NEW YORK STATE OF OPPORTUNITY. Office of Mental Health

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MEMORANDUM

TO: Mainstream Medicaid Managed Care Plans (MMCPs), Health and Recovery Plans (HARPs), HIV Special Needs Plans (HIV SNPs), and Medicaid Advantage Plus (MAP) Plans (herein collectively referred to as "MMCPs"), Personalized Recovery Oriented Services (PROS) Providers

FROM: New York State (NYS) Office of Mental Health (OMH)

DATE: April 16, 2024

SUBJECT: PROS Redesign: Billing and Reimbursement Changes

Dear Health Plan Administrator,

On December 28, 2023, NYS submitted the proposed State Plan Amendment (SPA) #23-0098 to the Center for Medicaid and Medicare Services (CMS) to implement a PROS program redesign which will also result in billing and reimbursement changes. The proposed effective date of the SPA is on or after July 1, 2024. The purpose of this memorandum is to provide an overview of the forthcoming billing and reimbursement changes to allow MMCPs and PROS program providers time to plan and implement the necessary configurations and adjustments needed to accommodate the statutorily required payment of government rates and other billing changes. As of the date of this memo, the SPA is pending review and approval from CMS.

Note: All proposed changes to the program and reimbursement model as outlined below and in the SPA are subject to final approval by the Division of Budget (DOB) and CMS. NYS will issue an additional notification to MMCPs and PROS providers upon DOB approval and changes will be effectuated 90 days from DOB approval.

I. PROS Redesign Background

Over the last three years, OMH has worked collaboratively with stakeholders to redesign and modernize the PROS model. This programmatic and reimbursement redesign is intended to respond to the changing needs and preferences of participants while supporting fiscal sustainability for years to come.

II. Brief Overview of Key Changes

The following list highlights changes proposed in the SPA:

- Simplifying the reimbursement model by redefining the PROS unit, eliminating the concept of program participation time, and reducing the number of monthly base rate tiers from five (5) to three (3);

- Adding Complex Care Management and Peer Support to the menu of services under the Community Rehabilitation and Support (CRS) component;
- Streamlining multiple CRS services into a single Psychosocial Rehabilitation Service;
- Moving Cognitive Remediation from the CRS component to the Intensive Rehabilitation (IR) component;
- Adding Licensed Occupational Therapists to the list of qualified Licensed Practitioners of the Healing Arts (LPHA);
- Adding Certified Psychiatric Rehabilitation Practitioners (CPRP) to the list of qualified professional staff; and
- Expanding the definition of Ongoing Rehabilitation and Support (ORS) to include support for individuals in educational programs.

OMH is not proposing any changes to the reimbursement rates for the PROS add-on components: IR, ORS, and Clinical Treatment (CT) at this time. OMH will closely monitor and evaluate the fiscal impact of redesign on program revenue and may propose future changes to the add-on components if needed. Additionally, the PROS redesign does not impact the utilization management policy for Medicaid managed care enrollees. The billing and reimbursement changes are outlined below.

III. Rate Codes and Other Billing Changes

A. Rate Code Changes

Subject to CMS and DOB approval, the existing rate codes 4520 – 4524 for the monthly base rate will be retired and replaced by new rate codes 4516 – 4518 to accommodate moving from a five-tier model to a three-tier model. The new rate code, procedure code, and modifier combinations are outlined below in Table 1. PROS billing codes remain unchanged for all other services outside of CRS.

Table 1: Updated PROS Monthly Base Rate Coding Taxonomy

Rate Code Service Title	Rate Code	Procedure Code	Modifiers	Units of Service
PROS Monthly Base Rate – Tier 1	4516	H2019	U1	4 - 11
PROS Monthly Base Rate – Tier 2	4517	H2019	U2	12 - 43
PROS Monthly Base Rate – Tier 3	4518	H2019	U3	44+

B. Other Billing Changes

The proposed rates for the 3-tier PROS model are available on the OMH Medicaid Reimbursement webpage. Additionally, pending DOB approval, the following PROS billing changes will be implemented:

1. One unit will be defined as **15 continuous minutes** of service provided to an individual or collateral, or **30 continuous minutes** of service provided to an individual or collateral in a group setting. Previously, the PROS unit was calculated by converting daily "program participation time" and service delivery using the PROS unit conversion chart.
2. The monthly base rate will be calculated by adding all PROS units, including CRS, IR, ORS, and CT services, accrued over the course of the month. However, the base rate must include a minimum of 4 CRS units (see #4 below).
3. For purposes of calculating units, off-site services provided for the same duration will be counted as two units instead of one**. This applies to both CRS and add-on components.** For example: 45 minutes of PROS CRS provided off-site to an individual would result in 6 units instead of 3 when calculating the units to determine the base rate tier. 60 minutes of off-site group services would result in 4 units instead of 2. Note that for PROS programs, "off-site" is defined as any clinically appropriate location in the community, other than a licensed PROS site, where an individual may receive services. Off-site does not include any space that is co-located at the same address as the PROS program.
4. A minimum of 4 units of CRS services must be provided during a calendar month to bill the PROS monthly base rate for reimbursement. These services may be provided on or off-site and must be provided for a minimum duration of 60 minutes for individual services or 120 minutes for group services over the course of the month. In other words, for purposes of determining if the PROS program has met the minimum duration requirement for billing the monthly base rate, off-site services do not count for double the number of units. However, once the minimum duration requirement has been met, off-site services for the same duration count twice for purposes of calculating the applicable reimbursement tier.
5. A **minimum** of 6 units of services, including at least one IR service, must be provided during a calendar month in order to bill the IR add-on component. These services may be provided on or off-site and must be provided for a minimum duration of 90 minutes for individual services or 180 minutes for group services over the course of the month. In other words, for purposes of determining if the PROS program has met the minimum duration requirement for billing the IR add-on, off-site services do not count for double the number of units.
6. A **maximum** of five units may be accumulated per calendar day for services delivered onsite[1]. For services delivered off-site, the daily maximum is 10 units, which is equivalent to 75 minutes of 1:1 services or 150 minutes of group-based services.
7. PROS providers will be required to report the number of actual units on the claim to support the State's monitoring of service utilization within the monthly base rate.

Note: Examples illustrating the billing rules outlined in this section can be found in Appendix A.

[1] Providers approved for telehealth, should count units the same as onsite services delivered in-person.

IV. Additional MMCP Requirements

1. PROS Policies and Procedures and Staff Training: MMCPs must ensure all applicable policies and procedures are updated and provider relations staff, billing/claiming, and other relevant staff are trained on the new PROS rate codes and billing changes to ensure they can assist providers as needed.
2. Network and Contracting: MMCPs must update or amend existing contracts with PROS providers, if applicable.
3. Claim Testing and Technical Assistance: MMCPs must offer claims testing to PROS providers to ensure claims will be processed and paid appropriately as required and offer technical assistance as needed.

OMH has partnered with the Managed Care Technical Assistance Center (MCTAC) to develop a comprehensive implementation training plan. Training dates and topics will be released as soon as the State and CMS approvals are granted for the State Plan Amendment and rates.

Please note: This document is only being transmitted electronically. No hard copy will be forthcoming. If you have any questions regarding these changes, please contact OMH Managed Care by phone at 518-402-2822 or by email at BHO@omh.ny.gov (MMCP inquiries) or OMH-Managed-Care@omh.ny.gov (provider inquiries).

Appendix A. PROS Billing Examples

The below examples are intended to illustrate the billing rules outlined in section B. Other Billing Changes. Some PROS providers may have group sessions that are scheduled longer than 30 minutes (e.g., 45mins), to ensure all participants can meet the full 30 minutes billable duration per session. For demonstration purposes, 30-minute billable durations are used for the examples below including PROS services delivered in groups, rather than the actual session length (e.g. 45 minutes). The monthly totals are based on 4.5 weeks in a month.

- ***Example 1*** – *CRS onsite and IR off-site:* An individual attends four (4) 30-minute *onsite* CRS groups per week (18) 30-minute groups over the course of the month and receives one (1) 45-minute 1:1 IR service off-site, in their home.
    - Their *total units* for the month would equal 24 (18 CRS + 6 IR off-site).
    - The program would bill for a Tier 2 monthly base rate plus the IR add-on.
- ***Example 2*** – *No Bill:* An individual attends one (1) 15-minute onsite CRS session and three (3) 30-minute onsite IR groups.
    - Their *total units* for the month would equal four (4).
    - The program *would not bill*, as this individual did not meet the minimum threshold for either the monthly base rate *or* IR add-on.[2]
- ***Example 3*** – *IR only, off-site:* An individual receives weekly 30-minute 1:1 IR sessions off-site in various community locations (five sessions over the course of the month).
    - Their *total units* for the month would equal 20.
    - The program would bill for the IR add-on *only*, as the individual did not meet the minimum threshold for the monthly base rate.
- ***Example 4*** – *ORS only, telehealth:* An individual receives weekly 15-minute 1:1 ORS sessions via telehealth (4 total over the course of the month).
    - Their *total units* for the month would equal 4.
    - The program would bill for the ORS add-on only, as the individual did not meet the minimum threshold for the monthly base rate.[3]
- ***Example 5*** – *ORS only, off-site:* An individual receives two (2) 30-minute 1:1 ORS sessions off-site over the course of the month.
    - Their *total units* for the month would equal 8.
    - The program would bill the ORS add-on only, as the individual did not meet the minimum threshold for the monthly base rate.
- ***Example 6*** – *CT, CRS, and IR onsite:* An individual receives weekly 1:1 45-minute onsite Clinical Treatment[4] sessions (five sessions per month), attends five (5) 30-minute onsite CRS groups per week (22 group sessions per month), and attends one (1) onsite 60-minute IR group per week (5 groups per month).
    - Their *total units* for the month would equal 47 (15 CT, 22 CRS, and 10 IR).
    - The program would bill for a Tier 3 monthly base rate, the CT add-on, and the IR add-on.
- ***Example 7*** – *CRS, IR, and ORS, onsite and telehealth:* An individual receives weekly 15-minute ORS sessions via telehealth (five sessions over the course of the month), attends one weekly 30-minute onsite CRS group (five groups over the course of the month) and

[2] To bill for the IR add-on only, the individual must have received at least six (6) PROS Service Units during the month, including at least one IR service.

[3] Reimbursement requires a minimum of four units of ongoing rehabilitation and support per month, which must occur on a minimum of two separate days. At least one service per month must be with the individual only.

[4] In order to receive reimbursement, the individual must receive a minimum of one Clinical Treatment service must be provided during the month. 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.

attends one weekly 30-minute onsite IR group (four sessions over the course of the month).
    - Their *total units* for the month would equal 14 (5 ORS, 5 CRS, and 4 IR)
    - The program would bill for a Tier 2 monthly base rate and *either* the IR add-on *or* the ORS add-on. Note that because the IR and ORS add-ons cannot be claimed in the same month for the same individual, the program needs to choose which add-on to bill. All units count toward the base rate regardless.
- ***Example 8*** – *CRS on-site and off-site:* An individual receives 3 hours of 1:1 CRS in their home for the purposes of assessing skill performance and environmental barriers related to their goal (24 units). They also engage in two (2) 30-minute onsite CRS groups per week (9 groups per month) and one (1) bi-weekly 1:1 15-minute CRS service (two sessions per month).
    - Their *total units* for the month would equal 21 (10 CRS off-site, 11 CRS on-site). Note that because off-site units are capped at 10 per day, the 3-hour (24 unit) 1:1 off-site session will only count as 10 units.
    - The program would bill for a Tier 2 monthly base rate.