14 NYCRR Part 512
<u>Express Terms</u>

1. Subdivisions (g), (x) and (z) of Section 512.4 of Title 14 NYCRR are amended and subdivisions (aa) through (al) are renumbered as (z) through (ak) respectively, as follows:

(g) *Collateral* means a person who is:

(1) a significant other or member of the PROS participant's family or household, academic, workplace or residential setting, who regularly interacts with the individual and is directly affected by, or has the capability of affecting, his or her condition; and

(2) identified in the Individualized Recovery Plan, and approved by the individual, as having a role in services and/or is identified in the pre-admission [or pre-registration] notes as being necessary for participation in the evaluation and assessment of the individual prior to admission; and

(3) not a staff member of the PROS program or any other mental health service provider except when the staff member is participating in services in his or her role as the recipient's collateral, and not in his or her staff member role.

(x) *On-Site Program Participation* means the duration of time that [elapses between the time] a PROS participant or collateral <u>is in attendance at</u> [signs in to the PROS program and the time he or she signs out of] the PROS program on a given day.

(1) Scheduled meal periods or planned recreational activities that are not specifically designated as medically necessary in the individual's Individualized Recovery Plan shall be excluded from the calculation of program participation.

(2) Time spent in the program by a collateral shall not be considered on-site program participation if the PROS participant is simultaneously being credited with program participation on a given day.

(z) [*Pre-Registration Status* means the time period that begins when a PROS program submits a PROS registration form on behalf of an individual, and ends on the date on which such registration request is either accepted or denied.

(aa)] *Professional Staff* means members of the clinical staff who are qualified by credentials, training and experience to provide supervision and direct service related to the care or treatment of persons with a designated mental illness diagnosis, and shall include the following:

(1) *creative arts therapist*, which means an individual who is currently licensed as a creative arts therapist by the New York State Education Department or who has a master's degree in a mental health field from a program approved by the New York State Education Department, and registration or certification by the American Art Therapy Association,

American Dance Therapy Association, National Association of Music Therapy or American Association for Music Therapy;

(2) *credentialed alcoholism and substance abuse counselor*, which means an individual who is currently credentialed by the New York State Office of Alcoholism and Substance Abuse Services in accordance with Part 853 of this Title;

(3) *marriage and family therapist*, which means an individual who is currently licensed as a marriage and family therapist by the New York State Education Department;

(4) *mental health counselor*, which means an individual who is currently licensed as a mental health counselor by the New York State Education Department;

(5) *nurse practitioner*, which means an individual who is currently certified as a nurse practitioner by the New York State Education Department;

(6) *nurse practitioner in psychiatry*, which means an individual who is currently certified as a nurse practitioner in psychiatry by the New York State Education Department. For purposes of this Part, nurse practitioner in psychiatry shall have the same meaning as psychiatric nurse practitioner, as defined by the New York State Education Department;

(7) *occupational therapist*, which means an individual who is currently licensed as an occupational therapist by the New York State Education Department;

[(7)](8) *pastoral counselor*, which means an individual who has a master's degree or equivalent in pastoral counseling or is a Fellow of the American Association of Pastoral Counselors;

[(8)](9) *physician*, which means an individual who is currently licensed as a physician by the New York State Education Department;

[(9)](10) *physician's assistant*, which means an individual who is currently registered as a physician's assistant or a specialist's assistant by the New York State Education Department;

[(10) *psychiatric nurse practitioner*, which means an individual who is currently registered as a psychiatric nurse practitioner by the New York State Education Department;]

(11) *psychiatrist*, which means an individual who is currently licensed as a physician by the New York State Education Department and who is certified by, or eligible to be certified by, the American Board of Psychiatry and Neurology;

(12) *psychoanalyst*, which means an individual who is currently licensed as a psychoanalyst by the New York State Education Department;

(13) *psychologist*, which means an individual who is currently licensed as a psychologist by the New York State Education Department. Individuals with at least a master's degree in psychology who do not meet this definition may not be considered licensed practitioners of the healing arts, and may not be assigned supervisory responsibility. However, individuals who have obtained at least a master's degree in psychology may be considered professional staff for the purposes of calculating professional staff and full-time equivalent professional staff;

(14) *registered professional nurse*, which means an individual who is currently licensed as a registered professional nurse by the New York State Education Department;

(15) *rehabilitation counselor*, which means an individual who has either a master's degree in rehabilitation counseling from a program approved by the New York State Education Department or current certification by the Commission on Rehabilitation Counselor Certification;

(16) *social worker*, which means an individual who is currently licensed as a master social worker or clinical social worker by the New York State Education Department. Social workers who do not meet this definition may not be considered licensed practitioners of the healing arts. However, social workers who have obtained at least a master's degree in social work from a program approved by the New York State Education Department may be considered professional staff for the purposes of calculating professional staff and full-time equivalent professional staff;

(17) *therapeutic recreation specialist*, which means an individual who has either a master's degree in therapeutic recreation from a program approved by the New York State Education Department or registration as a therapeutic recreation specialist by the National Therapeutic Recreation Society; and

(18) other staff may be included as professional staff with the prior written approval of the Office, when such individuals have specified training or experience in the care or treatment of individuals diagnosed with mental illness. Such staff may include, but are not limited to, persons who are registered or certified by the United States Psychiatric Rehabilitation Association (USPRA).

[(ab)]<u>(aa)</u> *Program Participation* means a combination of on-site program participation and off-site program participation for a specific individual on a given day.

[(ac)]<u>(ab)</u> *PROS Program or PROS Provider*, unless otherwise specified, means a Comprehensive PROS program or a Limited License PROS program.

[(ad)]<u>(ac)</u> *PROS Unit* is determined by a combination of on-site and off-site program participation and service frequency.

[(ae)]<u>(ad)</u> *Provider of Service* means the entity that is legally responsible for the operation of a PROS program. Such entity may be an individual, partnership, association, limited liability corporation, or corporation.

[(af)](ae) *Recipient Attestation Form* is a form provided to a recipient by a PROS program for him or her to sign when he or she has chosen to participate in one or more components of the PROS program.

[(ag)](af) *Recipient Employee* means an individual who is financially compensated by a provider for providing clinical or non-clinical PROS services in the same program where the individual also receives PROS services.

[(ah)](ag) *Registration* is the process by which individuals are assigned to PROS programs and specific PROS components. The programs with which individuals are registered are recognized by the Office as authorized providers of PROS services for those individuals.

[(ai)](ah) *Registration Date* means the first calendar month for which all PROS components and monthly base rate levels can be billed for Medicaid-eligible individuals.

[(aj)](ai) *Relapse Prevention Plan* means the written identification of a series of actions to be taken in order to prevent decompensation. The overall goal of this plan is to prevent decompensation, and to respond to warning signs early and effectively in order to minimize the likelihood of hospitalization.

[(ak)](aj) *Site* means a location where PROS services are provided on a regular and routine basis, and which is authorized by a PROS operating certificate.

[(al)](ak) *Sponsor* means the provider of service or an entity that substantially controls or has the ability to substantially control the provider of service. For the purpose of this Part, factors used to determine whether there is substantial control shall include, but are not limited to, the following:

(1) the right to appoint and remove directors or officers;

(2) the right to approve bylaws or articles of incorporation;

(3) the right to approve strategic or financial plans for a provider of service; or

(4) the right to approve operating or capital budgets for a provider of service.

2. Paragraph (3) of subdivision (b) of Section 512.7 is amended as follows:

(3) When CRS services are provided in a group format, such group size shall not [exceed], on a routine and regular basis, exceed 12 members. However, on an occasional basis, group sizes of between 13 and 24 members are permissible if the group is co-facilitated by at least two staff members, and there is documentation that the expanded group size is clinically appropriate for the service being provided. Pursuant to section 512.11(b)(13) of this Part, a PROS program may, within the specified limits, [allow group sizes to exceed the 12:1 and 24:2 recipient to staff ratios on an occasional basis, and] still use the service to satisfy the service frequency requirement of section 512.11(b)(11) of this Part for some group participants.

3. Paragraphs (10) and (11) of subdivision (c) of Section 512.7 of Title 14 NYCRR are amended, and paragraphs (12), (13) and (14) are renumbered as (11), (12), and (13), respectively, as follows:

(10) Upon admission of an individual and the completion of the Recipient Attestation Form, the PROS program shall complete and submit a PROS registration form, using the registration system approved by the Office.

(i) Such registration process must include the identification of the specific PROS program components in which the individual will be participating.

(ii) Individuals may register in multiple PROS programs for unduplicated components of service. However, in no event shall an individual be registered for Clinical Treatment only.

[(iii) An individual shall be considered to be in pre-registration status until the registration request on behalf of the individual is either accepted or denied, effective on the date provided by the Office.

(11) While an individual is in pre-registration status, he or she is eligible to receive any clinically appropriate services.

(12)](11) The PROS admission date for an individual shall be the date that the PROS program submits a completed registration pursuant to paragraph (10) of this subdivision.

[(13)](12) Upon confirmation of acceptance of the registration request on behalf of an individual, such individual shall be considered registered in the PROS program, effective on the date provided by the Office. Individuals who are registered in a PROS program are not restricted to the limitations of pre-admission [and pre-registration] billing pursuant to section 512.11(e) of this Part.

[(14)](13) If a registration request on behalf of an individual is denied, such individual shall be discharged from the PROS program. The discharge summary shall identify any referrals made to other programs or services.

4. Paragraph (7) of subdivision (d) of Section 512.7 of Title 14 NYCRR is amended to read as follows:

(7) PROS providers shall maintain an adequate and appropriate number of staff in proportion to the number of individuals served. Providers shall be deemed to have met such standard if their staffing ratios, based on average attendance, are at least in accordance with the following:

(i) for CRS, a ratio of one clinical staff member to every 12 individuals receiving CRS group services;

(ii) for IR, a ratio of one clinical staff member to every eight individuals receiving IR group services:

(iii) for ORS, a case load of no more than 22 individuals per clinical staff member; and

(iv) for comprehensive PROS programs with clinical treatment, the following additional standards shall apply:

(*a* PROS staffing must include a minimum of .125 FTE psychiatrist and .125 FTE registered professional nurse for every 40 individuals receiving clinical treatment services; and

(*b*) additional psychiatry, nursing and other staff shall be included, as necessary, to meet the volume and clinical needs of persons receiving clinical treatment services;

(v) Programs may use [psychiatric] nurse practitioners in psychiatry to partially offset the requirement for psychiatrist coverage pursuant to clause (iv)(*a*) of this paragraph, consistent with the following requirements:

(*a*) all programs must maintain a minimum .125 FTE psychiatrist;

(*b*) after having met the minimum .125 FTE psychiatrist required in clause (*a*) of this subparagraph, programs may elect to substitute [psychiatric] nurse practitioner in psychiatry FTE for the additional required psychiatrist FTE at a ratio not to exceed 50 percent of the total psychiatry requirement;

(*c*) programs must ensure clinical collaboration between the [psychiatric] nurse practitioner in psychiatry and a psychiatrist who is employed by the sponsor, consistent with New York State Education Law governing the licensure of nurse practitioners;

(*d*) nurse practitioners used to offset required psychiatrist staffing must be certified as [psychiatric] nurse practitioners in psychiatry;

(*e*) [all IRPs developed by the psychiatric nurse practitioners must also be signed by a psychiatrist who is a member of the PROS staff;

(*f*) psychiatric] nurse practitioner in psychiatry FTE may not be used to simultaneously satisfy the nurse staffing requirement pursuant to clause (iv)(*a*) of this paragraph, and to offset the psychiatrist staffing requirement.

5. Section 512.8 is amended to read as follows:

(a) Case records.

(1) There shall be a complete case record maintained for each person admitted to a PROS program. Such case record shall be maintained in accordance with recognized and acceptable principles of record keeping as follows:

(i) any case record entries shall be legible and non-erasable;

(ii) case records shall be periodically reviewed for quality and completeness; and

(iii) all entries in case records shall be dated and signed by appropriate staff.

(2) The case record shall be available to all staff who are providing services to the individual, and to any staff who have need for access, consistent with state and federal confidentiality requirements.

(3) The case record shall include the following information:

(i) any pre-admission screening [or pre-registration] notes;

(ii) identifying information and history;

(iii) mental illness diagnosis;

(iv) required assessments;

(v) for individuals receiving Clinical Treatment component services from the PROS program, an assessment of the individual's psychiatric and physical needs, and dated and signed records of all medications prescribed;

(vi) reports of any mental and physical diagnostic exams, tests and consultations;

(vii) screening and admission note;

(viii) attestation form;

(ix) the Individualized Recovery Plan (IRP), IRP service addition form, and all reviews of the IRP;

(x) [record of service] documentation satisfying the requirements in subdivision (d) of this section;

(xi) dated progress notes;

(xii) [individual contact notes;

(xiii)] any referrals to other programs and services;

[(xiv)](xiii) any consent forms; and

[(xv)](xiv) discharge plan and/or summary, as appropriate.

(4) Case records may include relevant history and assessment documents completed by other providers of service.

(5) For persons who are discharged from a PROS program and referred to another provider, the discharge summary shall be transmitted to the receiving program within two weeks.

(6) Case records shall be retained for a minimum of six years following an individual's discharge from the program.

(b) Individualized recovery plan (IRP).

(1) Each individual's IRP shall include, at a minimum, the following:

(i) a description of the individual's strengths and challenges related to program participation as identified by any screenings and assessments conducted by the PROS program;

(ii) a statement of the individual's recovery goals and program participation objectives;

(iii) identification of the barriers, due to the individual's mental illness, that are preventing the achievement of the individual's recovery goals;

(iv) an individualized course of action to be taken, including the specific services to be provided, the expected frequency of service delivery, the expected duration of the course of service delivery, and the anticipated outcome;

(v) for individuals receiving IR, ORS or clinical treatment services, the IRP shall identify the reasons why these services are needed, in addition to the CRS services, to achieve the individual's recovery goals[.];

(vi) criteria to determine when goals and objectives have been met so that the individual can move forward in his or her recovery process;

(vii) the identification of any collaterals who will assist the individual in his or her recovery;

(viii) a relapse prevention plan, which includes a description of the individual's preferences regarding treatment in the event of a crisis;

(ix) any other advance directives or preferences expressed by the individual;

(x) description and goals of any linkage and coordination activities with other service providers;

(xi) for PROS participants receiving treatment services from a clinic licensed pursuant to Part 587 of this Title, a description of how such services are integrated with the individual's IRP; and

(xii) signature as follows:

*(a)* the PROS participant's signature;

*(b)* the signature of the clinical staff member who prepared the IRP;

*(c)* if the clinical staff member who prepared the IRP is not a member of the professional staff, the signature of the professional staff member supervising or participating in the IRP process shall also be included; and

*(d)* for persons receiving clinical treatment, the IRP shall include a physician's signature or the signature of a [psychiatric] nurse practitioner in psychiatry.

(2) The inclusion of all required staff's signatures on the IRP is a representation that the identified PROS services are deemed to be medically necessary.

(3) An IRP is considered completed when all required staff signatures are provided. The latest date of signature is the IRP's official completion date.

(4) Services may be provided on an interim basis and be considered part of the IRP by completing a service addition form. The IRP must be modified no later than the last day of the month following the month in which the service addition form was completed. The service addition form must include the following:

(i) the name of the service(s) to be provided and the reason for the service(s) addition;

(ii) the signature of the individual and a member of the clinical staff; and

(iii) the signature of the psychiatrist [and] or [psychiatric] nurse practitioner in psychiatry if the service is a clinic treatment service.

(c) Progress notes.

(1) Progress notes shall be maintained for each individual and shall be dated, signed by a clinical member of the PROS program staff, and indicate the period of time covered by the note.

(2) Progress notes shall include, at a minimum:

(i) a summary of services received subsequent to the last progress note;

(ii) a description of the progress made toward the goals identified in the IRP subsequent to the last progress note; and

(iii) identification of any necessary changes to the IRP and services related to such changes.

(3) Progress notes shall be completed, at a minimum, [two times] <u>once</u> each month.

(4) A progress note must also be completed for any significant event and/or unexpected incident.

(d) Supporting documentation.

(1) The PROS program shall maintain [a record of service for each individual] <u>documentation for each participant</u> indicating:

(i) <u>duration of</u> onsite and off-site program participation per day;

(ii) types and numbers of PROS services provided per day;

(iii) number of PROS units accrued per day; and

(iv) total PROS units accumulated per month verified by the signature of a staff member.

(2) The PROS program shall maintain documentation that supports the duration of program participation identified pursuant to subparagraph (1)(i) of this subdivision. Daily sign-in/sign-out sheets shall be used to satisfy this requirement for on-site program participation and shall include:

(i) proram name;

(ii) date;

(iii) recipient or collateral name;

(iv) time in;

(v) time out;

(vi) signature or initials of recipient or collateral; and

(vii) staff signature.

(3) In the event that a recipient or collateral fails to sign-in or sign-out of the program, pursuant to paragraph (2) of this subdivision, on a day in which he or she has otherwise participated in the PROS program, a staff member shall provide a written, signed explanation as to why the required information is missing from the daily sign-in/sign-out sheet. In this instance, the provider may rely on alternative modes of supporting documentation to verify the duration of program participation.

(4) The PROS program shall maintain documentation that supports individuals' attendance in structured skill development and support and other group activities. Group attendance sheets shall be used to satisfy this requirement and shall include:

(i) program name;

(ii) date;

(iii) location of service (on-site or off-site);

(iv) type of activity;

(v) names of recipients and collaterals; and

(vi) signature of the staff member who provided the service, verifying that the individual received the service and the minimum service duration was met, pursuant to section 512.11(b)(12)(i) of this Part.

(5) The PROS program shall maintain documentation supporting the delivery of services in an individual modality. Contact notes shall be used to satisfy this requirement and shall include:

(i) program name;

(ii) date;

(iii) location of service (on-site or off-site);

(iv) name of recipient or collateral;

(v) brief description of service provided; and

(vi ) signature of the staff member who provided the service, verifying that the individual received the service and the minimum service duration was met, pursuant to section 512.11(b)(12)(ii) of this Part.

(6)] The PROS program shall maintain a daily program schedule that includes scheduled meal periods and planned recreational activities.

6. Subdivisions (a) through (g) of Section 512.11 are amended as follows:

(a) General reimbursement requirements for PROS providers.

(1) Reimbursement shall be made only for individuals who:

(i) are in pre-admission status pursuant to section 512.7(c)(4) of this Part;

(ii) [are in pre-registration status pursuant to section 512.7(c)(10) of this Part;

(iii)] are registered in a PROS program pursuant to section 512.7(c)(13) of this Part; or

[(iv)](iii) are collaterals of persons who are registered in a PROS program, or are in [pre-registration or] pre-admission status.

(2) [An individual's registration date is the first month for which all PROS components and monthly base rate levels can be billed. The registration date is determined as follows:

(i) Individuals who are not currently registered in a PROS program and whose registration request is received on or before the 15th of the calendar month will be registered for that month.

(ii) Individuals who are not currently registered in a PROS program and whose registration request is received after the 15th of the calendar month will be registered for the following calendar month.

(iii) Individuals who are transferring from one PROS program to another PROS program and whose registration request from the new PROS program is received on or before the 15th of the calendar month will be registered for the following calendar month.

(iv) Individuals who are transferring from one PROS program to another PROS program and whose registration request from the new PROS program is received after the 15th of the calendar month will be registered for the month following the next calendar month.

(v) If more than one PROS provider attempts to register an individual who is not currently registered in a PROS program, the first registration request received on or before the 15th of the calendar month shall be accepted.

(vi) If more than one PROS provider attempts to register an individual who is currently registered in a PROS program, the last registration request received on or before the 15th of the calendar month shall be accepted.

(vii) The registration rules identified in this paragraph apply separately to each PROS program component.

(3)] Unless an individual is registered with a PROS program pursuant to section 512.7(c)[(13)](12) of this Part, reimbursement is limited to the Pre-Admission[/Pre-Registration] Monthly Base Rate, consistent with section 512.12(e) of this Part.

[(4)](3) For purposes of reimbursement for individuals enrolled in Medicaid managed care, a PROS program is considered to be a carved-out service.

[(5)](4) When available and appropriate, PROS providers shall maximize the use of funding from the Office of Vocational and Educational Services for Individuals with Disabilities (VESID). Time spent in such funded activities shall not be included in the duration of program participation pursuant to paragraph (b)(4) of this section.

[(6)](5) In order to be eligible for reimbursement, any PROS service provided to a PROS participant in the participant's employment setting and any ORS service shall be on a one-to-one basis.

(b) Reimbursement for comprehensive PROS programs.

(1) A Comprehensive PROS program shall be reimbursed on a monthly case payment basis.

(2) The reimbursement structure for a Comprehensive PROS program consists of the following four elements:

(i) Monthly base rate;
(ii) IR component add-on;
(iii) ORS component add-on; and
(iv) Clinical Treatment component add-on.

(3) The basic measure for the PROS monthly base rate is the PROS unit. PROS units are accumulated during the course of each day that the individual participates in the PROS program, and are aggregated up to a monthly total to determine the amount of the PROS monthly base rate that can be billed for the individual during a particular month.

(4) The PROS unit is determined by the duration of program participation, which includes a combination of on-site and off-site program participation, as defined in section 512.4 of this Part, and service frequency, as defined in paragraph (6) of this subdivision. The PROS unit approach supports the billing concept of a "modified threshold visit."

(5) Program participation is measured and accumulated in 15 minute increments. Increments of less than 15 minutes must be rounded down to the nearest quarter hour to determine the program participation for the day.

(6) Service frequency is the number of medically necessary PROS services delivered to an individual or collateral during the course of a program day. Notwithstanding paragraph 512.4(x)(2) of this Part, services to collaterals may be included in the calculation of service frequency.

(7) Medically necessary PROS services include:

(i) assessment services;

(ii) crisis intervention services;

(iii) engagement services;

(iv) individualized recovery planning services;

(v) pre-admission screening services provided during pre-admission status and documented in a pre-admission screening note;

(vi) services delineated in the screening and admission note pursuant to section 512.7(c)(7) of this Part, which are provided subsequent to the individual's admission date, but prior to the completion of the initial IRP, and documented in [a pre-registration] <u>the progress</u> note; and

(vii) services identified in, and provided in accordance with, the individual's IRP.

(8) If a recipient employee provides a medically necessary service to other participants in the PROS program, such service may be included in the calculation of PROS units for such participants, as applicable. However, such service may not be included in the calculation of PROS units for the recipient employee.

(9) In order to accumulate any PROS units for a day, a PROS program must deliver a minimum of one medically necessary PROS service to an individual or collateral during the course of the day.

(10) PROS units are accumulated in intervals of 0.25. The maximum number of PROS units per individual per day is five.

(11) The formula for accumulating PROS units during a program day is as follows:

(i) If one medically necessary PROS service is delivered, the number of PROS units is equal to the duration of program participation, rounded down to the nearest quarter hour, or two units, whichever is less.

(ii) If two medically necessary PROS services are delivered, the number of PROS units is equal to the duration of program participation, rounded down to the nearest quarter hour, or four units, whichever is less.

(iii) If three or more medically necessary PROS services are delivered, the number of PROS units is equal to the duration of program participation, rounded down to the nearest quarter hour, or five units, whichever is less.

(12) To satisfy the service frequency requirement of paragraph (11) of this subdivision, services must be provided in accordance with the following:

(i) services provided in a group format shall be at least 30 minutes in duration; and

(ii) services provided in an individual modality shall be at least 15 minutes in duration.

(13) When a medically necessary CRS service is provided in a group format, such service shall not be used to satisfy the service frequency requirement of paragraph (11) of this subdivision for[:

(i)] more than 12 members of the group per each participating staff member[; or

(ii) any members of the group, in the event that the group size exceeds 15 members per each participating staff member].

(14) To determine the monthly base rate, the daily PROS units accumulated during the calendar month are aggregated and translated into one of five payment levels, in accordance with section 512.12(e) of this Part.

(15) A minimum of two PROS units must be accrued for an individual during a calendar month in order to bill the monthly base rate.

(c) Reimbursement for component add-ons in comprehensive PROS programs.

(1) The three component add-ons pursuant to paragraph (b)(2) of this section are provided in recognition that certain activities involve increased costs due to their intensity or the need for specialized staff expertise.

(i) Up to two component add-ons may be billed per individual per month.

(ii) In no event shall an ORS component add-on and an IR component add-on be billed in the same month for the same individual.

(iii) Component add-ons shall not be billed prior to the calendar month in which the individual is registered with the PROS program.

(2) Intensive Rehabilitation.

(i) In order to bill the IR component add-on, an individual must have received at least six PROS units during the month, including at least one IR service, as identified in section 512.7(b)(4) of this Part.

(ii) When a medically necessary IR service, other than Family Psychoeducation, is provided in a group format, such service shall not be used to satisfy the service frequency requirement of paragraph (11) of this subdivision, or the IR service requirement of subparagraph (i) of this paragraph, for[:

(*a*)] more than eight members of the group[;

(*b*) any members of the group, in the event that the group size exceeds 10 members].

(iii) When a medically necessary Family Psychoeducation IR service is provided in a group format, such service shall not be used to satisfy the service frequency requirement of paragraph (11) of this subdivision, or the IR service requirement of subparagraph (i) of this paragraph, for[:

(*a*)] more than 16 members of the group[;

(*b*) any members of the group, in the event that the group size exceeds 20 members].

(iv) Medicaid may reimburse the IR component add-on for up to 50 percent of a provider's total number of monthly base rate bills submitted annually.

(v) In instances where a Comprehensive PROS program provides IR services to an individual, but CRS services are provided by another provider of service or no CRS services are provided in the month, the Comprehensive PROS provider shall submit an IR-only bill. When an IR-only bill is submitted, the minimum six PROS units required pursuant to subparagraph (i) of this paragraph shall be limited to the provision of IR services.

(3) Ongoing Rehabilitation and Support

(i) PROS programs may only bill the ORS component add-on for individuals who work in an integrated competitive job for a minimum of [15]10 hours per week. However, to allow for periodic absences due to illness, vacations, or temporary work stoppages, individuals who are scheduled to work at least [15]10 hours per week and have worked at least one week within the month for [15]10 hours qualify for reimbursement.

(ii) A minimum of two face-to-face contacts with the individual and/or identified collateral, which include ongoing rehabilitation and support services, must be provided per month. A minimum contact is 30 continuous minutes in duration. At least two of the face-to-face contacts must occur on separate days. A contact may be split between the individual and the collateral. At least one visit per month shall be with the individual only.

(iii) In instances where a Comprehensive PROS program provides ORS services to an individual, but CRS services are provided by another provider of service or no CRS services are provided in the month, the Comprehensive PROS provider shall submit an ORS-only bill. Notwithstanding paragraph (b)(15) of this section, the minimum service requirement for submission of an ORS-only bill shall be consistent with subparagraph (ii) of this paragraph.

(4) Clinical Treatment

(i) In order to bill the Clinical Treatment add-on, a minimum of one Clinical Treatment service, as identified in section 512.7(b)(9) of this Part, must be provided during the month.

(ii) Individuals receiving Clinical Treatment must have, at a minimum, one face-to-face contact with a psychiatrist or [psychiatric] nurse practitioner in psychiatry every three months, or more frequently as clinically appropriate. Such contact during any of the first three calendar months of the individual's admission will enable billing for the month of contact, any preceding months in which the client has been registered with the PROS program, and the two months following the month of contact. Thereafter, each month that contains a contact with a psychiatrist or [psychiatric] nurse practitioner in psychiatry will enable billing for that month and the next two months.

(iii) The Clinical Treatment component may only be reimbursed in conjunction with the monthly base rate and/or the Intensive Rehabilitation or Ongoing Rehabilitation and Support add-on.

(iv) If it is clinically appropriate to deliver a Clinical Treatment service in a group format, the group size limitations for CRS services in sections 512.7(b)(3) and 512.11(b)(13) of this Part shall apply.

(d) Reimbursement for limited license PROS programs.

(1) A Limited License PROS program shall be reimbursed on a monthly case payment basis.

(2) A Limited License PROS program may be reimbursed in a given month for either one monthly IR component or one monthly ORS component per individual.

(3) To bill the IR component on behalf of an individual, the individual must participate in at least six hours of IR services per month.

(4) To bill the ORS component on behalf of an individual, notwithstanding paragraph (b)(15) of this section, a minimum of two face-to-face contacts per month must be provided. A minimum contact is 30 continuous minutes in duration. At least two of the face-to-face contacts must occur on separate days.

(5) PROS programs may only bill the ORS component for individuals who work in an integrated competitive job for a minimum of [15]10 hours per week. However, to allow for periodic absences due to illness, vacations, or temporary work stoppages, individuals who are scheduled to work at least [15]10 hours per week and have worked at least one week within the month for [15]10 hours qualify for reimbursement.

(e) Reimbursement for pre-admission [and pre-registration] program participation.

(1) Reimbursement for individuals who are in continuous pre-admission status is limited to two consecutive months, whether or not the individual is ultimately admitted to the program.

(i) If pre-admission program participation occurs in the month preceding the month of admission, reimbursement cannot exceed the Pre-Admission[/Pre-Registration] Monthly Base Rate pursuant to subdivision 512.12(e) of this Part.

(ii) If pre-admission program participation occurs during the month of admission, but the individual has not been registered in the PROS program during that month, reimbursement cannot exceed the Pre-Admission[/Pre- Registration] Monthly Base Rate pursuant to section 512.12(e) of this Part.

[(iii)]<u>(2)</u> If pre-admission program participation occurs during the month of admission, [and the individual has been registered in the PROS program during that month,] the pre-admission program participation may be included in the total number of PROS units accumulated during the calendar month.

[(2) Reimbursement for individuals who are in pre-registration status pursuant to section 512.7(c)(10) of this Part is limited to the month of admission, and the month following admission.

(i) If pre-registration program participation occurs in the calendar month of admission, but the individual has not been registered in the PROS program during that month, reimbursement cannot exceed the Pre-Admission/Pre-Registration Monthly Base Rate pursuant to section 512.12(e) of this Part.

(ii) If pre-registration program participation occurs during the month following admission, but the individual has not been registered in the PROS program during that month, reimbursement cannot exceed the Pre-Admission/Pre-Registration Monthly Base Rate pursuant to section 512.12(e) of this Part.

(iii) If pre-registration program participation occurs during the month of registration, the pre-registration program participation may be included in the total number of PROS units accumulated during the calendar month.]

(3) In no event shall the use of the Pre-Admission[/Pre-Registration] Monthly Base Rate exceed two consecutive months per individual.

(f) Co-enrollment limitations.

(1) General rules.

(i) When an individual is registered in a PROS program, Medicaid reimbursement for participation in other community-based programs may be limited, depending upon the level of PROS participation and the category of the community-based program. This subdivision

describes the conditions under which Medicaid will pay for those services.

(ii) If an individual is in pre-admission [or pre-registration] status pursuant to subdivision 512.7(c) of this Part, the co-enrollment limitations described in this subdivision are not applicable. This exception shall be limited to two consecutive calendar months for each pre-admission [or pre-registration] episode.

(iii) When co-enrollment is otherwise permitted by this Part, participation in multiple programs may occur on the same day.

(iv) In some instances, the PROS registration system can be used to enforce the co-enrollment rules described in this subdivision. In those circumstances, the registration system precludes initial payment to providers other than the PROS provider with whom an individual is registered. In circumstances in which the PROS registration system cannot be used to enforce the co-enrollment rules described in this subdivision, any post-payment recoveries will be conducted pursuant to subdivision (g) of this section.

(v) If an individual is registered in a Medicaid-eligible program that has a restriction/exception code or a Medicaid coverage code in the Welfare Management System and the New York State Department of Health has designated the program as not eligible for co-enrollment with the PROS program, the PROS program shall not receive reimbursement.

(2) Multiple PROS programs. Medicaid may reimburse for unduplicated components of service provided to an individual in a given month in multiple PROS programs. However, Medicaid shall not reimburse an IR component and an ORS component in a given month for the same individual.

(3) OMH-Licensed or OMRDD-licensed Clinic and PROS Program.

(i) Medicaid shall not reimburse for both Clinical Treatment services provided to an individual in a given month in the Clinical Treatment component of a Comprehensive PROS program and a clinic licensed pursuant to Part 587 or Part 679 of this Title.

(ii) Medicaid may reimburse for services provided to a PROS participant in a given month in a clinic, only if the clinic provider and the PROS provider are not operated by the same sponsor, and the individual is not registered in the PROS Clinical Treatment component.

(iii) Medicaid may reimburse for services provided to an individual in a given month in both a Limited License PROS program and a clinic licensed pursuant to Part 587 or Part 679 of this Title.

(4) OMH-Licensed Continuing Day Treatment (CDT) Program and PROS Program.

(i) Medicaid shall not reimburse for both services provided to an individual in a given month in a Comprehensive PROS program and a CDT program licensed pursuant to Part 587 of this Title.

(ii) Medicaid may reimburse for the IR or ORS components of service provided to an individual in a given month in a Limited License PROS program and for services provided in a CDT program licensed pursuant to Part 587 of this Title only if the CDT provider and the PROS provider are not operated by the same sponsor.

(5) OMH-Licensed Partial Hospitalization (PH) Program and PROS Program. Medicaid may reimburse for services provided to an individual in a given month in both a PROS program and a PH program licensed pursuant to Part 587 of this Title.

(6) OMH-Licensed Intensive Psychiatric Rehabilitation Treatment Program (IPRT) and PROS Program. Medicaid shall not reimburse for both services in a given month provided in a PROS program and an IPRT.

(7) OMH-Licensed Assertive Community Treatment (ACT) Program and PROS Program.

(i) Medicaid may reimburse for services provided to an individual in both a Comprehensive PROS program and an ACT program for no more than three months within any twelve-month period.

(ii) Medicaid reimbursement of the PROS provider shall be limited to Level 1, 2 or 3 of the PROS Monthly Base Rate.

(iii) Medicaid reimbursement of the ACT provider shall be limited to the supportive level payment rate or the intensive level partial payment rate, pursuant to section 508.5(b) of this Title.

(8) Intensive, Supportive or Blended Case Management (ICM/SCM/BCM) Program and PROS Program. Medicaid may reimburse for services in a given month provided in both a PROS program and an ICM/SCM/BCM program.

(9) Pre-paid Mental Health Plan (PMHP) Program and PROS Program. Medicaid shall not reimburse for both services in a given month provided in a PROS program and a PMHP program.

(10) OMRDD-sponsored Pre-vocational or Supported Employment Services and PROS Program.

(i) Medicaid shall not reimburse for both services provided to an individual in a given month in the IR component of a PROS program and pre-vocational or supported employment services pursuant to section 635-10.4(c) of this Title.

(ii) Medicaid shall not reimburse for both services provided to an individual in a given month in the ORS component of a PROS program

and pre-vocational or supported employment services pursuant to section 635-10.4(c) of this Title.

(11) OMRDD-sponsored Day Services and PROS Program. When medically necessary, Medicaid may reimburse for services provided to an individual in a given month in both OMRDD-licensed day treatment programs pursuant to Part 690 of this Title or OMRDD-sponsored day habilitation services pursuant to paragraph 635-10.4(b)(2) of this Title and a PROS program. Medicaid reimbursement of a Comprehensive PROS provider shall be limited to Level 1 or 2 of the PROS Monthly Base Rate.

(12) DOH-Licensed Outpatient Program and PROS Program.

(i) Medicaid shall not reimburse for any mental health services provided in a given month in an outpatient program licensed pursuant to Article 28 of the Public Health Law to an individual who is registered in a PROS program.

(ii) This paragraph is not applicable to outpatient programs that are licensed by both OMH and DOH.

(g) Post-payment audits and recoveries.

(1) In circumstances in which the PROS registration system cannot be used to enforce the co-enrollment rules pursuant to subdivision (f) of this section, or other reimbursement limitations described in this Part, providers will be subject to post-payment audits and recoveries in accordance with this subdivision.

(2) If Medicaid provided reimbursement to a PROS program that was not authorized pursuant to subparagraph (c)(2)(iv) of this section, the program is not entitled to retain Medicaid reimbursement for the IR component add-on in excess of the 50 percent limit.

(3) If Medicaid provided reimbursement to a PROS program and/or a clinic program that was not authorized pursuant to paragraph (f)(3) of this section, and both the PROS program and the clinic program are operated by the same sponsor:

(i) If both programs received reimbursement for the same individual, the clinic program is not entitled to retain any of the funds paid to the clinic program on behalf of that individual.

(ii) If only the clinic program received reimbursement for an individual who is registered in the PROS program, the clinic program is not entitled to retain any of the funds paid to the clinic program on behalf of that individual in excess of the amount of the PROS Clinical Treatment component add-on, described in paragraph 512.12(e)(1) of this Part.

(4 If Medicaid provided reimbursement to both a PROS program and a CDT program operated by the same sponsor that was not authorized pursuant to paragraph (f)(4) of this section, the CDT program is not entitled to retain any of the funds paid to the CDT program in a given month on behalf of the same individual.

(5) If Medicaid provided reimbursement to both a PROS program and an IPRT program operated by the same sponsor that was not authorized pursuant to paragraph (f)(6) of this section, the IPRT program is not entitled to retain any of the funds paid to the IPRT program in a given month on behalf of the same individual.

(6) If Medicaid provided reimbursement to a PROS program and an ACT program that are not authorized pursuant to paragraph (f)(7) of this section, such providers are not entitled to retain such reimbursement as follows:

> (i) If reimbursement to the PROS provider exceeds three months within a 12-month period, the PROS provider is not entitled to retain any reimbursement in excess of three months.
>
> (ii) If reimbursement to the PROS provider exceeds Level 3 of the Monthly Base Rate, the PROS provider is not entitled to retain any amounts in excess of Level 3 of the Monthly Base Rate.
>
> (iii) If reimbursement to the ACT provider exceeds the supportive level payment rate or the intensive level partial payment rate, the ACT provider is not entitled to retain any funds paid to the ACT provider in excess of the allowable payment.

(7) If Medicaid provided reimbursement to a PROS program and a PMHP program that was not authorized pursuant to paragraph (f)(9) of this section, the PMHP program is not entitled to retain the equivalent of any funds paid to the PROS provider, up to the amount paid to the PMHP provider on behalf of the same individual.

(8) If Medicaid provided reimbursement to a PROS program and an OMRDD-sponsored pre-vocational or supported employment program that was not authorized pursuant to paragraph (f)(10) of this section, the PROS provider is not entitled to retain the IR or ORS component add-on.

(9) If Medicaid provided reimbursement to a PROS program and an OMRDD-sponsored day program that was not authorized pursuant to paragraph (f)(11) of this section, the PROS provider is not entitled to retain any amounts in excess of Level 2 of the Monthly Base Rate.

(10) If Medicaid provided reimbursement to a PROS program and a DOH-licensed program that was not authorized pursuant to paragraph (f)(12) of this section, the DOH-licensed program is not entitled to retain any of the funds paid to the DOH-licensed program for mental health services on behalf of that individual.

(11) In the event that the PROS registration system fails to enforce the reimbursement limitations pursuant to this Part, the State reserves the right to recover any duplicative or improper payments.

7. Section 512.12 of Title 14 NYCRR is amended to read as follows:

(a) Rates of payment shall be established on a prospective basis.

(b) Each rate of payment established pursuant to this section shall be a monthly rate determined by the [commissioner] Commissioner and approved by the Division of the Budget.

(c) For purposes of this section, the Downstate Region shall mean the following counties: Bronx, Kings, New York, Queens, Richmond, Nassau, Putnam, Rockland, Suffolk and Westchester.

(d) For purposes of this section, the Upstate Region shall mean those counties of New York State that are not listed in subdivision (c) of this section.

(e) [The]Effective April 1, 2008, the monthly base rate and component add-on schedules for PROS programs are as follows:

(1) Comprehensive PROS programs:

(i) for programs operated in the Downstate Region:

| Monthly Base Rate* | | | | | | Component Add-On | | |
|---|---|---|---|---|---|---|---|---|
| Pre-Adm[/Pre-Reg] | Level 1 2-12 Units | Level 2 13-27 Units | Level 3 28-43 Units | Level 4 44-60 Units | Level 5 61+ Units | IR | ORS | CT |
| $[150] 155 | $[200] 206 | $[433] 447 | $[666] 687 | $[866] 894 | $[1052] 1,086 | $[406] 419 | $[348] 359 | $244.51 |

* The Monthly Base Rate is determined by the total PROS units associated with a single PROS participant and his or her collateral(s) in a given month.

(ii) for programs operated in the Upstate Region:

| Monthly Base Rate* | | | | | | Component Add-On | | |
|---|---|---|---|---|---|---|---|---|
| Pre-Adm[/Pre-Reg] | Level 1 2-12 Units | Level 2 13-27 Units | Level 3 28-43 Units | Level 4 44-60 Units | Level 5 61+ Units | IR | ORS | CT |
| $[137] 141 | $[182] 188 | $[394] 407 | $[606] 625 | $[787] 812 | $[957] 988 | $[369] 381 | $[317] 327 | $244.51 |

* The Monthly Base Rate is determined by the total PROS units associated with a single PROS participant and his or her collateral(s) in a given month.

(2) Limited license PROS programs:

(i) for programs operated in the Downstate Region:

| Reimbursement Category | Monthly Fee |
| --- | --- |
| Intensive Rehabilitation | $[464]479 |
| Ongoing Rehabilitation and Support | $[383]395 |

(ii) for programs operated in the Upstate Region:

| Reimbursement Category | Monthly Fee |
| --- | --- |
| Intensive Rehabilitation | $[422]436$[422]436 |
| Ongoing Rehabilitation and Support | $[348]359 |

(f) Hospital-based providers may receive an add-on to their monthly case payment that reflects their capital costs. The [commissioner] Commissioner may impose a cap on the revenues generated from this rate add-on.

(1) For PROS programs operated by providers licensed pursuant to Article 28 of the Public Health Law, there shall be added an allowance for the cost of capital, which shall be determined by the application of the principles of cost-finding for the Medicare program. No capital expenditure for which approval by the Office is required under the applicable provisions of the Mental Hygiene Law or Part 551 of this Title shall be included in allowable capital costs for purposes of rate computation unless such approval has been secured.

(2) Allowable capital expenditures shall not include costs specifically excluded pursuant to Section 2807-c of the Public Health Law.

(3) The capital payment per service month for a provider's PROS licensed outpatient mental health programs shall be determined by dividing all allowable capital costs of the provider's PROS programs, after deducting any exclusions, by the annual number of service months for all enrollees of the PROS program.

512.TEXT.1.8.10