP principles in addition to the below when engaging children and their families/caregivers in the service delivery process.

- Strength-based
- Trauma Informed
- Developmentally Appropriate

CFTSS 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. CFTSS are intended to be individualized to the specific needs of the child and their family.

What are CFTSS?

NYS established six (only five of the six services are included in the CMHRS regulation) new children's behavioral health services called Children and Family Treatment and Support Services (CFTSS), to benefit children from birth to 21 years of age enrolled in Medicaid. The aim of the CFTS service array is to more effectively meet the needs of children, youth and families by expanding access, flexibility and choice to families of children and youth from infancy through young adulthood. Each CFTS service is intended to be delivered primarily in nontraditional settings, allowing interventions to take place in the home and other natural community-based locations where children/youth and families live, attend school or engage in services. Each service is available to any child with a behavioral health need that meets the admission criteria ("medical necessity") for that service.

These services are not contingent upon one another, a child and family may receive one or multiple services depending on eligibility and family choice. Each service has unique Medical Necessity criteria (eligibility criteria) that a child must meet to access the service.

- *Resources:*

  The CFTSS that comprise CMHRS are required to follow established Manuals (and guidance documents) (see 511-2 *Incorporation by Reference*). The Medicaid State Plan Children and Family Treatment and Support Services Provider Manual for Children's Behavioral Health Early and Periodic Screening and Diagnostic Treatment (EPSDT) Services outlines the service definitions, qualifications of staff, eligibility criteria (Medical Necessity) and the Standards of Care (SoC); most notably.

COMPLETING A CPAR APPLICATION

A CPAR application is in paper form and can be requested from the regional OMH Field Office (https://www.omh.ny.gov/omhweb/aboutomh/fieldoffices.html) or OMH Bureau of Inspection and Certification (BIC) on the Prior Approval Review (PAR) Resource webpage (https://www.omh.ny.gov/omhweb/email/compose_mail.php?tid=QM_PAR_1)

Establish Program:

Code 4960, CFTSS: Children's Mental Health Rehabilitation Program (which is a combination of OLP and CPST) is a licensed program type code. This code will be used for internal, OMH processes and for the establishment of CMHRS; individual program codes, by service, will be used operationally.

The CPAR is a general application, used for multiple licensing types; it was not specifically created for the purpose of CMHRS Programs. The CPAR template may not prompt the

applicant to include specific information referenced in this guide. The applicant may use the narrative text boxes to further elaborate on points, and/or may append attachments to the application to completely and comprehensively demonstrate its ability to adhere to requirements and standards.

Tip: For each content area below, indicate, via attachment to the CPAR if the question is not directly stated in the application, how the agency is able to meet the regulatory requirement and/or standard. The applicant may note that much of the information requested herein, if not directed asked via the application, may be attached via Section J, 'Attachment for New Program or New Satellite Location' (#6 – Functional Program).

CPAR Review: Content

Section B – General Information

1. *Agency Expertise and Experience:*

CPAR applicants must demonstrate the agency's expertise and experience in not just serving children with mental health needs (ages birth to 21) and their families/caregivers but also, any experience in the provision of community-based services. Further, depending on the service(s) the agency intends to provide, in addition to OLP and CPST, the agency must indicate via written response, their experience in serving this population via clinical and rehabilitative services. For instance, what services/programs does the agency currently operate that speaks to expertise with this specific population, setting and service delivery? How is the agency experienced and/or equipped to provide services in the community and/or a home-based setting? Are specific treatment modalities and/or Evidence Based Practices utilized? What trainings, resources, supports are made available to staff to enhance knowledge, skills and competencies as relevant to CMHRS? Does the agency currently maintain connections, partnerships, agreements, etc. with other child-serving systems in the identified catchment area (i.e., schools, child-serving provider agencies, county mental health, etc.).

Tip: Any relevant expertise and experience, in addition to the categories outlined above, should be delineated in narrative form to expound upon the agency's capacity to appropriately implement a CMHRS Program. For instance, if an agency has experience providing clinical services to children with mental health needs but in a traditional, off-based setting versus community-based, that experience should be comprehensively outlined.

If the agency's current experience and expertise is limited in any given area (population, setting, or service delivery), indicate the agency's plan to develop the knowledge, skills and infrastructure to implement a CMHRS Program.

Section D – Prior Consult

2. *Letter of Support (LOS):*

To support communication and collaboration, providers are required to consult with Local Government Unit (LGUs) in all counties within the agency's identified catchment area. However, a Letter of Support is only needed from the county in which the program is based (main site). The applicant must demonstrate the completion of consultation with all LGUs within the identified catchment area within the application; in doing so, please indicate the individual (LGU) name, county, date of consultation and append the Letter of Intent shared with the county(ies).

Tip: Please document information regarding consultation with counties via 'Prior Consult', Section D, #1 of the CPAR application. Also, for *sample* Letters of Intent and *sample* Letters of Support please see the NYS OMH website at: https://www.omh.ny.gov/omhweb/par/application.html.

3. Prior Consultation:

Agencies are required to contact their OMH regional Field Office (based on the location of their main site) prior to initiating the CPAR application. This process provides an opportunity for the applicant to review their intent and plan for the implementation of a CMHRS Program with OMH. Additionally, the Field Office can acclimate the applicant to the licensure application process and provide any needed technical assistance and support. OMH Field Offices are acutely aware of the need, current services/programs and logistics of the region and can assist applicants in further articulating their plan prior to application submittal.

Tip: Please document information regarding prior consultation with the regional OMH Field Office via 'Prior Consult', Section D, #2 of the CPAR application. To contact your Regional OMH Field Office please see NYS OMH at: https://www.omh.ny.gov/omhweb/aboutomh/fieldoffices.html .

4. Services:

Applicants are required to provide OLP and CPST directly, as per the CMHRS program regulation. In addition, applicants will need to indicate which of the rehabilitative services (PSR, FPSS and YPST) they intend to provide (in alignment with the agency designation approval) directly. In turn, current and projected staffing and appropriate supervision plans, in accordance with current and forecasted capacity with details regarding caseload sizes per service; and program access (process for incoming referrals and/or recommendations, admission process*). **These topics are reviewed in greater detail below*.

Tip: If the applicant is currently designated, or plans to become designated, for any of the unlicensed services, as relevant to CMHRS (PSR, FPSS and YPST) and subsequently, plans to provide these services directly, the application must clearly indicate the agency's current practices and/or plans with these services included. For instance, the staffing and budget plan

must include the directly provided unlicensed services in addition to any other relevant operational components.

If, in completing the CPAR, the services and catchment area vary from the information approved via the designation process, the agency will be instructed to update their designation application to align with information included in the CPAR once approved.

5. Access, Engagement and Initial Contact (511-2.7(5):

Anyone can make a referral for services, but a recommendation must be completed by a Licensed Practitioner of the Healing Arts (LPHA) to determine if the child meets Medical Necessity criteria for a given service prior to program admission. Eligibility is not *program* specific, it is *service* specific.

Per Standard II.A, service access is to be initiated in a timely manner to meet the need(s) of the child and family. Further, as part of the admission process, the child and family are expected to be oriented to services and provided with necessary documentation regarding scope of services, confidentiality and information sharing. Through an integrated, team approach; with diversity and culturally aware practice, providers will identify and address barriers to enhance connectiveness (for further information, see #7 below regarding required policies and procedures).

The agency will demonstrate via application, the ability to provide timely access to needed services in accordance with Standard 11.A and orientation process for newly enrolled children and families. In addition, plans to manage waitlists with information regarding prioritization.

The program demonstrates practices that include linking the child and family to other programs and/or services and provides notification to the referral source if the child is not admitted (511-2.7).

Tip: NYS is aware of challenges providers are facing that may contribute towards capacity concerns. Because of this, a Commissioner Waiver has been approved, (for more information see #6 below) however, agencies must illustrate their plans, in accordance with requirements outlined in this document and other referenced documents, to adhere to the regulation and meet the need of their identified catchment area.

Section E – Program Information

6. Addressing the Need (current capacity, anticipated volume, staffing, etc.):

Agencies must equitably offer (and directly deliver) services under CMHRS (OLP and CPST) to the full catchment area (511-2.5 (b)); the remaining three services must be made available either directly or via agreement to ensure full access across the CMHRS Program catchment area (511-2.5 (c)).

In the CPAR, applicant must document if the agency will be providing the remaining unlicensed services and/or if the agency has existing formal agreements. Please upload the agreements, if established, and/or indicate the agency's plan to establish needed agreements including, describing how your agency will work with the other agencies who will provide the unlicensed services to ensure coordinated and timely service delivery. Further, if the agency will be rendering services directly, information must also be provided indicating how the agency will be serving the identified catchment area.

Note: A Commissioner Waiver has been approved waiving the underlined requirement (511-2.5 (c)(1-3) to account for the implementation and expansion of these services. This is particularly important for YPST, which does not transition to becoming a CFTSS until January 2020. The waiver allows providers until July 2020 to build capacity and access.

Tip: Agencies are not limited to enter into a single agreement. Instead, agencies are welcome to develop multiple agreements to promote timely service access and family choice. Similarly, if an agency elects to directly deliver any of the unlicensed rehabilitative services, this does not preclude the agency from also entering into agreements with other designated agencies.

Although the Commissioner Waiver is intended to allow time to build capacity, it is expected that agencies will have an understanding of expected volume, with plans to address the community need within the intended catchment area. These services are not 'closed' to individuals already enrolled in existing programs within the agency rather, the agency is expected to meet the need of the community. This can be done via direct service delivery (OLP and CPST) or, as stated above, via written agreement with other designated agencies (for PSR, YPST and FPSS).

To further promote timely access and choice, CMHRS Programs are encouraged to engage in linkage/referral agreements with multiple agencies, as needed. And, certainly, if a child and family opt to work with a designated agency that the CMHRS Program has not engaged in a formal agreement with, accommodations will be made to allow for the family to work with that provider.

The applicant will demonstrate within the application, their ability to coordinate, as needed, within designated provider agencies in which they have not established a prior agreement.

Although the Commissioner Waiver postpones the requirement for full-service access (for PSR, FPSS and YPST), agencies must still present a plan for addressing the requirement to provide access to the full range of CMHRS Program services over the course of year (expiring in July 2020).

Agencies must demonstrate their ability to identify children in the community (demonstrate awareness and understanding of current need in the identified catchment area), establish a referral/recommendation pathway, if one does not already exist, and procedures for timely service access. The agency must also indicate their current and continued efforts to facilitate program access throughout the identified catchment area including, fostering equitable service access to referrals received from multiple sources (i.e., internal to the agency, community and inpatient providers, schools, parents/caregivers, etc.)

Tip: Please document information regarding capacity and the ability to identify and serve underserved areas/populations via 'Attachments for New Program or New Satellite Location', Section J, #3 of the CPAR application.

In addition, the applicant must identify caseload in accordance with Standard 1.E (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. (CFTSS Standards of Care)

Tip: Please document information regarding caseload via 'Program Information', Section E, #1 of the CPAR application.

7. Administration of Services: Policies and Procedures:

The following are required policies and procedures as delineated in the CFTSS Standards of Care. Providers are not required to include the following policies and procedures as part of the CPAR process unless specifically requested to do so. However, providers may reference their policies and procedures to demonstrate adherence to the Standards and other requirements. The Agency policy and procedures will be requested and reviewed during the next on-site licensure monitoring visit by OMH.

a. Compliance with regulatory and quality of care standards
b. Service Operations
    - *Policies and procedures supporting the availability and delivery of services that uphold child's rights, are culturally and linguistically responsive and adhere to clinical quality standard.*
c. *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. 511-2.9*
d. Employee Staffing (see 'Staffing' below for more information)
e. Orientation and Training of Staff
    - *Protocols to address personal safety of staff and provides training in de-escalation techniques; provider ensures staff have required experience and*

training that is trauma-informed, culturally competent, and appropriate to the developmental level of population served; policies that describe staff orientation, mandatory trainings or other offered trainings. ***There are no required trainings for the five CFTS services for the exception of Mandated Reporter.***

f. Health and Safety
   - *Policies and Procedures that address clinical/client emergencies, crisis events or disasters, prevention of abuse and/or neglect and incident reporting*

g. Quality Management
   - *Policies and procedures to monitor the quality and evaluate the effectiveness of services on systematic basis, and to implement quality improvements when indicated.*

h. Fiscal Compliance
   - *Policies and procedures regarding billing and compliance with all applicable funding sources.*

8. Treatment Plan and Case Record (511-2.8, 511-2.9 and Standard V)

Providers must adhere to requirements delineated in the above references (511-2.8 and Standard V) and CFTSS Provider Guidance: Health Record Documentation. Providers are encouraged to utilize an integrated treatment plan when a child and family are receiving multiple CFTS services when provided directly by the CMHRS Program. However, if services are rendered via agreement with another designated agency, a separate plan must be maintained by that agency for the purposes of their own billing and documentation. The CMHRS Program is expected to develop agreements that cultivate coordination and collaboration with other designated agencies. Please describe mechanisms the program has implemented in alignment with confidentiality and consent requirements to share necessary information for coordination purposes between providers. In addition, describe the circumstances in which it is determined that a Safety Plan is needed. What policies and/or procedures exist that support a nonclinical staff in identifying and supporting the child/family when it is believed that additional support/intervention/assessment/etc. is needed/warranted?

Section J - Attachments for New Program or New Satellite Location

9. Sites and Setting (Standard IV: A):

For the purpose of the CMHRS Program, only the main provider agency office will be *licensed* (have an Operating Certificate). The services within the CMHRS Program are intended to be delivered in community-based, non-traditional settings to promote the functioning of children in the context of their natural settings (e.g., home, community, school, etc.). However, office-based service delivery is also an option for children and families, if they preferred. The setting for these services must be driven by the identified need, family choice/consent, and in alignment with the nature and scope of the service. The setting is intended to be flexible and individualized; adjusting to meet the needs of the child and family. In some cases, it may be

clinically appropriate to deliver services in a traditional, office-based setting versus the home/community. For this reason, access to office-based settings may be appropriate.

Despite agencies having been designated for multiple sites, only the "main site" is relevant to CMHRS for the purpose of licensure.

Agencies must identify their intended catchment area and plans for providing OLP and CPST (the two licensed services) to the full catchment area, **directly**. If, for example, an agency plans to serve eight counties (in alignment with approved designation), they must also illustrate their ability to deliver the two licensed service to all eight counties, and how they will assure access to the remaining three rehabilitative services in all counties either directly or through agreements.

Tip: As stated under #6, providers must submit a plan outlining the activities that will occur to adhere to the Part 511-2.5 (b) (establishing agreements with designated provides to assure access to the three unlicensed services for the full identified catchment area) to be in compliance by July 2020 (the expiration of the proposed waiver).

Designated sites may be mentioned in the application process to illustrate staffing plans to meet current/forecasted capacity and coverage throughout the catchment area, and where agencies plan to serve the general mental health population.

Schools – Schools are an allowable setting for the delivery of CFTS services. These services are not like clinic; there will be no "satellite" sites/locations under CMHRS licensure. If the agency indicates that school settings will be used for the delivery of CFTSS, service delivery must follow the parameters as currently delineated in the Medicaid State Plan Children and Family Treatment and Support Services Provider Manual for Children's Behavioral Health Early and Periodic Screening and Diagnostic Treatment (EPSDT) Services. We encourage providers to develop relationships with schools to promote communication and coordination.

Again, the setting for service delivery is determined based on family choice, clinical appropriateness and in alignment with the nature and scope of the actual service/intervention (goals/objectives as delineated in the treatment plan) delivered. Essentially, settings are individualized and flexible to meet the unique needs of the child and family. In all cases, while the providers may have designated "sites," if the child and family warrant services to be provided in their home or community, the provider must have the capacity to do so.

As part of OMH oversight, it is important to assure that agencies are delivering CFTSS in an individualized manner and in settings commensurate with a child and family's identified need(s), service(s) and preferences. If agencies are utilizing schools as a "base" from which to deliver services in a regular and routine way that is not supported by the recipients' *individualized* treatment plans, or if the school setting becomes the primary or only setting offered to families, then the provider agency is not adhering to the intent of the design. Justification for the agreed

upon setting(s) must be delineated in the treatment plan. If, for instance, a child's need manifests in the home, yet services are only rendered in the school, the case record should reflect efforts made by the provider to explore and engage the family in participating in services in the home. Via the CPAR application, the applicant must demonstrate their ability to provide services in settings that adhere to the above.

10. Premises (511-2.13):

The premises for service delivery (whether in the community or office location) must be appropriate for the service and modality (individual, family, group, etc.) and supported by the goals/objectives as delineated in the treatment plan. The site and space for service delivery is intended to promote efficacy, family choice, and engagement.

The applicant must illustrate their ability to deliver services in settings that align with the above requirements as delineated in Part 511-2.13. Note: a copy of the lease and Certificate of Occupancy must be included as well.

Section F - Staffing

11. Staffing (511-2.7(b) & Standard I:E:

Staff qualifications by service are outlined in the Medicaid State Plan Children and Family Treatment and Support Services Provider Manual for Children's Behavioral Health Early and Periodic Screening and Diagnostic Treatment (EPSDT) Services and must be maintained in accordance with Standard I:E (found in Appendix VI in above Manual):

- **Provider maintains organization chart that provides visual description outlining organizational relationships in the agency. Chart that identifies lines of authority and distribution of all staff.**
- Each position has written description
- New staff 'onboarding' policies and procedures to orient staff to the agency and program
- Agency maintains records of staff licensure, certification or registration; and are qualified to deliver CFTSS within scope of practice
- **Agency provides that staffing is adequate to meet needs of population served** and assigns cases based on presenting needs, acuity, preference and staff expertise; caseload size and supervision ratios are monitored.

The elements **bolded** above must be included in the CPAR application.

Tip: The applicant can include information regarding staffing via 'Staffing', Section F, #1 or can attached a staffing grid to the CPAR application.

Section G – Financial

12. Budget:

Complete CMHRS Program State-Issued Budget Template. In acknowledgment of challenges provider agencies may be facing to build capacity, if the program budget is not currently balanced, the applicant will provide forecasted volume, staffing, etc. with corresponding timelines until the budget is projected to be balanced.

13. Other Considerations:

The two licensed services comprising a CMHRS Program (OLP and CPST) are clinical in nature. However, it is important to note that Sub-Part 511-2 is a unique licensure category; an agency applying for licensure under this Sub-Part is not required to have an existing clinic or other OMH licensed program. 511-2 creates a pathway for existing CFTSS providers to transition from unlicensed CFTS service provider to a licensed program and for agencies not otherwise licensed by OMH, to apply.

Please describe the program's current and forecasted practices regarding data collection for the purpose of informing service performance, participant feedback, disparities of in care across cultural groups, clinical supervision, grievance and complaints, and critical incidents.

Include plans regarding how the applicant will identify engage underserved, underrepresented populations within the identified catchment area.

511-2.6 (c)

CMHRS Programs will not be permitted to identify a specialty population on the Operating Certificate. Meaning, the expectation, in alignment with CFTSS, is that CMHRS Programs will appropriately and adequately meet the needs of the population served (general mental health); inclusive of children, birth to 21, that meet Medical Necessity criteria and are consistent with admission criteria.