CPST Provider Manual: Community Setting (Youth and Adult)

Summary of Major Content Changes: Draft V2 (12.15.2025) to Draft V3 (06.08.2026)

Prepared for Stakeholder Review | June 2026

Section 1. Definitions

- Three new defined terms were added that did not appear in V2:
  - CPST Clinical Director — A formal definition was added describing this role's scope of duties, oversight accountability, multi-agency restrictions, and in-person availability requirements.
  - Crisis Mitigation Plan — Added as a standalone definition, formalizing the individualized plan for crisis prevention and management.
  - Natural Supports — Added as a standalone definition clarifying the informal, unpaid, and individual-identified nature of these relationships.
- Full-time and One-to-one were also newly defined. One-to-one replaces the prior use of 'individual basis' throughout the document to clarify that the provider's full attention is directed exclusively to one individual per encounter.
- The LMHP definition was streamlined. V2 included a list of specific qualifying license types; V3 refers to 12VAC35-105-20 by reference only.

Section 2. Service Definition/Critical Features

- Condensed and reorganized. V2 contained multiple lengthy paragraphs; V3 presents a more concise service description while preserving all substantive requirements.

Section 3. Required Evidence-Based Practices (EBP)

3.1 Measurement-Based Care / 3.2 Referral to Standalone EBPs

- The four categories of evidence-based approaches (protocols, principles, practices, and policies) are now formatted as a bulleted list with bolded labels, improving clarity over V2's prose format.
- Section 3.2 was substantially restructured:
  - V2 presented referral requirements as a single section. V3 splits this into three subsections: Purpose and Intent (3.2.1), Required EBP Referrals (3.2.2), and When a Standalone EBP Is Unavailable (3.2.3).
  - New language in 3.2.1 explicitly frames CPST as a service for individuals whose needs are not fully met by standalone EBPs, for whom EBPs are unavailable, inappropriate, or have been attempted and proven insufficient.
  - New language in 3.2.3 specifies documentation requirements when a standalone EBP is unavailable, including documenting specific barriers, coordination with the MCO, and including a transition plan in the ISP.
- The referral requirement now also applies when an individual has remained at the same Level of Need for 18 calendar months or more.

3.3 Required Provider Training and Documentation

- Training content was moved in its entirety to a new Attachment 1. Section 3.3 in V3 now serves solely as a cross-reference to that attachment.

- Attachment 1 reorganizes training requirements into structured tables by professional credential type and adds specificity to MAP credentialing requirements for youth-serving staff, including a defined timeline of 18 calendar months from enrollment for all LMHPs/LMHP-types to achieve MAP Credentialed Therapist status.
- Transdiagnostic Cognitive Behavioral Therapy was added to the list of required adult-track EBP training options for LMHPs.
- Illness Management and Recovery (IMR) was added to the list of relevant and suggested EBPs for the adult track.

Section 4. Required Service Oversight and Supervision

- Section 4 was substantially reorganized. V2 combined LMHP oversight requirements, supervision of staff, and caseload requirements in two subsections (4.1 and 4.2). V3 separates these into seven distinct subsections (4.1 through 4.7) and relocates detailed supervision and caseload content to Attachment 1.

4.1 LMHP Requirements / 4.2 CPST Clinical Director

- New transitional provision: DMAS will allow the CPST Clinical Director and any LMHP Clinical Supervisor to hold LMHP-type status with 50% or fewer Board-approved supervision hours remaining before achieving independent licensure, through June 30, 2029. DMAS will also honor specific DBHDS variances for the Clinical Director through the same date. This provision was not in V2.
- Restriction clarified: A CPST Clinical Director may not simultaneously serve as the Clinical Director for more than one DBHDS-licensed agency. A Director may, however, oversee both a youth and adult CPST program within the same licensed agency.
- The prior 24/7 on-call LMHP experience threshold was reduced from two years to one year of experience working with individuals with SMI or SED.

4.3 Required LMHP Face-to-Face Contact

- New section in V3 specifying that each 90-day face-to-face contact shall include at least one of: a formal ISP review and update, a clinical reassessment of functional status and progress, or a psychotherapy session. V2 did not specify the content of the required 90-day contact.

4.6 / Attachment 1, Section 3 — Supervision

- The substantive supervision content retained from V2 was moved to Attachment 1, Section 3, and presented in a structured chart format.
- The supervision frequency table in V3 clarifies that the minimum 2-hour monthly individual and group supervision requirement for full-time non-licensed staff includes a minimum of 1 hour of individual supervision. This specificity was not present in V2.
- New language in Attachment 1 (Section 3.4) clarifies the relationship between DHP board-required supervision and CPST supervision requirements: where DHP standards exceed CPST minimums, DHP governs; where CPST standards exceed DHP, CPST governs. Supervision by a board-approved supervisor satisfies CPST requirements only if provided by an LMHP employed by or under contract with the CPST agency.

4.7 / Attachment 1, Section 4 — Staff Caseloads

- New tiered Clinical Director/LMHP Clinical Supervisor caseload caps were introduced based on team composition:

  - 120 cases per month when supervising primarily LMHPs or LMHP-types completing assessment, treatment planning, and psychotherapy.
  - 75 cases per month when supervising primarily QMHPs, QMHP-Ts, or BHTs while directly providing assessment and treatment planning.
  - Up to 100 cases per month for mixed teams, with the cap determined by the Clinical Director based on documented team composition.
- V2 had a single 120-case limit with general guidance that this may be lower depending on team composition. V3 formalizes the lower caps with specific thresholds.
- The non-licensed staff billing cap was raised from 600 to 750 CPST units per calendar month across all employing agencies. Compliance will be assessed on a rolling 6-month average basis.

Section 5. Required Service Components

- The weekly office-based service cap was increased from two hours to three hours per week (Sunday-Saturday). This change applies throughout Sections 5 and 9.

5.1 Assessment

- New provision: A CANS Lifetime assessment completed by another DMAS-enrolled provider within the previous 12 calendar months may be used to satisfy the assessment requirement, subject to conditions including written consent, LMHP attestation, and a documented determination of whether a new assessment is clinically indicated.
- The assessment timing requirement for service authorization was revised: V2 required assessment no more than 30 days prior to starting services. V3 requires assessment within 12 months prior to admission, with an LMHP attestation required if the assessment was completed more than 30 days prior.

5.2 Treatment Planning

- The ISP section was expanded and reorganized into two subsections: 5.2.1 (Individual Service Plan) and 5.2.2 (ISP Reviews and Updates).
- New requirement: The ISP must document the specific EBP protocols and principles incorporated into treatment, including a brief clinical statement for each identifying the responsible professional type and the clinical rationale tied to diagnosis, functional impairments, and CANS Lifetime findings. This level of EBP documentation specificity was not required in V2.
- New provision: The use of a MAP ISP dashboard that includes the required components is considered to meet ISP requirements.
- ISP review: V3 clarifies that the 90-day ISP review shall include a LMHP or LMHP-type (not just the LMHP Clinical Supervisor as stated in V2) along with additional team members, the individual, and family/caregiver when clinically appropriate.

5.3 Crisis Support

- Significantly expanded. V3 adds two subsections: 5.3.1 (Crisis Mitigation Plan and Tiered Crisis Response Approach) and 5.3.2 (Crisis Support Procedures).
- New emphasis: Individuals shall be educated on how to access crisis resources directly, including the 988 Suicide and Crisis Lifeline. The individual's capacity to self-initiate crisis contacts is now a stated goal of crisis support reflected in the crisis mitigation plan.
- New requirement: The crisis mitigation plan must establish the CPST provider as the primary crisis contact and document the individual's understanding that contacting the CPST provider or 988

prior to calling 911 is preferred when safely possible. Nothing in the policy limits an individual's right to contact 911 directly.

- V2 specified that in-person crisis support must be provided prior to any referral to Comprehensive Crisis and Transition Services unless there is an acute crisis with safety concerns. V3 reframes this as a tiered response framework with defined criteria for when an external referral may be made without a prior internal attempt.
- New requirement: When a provider-initiated referral to an external crisis resource is made, the CPST provider must contact the individual's MCO and transmit the current ISP and crisis mitigation plan to the receiving provider at the time of referral.
- The requirement that CPST and affiliated providers not provide Mobile Crisis Response, 23-Hour Crisis Stabilization, or Residential Crisis Stabilization Unit to individuals receiving CPST is retained, with a new exception for Community Services Boards licensed to provide 23-hour or RCSU services.

5.4 Restorative Life Skills Training

- New content: V3 includes an explicit, non-exhaustive list of example Restorative Life Skills Training interventions. This list was not present in V2.
- Telemedicine requirement clarified: V3 specifies that the clinical rationale for telemedicine delivery of restorative life skills shall be documented in both the ISP and the relevant progress note, and telehealth shall not exceed half of the units billed for restorative life skills per week. V2 required documentation that telemedicine was clinically appropriate but did not specify a weekly cap.
- The group delivery limitation (at least half of units provided individually) was retained for Tier 2 only in V3. V2 applied this requirement without a tier distinction.

5.5 Care Coordination

- Enhanced specificity: V3 requires consistent and regular communication not only with the MCO Care Coordinator but also with the Community Services Board Case Manager, when applicable, including updates on progress, changes in Level of Need, and barriers to service access.
- MCO communication: V3 requires timely response to MCO Utilization Management Reviewer requests and specifies that this includes requests to communicate with the LMHP overseeing the case.

Section 7. Provider Qualification Requirements

- Significant new content added throughout. V2 used placeholder language ('To be determined') for DBHDS licensing types and DMAS specialty codes. V3 specifies:
  - DBHDS license types: 03-020 (Adult CPST, Community) and 03-021 (Youth CPST, Community).
  - DMAS provider specialty codes: 926 (Adult) and 925 (Youth).
  - Taxonomy code: 251S00000X.
  - NPI type: Type 1 Organizational NPI associated with the DBHDS license.
- Enrollment submission requirements now specify that providers must include the DBHDS license and the DHP license of the Clinical Director with their enrollment application, and must update the Clinical Director's DHP license within 30 calendar days of any change.
- New DBHDS corrective action plan requirement: Providers must communicate DBHDS Corrective Action Plans to MCOs within 30 calendar days, and MCOs may take network action if appropriate.

- Provider Accreditation (Section 7.3): The 18-month accreditation deadline was reframed. V2 referenced 18 months from July 1, 2026. V3 references 18 months from the effective date of the applicable provider specialty in the DMAS Provider Enrollment System. Ongoing accreditation updates must be submitted to DMAS within 30 calendar days of any change.
- New Section 7.4: Providers must submit staff qualification information to the CEP-VA CPST Finder and keep that information current. This requirement was not present in V2.

Section 8. CPST Medical Necessity Criteria

8.1 / 8.3 Admission Criteria — Assessment Requirements

- CANS Lifetime assessment window expanded: V2 required assessment within 30 days prior to admission. V3 allows assessments completed within 12 calendar months,
- Functional impairment criteria are now presented in a summary table for both Tier 1 and Tier 2, improving navigation and usability. The substantive criteria are unchanged from V2.

8.3 Tier 2 Admission — Intensive Service Criteria

- V3 adds a new clinical pathway for individuals admitted directly to Tier 2 without prior Tier 1 services. V2 required only that Tier 1 was or had been insufficient. V3 also permits direct Tier 2 admission when clinical documentation demonstrates that the severity of functional impairment at the outset requires Tier 2 intensity and Tier 1 would not meet clinical needs.

8.4 Tier 2 Youth Criteria

- Family/caregiver participation requirement reduced from two hours per week to one hour per week. All other youth criteria are unchanged.

8.6 Continued Stay Criteria

- Substantially enhanced. V3 adds a specific enumerated list of objective evidence types required to demonstrate continued benefit. At least one of the following must be documented:
    - Reduction in frequency, duration, or severity of symptoms on a standardized tool.
    - Reduction in crisis contacts, ER visits, hospitalizations, or law enforcement contacts.
    - Improvement in LON score or CANS Lifetime domain scores.
    - Improvement in functional outcomes in at least one ISP goal domain with specific data.
    - Increased engagement with natural supports or self-initiated use of crisis resources.
    - For individuals without measurable improvement: documented clinical evidence of a specific ISP change implemented and measurable improvement expected within 90 days, with a specific outcome target.
- V2 required only that there be a 'reasonable likelihood of continued substantial benefit' without specifying how that must be demonstrated.
- V3 also adds a requirement to consider alternative treatments and services in the instance of limited progress, in addition to the V2 requirements of ISP changes and engagement efforts.

8.7 Step-Down Criteria (NEW)

- V3 introduces a new section (8.7) establishing formal step-down criteria from Tier 2 to Tier 1. This section had no equivalent in V2.

Section 9. Exclusions and Service Limitations

9.2 Admission and Concurrent Services Limitations

- The CPST referral exclusion criteria were modified: V3 adds that individuals who meet criteria for ACT, CSC, FFT, or MST are ineligible for CPST unless those EBP services have failed to address treatment goals adequately, those services are not feasibly accessible for the individual, or the individual expresses reasonable preference to participate in CPST. Any of these exceptions require documentation. V2 did not include the accessibility or preference exceptions.
- Applied Behavior Analysis, Intensive In-home Services, Mental Health Skill Building, Psychosocial Rehabilitation, and Therapeutic Day Treatment were added to the list of services that cannot be simultaneously authorized with CPST. These were not in V2's exclusion list.

9.3 Other Limitations

- Group delivery: V3 specifies that group delivery of CPST services is limited to Psychotherapy and Restorative Life Skills Training only. V2 did not expressly limit which components may be provided in groups.
- Tier 2 group cap: V3 adds that for Tier 2, group delivery of Restorative Life Skills Training may not exceed half of the units of restorative life skills provided with the individual per week.
- Office-based service cap: Increased from two hours to three hours per week (consistent with Section 5).

Section 10. Service Authorization

10.1 General Requirements

- New provisional authorization provision: For individuals with urgent clinical need who cannot complete the CANS Lifetime assessment without clinically inappropriate delay, MCOs or the FFS contractor may issue a provisional authorization for up to 30 calendar days.

10.2 Level of Need and CPST Service Authorization Requests

- V2 stated that the Level of Need model and corresponding units were 'still under development.' V3 provides a complete authorization table specifying: SA timeframe, number of units per authorization, and average weekly hours for each Level of Need from LON 2 through LON 6.
- The table introduces a new short-cycle authorization: a 3-month authorization (102 units) for individuals at LON 2 or 3 with a provisional diagnosis.
- An additional 16 units per month may be requested when psychotherapy is being provided, and those units may only be used for the psychotherapy service component.

10.3 Preservice Authorization

- V3 adds a requirement that the service authorization request form be completed and signed by an LMHP or LMHP-type. V2 did not specify this signature requirement.

Section 11. Additional Documentation Requirements and Utilization Review

- Condensed in V3. The detailed progress note requirements from V2 (items 1-5) were substantially streamlined.

Section 12. CPST Billing Requirements

12.1 General Billing Requirements (NEW)

- V3 introduces a new general billing requirements subsection. Key provisions:
  - Clarifies billing is limited to face-to-face time with the individual or family/caregiver when for the individual's benefit. Exceptions for audio only apply to Care Coordination and Crisis Support.
  - Non-licensed staff billing cap raised to 750 units per calendar month (from 600 in V2).

12.2 / 12.3 Billing Tables

- V3 splits the combined V2 billing table into two separate tables: one for CPST-Adult/Community and one for CPST-Youth/Community.

Attachment 1. Training, Supervision, and Caseloads (NEW)

- Attachment 1 is new in V3. It consolidates and significantly expands content that was distributed across Sections 3, 4, and 4.2 in V2 into a single organized reference document.
- Section 1 (Youth Training): Formalizes MAP credentialing timelines and introduces structured training tables by credential type. Introduces the CPST Intermediate Skills (IS) Curriculum requirement for QMHPs and BHTs.
- Section 2 (Adult Training): Reorganizes adult EBP training requirements into credential-based tables consistent with the youth track. Adds Transdiagnostic CBT to required training options. Adds Illness Management and Recovery to the suggested EBP list.
- Section 3 (Supervision): Consolidates and formalizes supervision requirements into a structured chart. Adds specificity to the 1-hour-of-individual-supervision minimum within the 2-hour monthly supervision requirement for non-licensed staff.
- Section 4 (Caseloads/Supervision of Cases): Formalizes the tiered LMHP case oversight caps by team composition. Introduces the 750-unit non-licensed staff billing cap and specifies rolling 6-month average compliance methodology.
- Section 5 (Reference Charts): Provides five summary reference charts including functional impairment criteria, Level of Need/service authorization standards, supervision requirements, caseload calculations, and staff types by service component

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This summary reflects major substantive content changes only. Readers should consult the full V3 draft for complete policy language.