New York State of Opportunity. | Office of Addiction Services and Supports

Summary
Notice of Proposed Rulemaking

Children and Family Treatment and Support Services
14 NYCRR Part 823

This regulation title is amended and updated consistent with the other state agencies which also provide such services. The proposed rule amends Part 823 to update the regulatory name in accordance with the SPA and other agencies (Children and Family Treatment and Support Services – CFTSS) and moves the incorporation by reference of the SPA Manual to Part 800. Service descriptions are already consistent with those outlined in the Manual published on the Department of Health website and utilized by the other state agencies including the Office of Mental Health and the Office of Children and Family Services. In addition, all documents, such as the Manual referenced herein, are incorporated by reference into Part 800 for clarity and consistency for all OASAS providers

Justification
Notice of Proposed Rulemaking

Amend 14 NYCRR PART 823
Children's Services

The proposed rule amends Part 823 to update language consistent with the other state agencies that also authorize use of these services as defined in the manual produced by the NYS Department of Health, which include the Office of Mental Health and the Office of Children and Family Services. In addition, amendments are made to correct and streamline documents incorporated by reference by the Office which are all included in Part 800 of this Title rather than in each individual Part for clarity and consistency.

14 NYCRR Part 823
[~~Children's services~~] **Children and Family Treatment and Support Services**

(Statutory authority: Mental Hygiene Law §§ 19.07(e), 19.09(b), 32.01; 42 U.S.C. § 1396d(r)(5); 18 NYCRR 505.38)

Section:

823.1 Background and intent
823.2 Applicability
823.3 Legal base
823.4 Definitions
823.5 General program standards
823.6 Authorized services
823.7 Application Process
823.8 Standards pertaining to Medicaid reimbursement
823.9 [~~Incorporation by Reference~~
~~823.10~~] Severability

§823.1 is amended to read as follows:

This regulation contains requirements applicable to rehabilitative health and behavioral health services available to children/youth, up to age twenty-one (21) and their families through the federal Early Periodic Screening, Diagnostic and Treatment (EPSDT) program in New York. **These services are hereby referred to by the state agencies as Children and Family Treatment and Support Services (CFTSS).**

§823.2 is amended to read as follows:

The provisions of this Part are applicable to all programs and providers **certified,** funded or [~~certified~~] **otherwise authorized** by the Office who seek certification **or designation** by the Office to offer rehabilitative health and behavioral health services for children/youth as such services are defined in this Part.

§823.3 is amended to read as follows:

(a) Section 19.07(e) of the Mental Hygiene Law authorizes the Commissioner of the Office of Alcoholism and Substance Abuse Services (Commissioner) to adopt standards including necessary rules and regulations pertaining to [~~chemical dependence~~]**addiction** services.

Existing §823.9 is deleted as follows and §823.10 is renumbered §823.9:

~~823.9 Incorporation by Reference~~

~~The provisions of the Children's Health and Behavioral Health Services Transformation Medicaid State Plan Provider Manual which have been incorporated by reference in this Part, have been filed in the Office of the Secretary of the State of New York, the publication so filed being the document entitled:~~ ~~*Children's Health and Behavioral Health Services Transformation Medicaid State Plan Provider Manual*~~~~, published in March 2016 and any subsequent updates. This document incorporated by reference may be examined at the Office of the Department of State, 99 Washington Avenue, Albany, NY 12231 or obtained from the Office of Alcoholism and Substance Abuse Services, 1450 Western Avenue, Albany, NY 12203.~~]

Summary
Notice of Proposed Rulemaking

14 NYCRR Part 836
Incident Reporting in OASAS Certified, Licensed, Funded, or Operated Services

The amendments to this rule bring the regulatory language in Part 841 in alignment with current and less stigmatizing terminology (such as OASAS/Office of Addiction Services and Supports) and clarifies reporting requirements in the regulation. OASAS worked closely in conjunction with the Justice Center to clarify and simplify this language. The clarification of the reporting requirements provides the benefit of enabling providers to better understand the requirements, and therefore better able to follow the requirements. In addition, the proposed rule amends Part 836 to update language consistent with agency statutory and regulatory provisions; adding references to VPCR online reporting availability; extending the time period at which reporting a missing adult client in a residential program from 24 to 48 hours, so as to align with current practice, statutory, and regulatory provisions.

Justification
Notice of Proposed Rulemaking

14 NYCRR Part 836
Incident Reporting in OASAS Certified, Licensed, Funded, or Operated Services

The purpose of the proposed rule is that it brings the regulatory language in Part 841 in alignment with current and less stigmatizing terminology (such as OASAS/Office of Addiction Services and Supports) and clarifies reporting requirements in the regulation. OASAS worked closely in conjunction with the Justice Center to clarify and simplify this language. The clarification of the reporting requirements provides the benefit of enabling providers to better understand the requirements, and therefore better able to understand and follow the requirements.

PART 836

INCIDENT REPORTING IN OASAS CERTIFIED, LICENSED, FUNDED, OR OPERATED SERVICES

(Statutory Authority: Mental Hygiene Law Sections 19.07(c), 19.07(e), 19.09(b), 19.20, 19.20-a, 19.21(b), 19.40, 22.07(c), 32.01, 32.02, 32.07(a), 33.16, 33.23, 33.25; Executive Law sections 296, 491 and 495, ; Civil Service Law section 50; Corrections Law Article 23-A; Protection of People with Special Needs Act (Chapter 501 of the Laws of 2012)

Section:

836.1 Background and intent
836.2 Legal base
836.3 Applicability
836.4 Definitions
836.5 Incident management plan and incident review committee
836.6 Incident reporting, notice, and investigations in facilities and provider agencies certified, licensed or operated by the Office
836.7 Incident reporting, notice, and investigations in programs funded, but not certified or licensed, by the Office
836.8 Additional notice and reporting requirements for reportable incidents
836.9 Recordkeeping and release of records to qualified persons
836.10 Duty to cooperate and inspection of facilities
836.11 Severability

§836.1 Background and intent

(a) The intent of this Part is to establish minimum standards for incident management programs of any **addiction** [~~chemical dependence or compulsive gambling~~]service provider certified, licensed, funded or operated by the Office [~~of Alcoholism and Substance Abuse Services (OASAS or "Office")~~]. Incident management programs are intended to strengthen and standardize the safety net for vulnerable persons such as those receiving services in the OASAS system, to bolster the ability of service providers and the Office to respond more effectively to abuse and neglect allegations and other significant incidents, to ensure that individuals with regular contact with patients are aware of their statutory obligations to adhere to a code of conduct including mandated reporting of certain incidents, and to prevent the recurrence of types of incidents in

order to enhance the quality of care and provide every individual receiving services with humane treatment and a safe environment.

(b) The purpose of an incident management program is to ensure a comprehensive strategy for:

(1) identifying, documenting, reporting, and investigating incidents on a timely basis;

(2) identifying incident patterns from the compilation and analysis of incident data;

(3) reviewing incidents and/or patterns to identify preventive or corrective action;

(4) implementing preventive and corrective action plans;

(5) monitoring incident management practices; **and**

(6) coordinating reporting, investigation, and responding to significant incidents and allegations of abuse and neglect with the Office, the Justice Center for the Protection of People with Special Needs ("Justice Center"), and the Vulnerable Persons' Central Register (hereinafter, "Vulnerable Persons' Register" or "VPCR").

§836.2 Legal base

(a) Section 19.07(c) of the Mental Hygiene Law charges the Office with the responsibility for seeing that persons in need of treatment for [~~chemical dependence~~]**addiction services** receive high quality care and treatment, and that the personal and civil rights of persons receiving care, treatment and rehabilitation are adequately protected.

(b) Section 19.07(e) of the Mental Hygiene Law authorizes the Commissioner ("Commissioner") of the Office to adopt standards including necessary rules and regulations pertaining to [~~chemical dependence~~]**addiction services**.

(c) Section 19.09(b) of the Mental Hygiene Law authorizes the Commissioner to adopt regulations necessary and proper to implement any matter under [~~his or her~~]**their** jurisdiction.

(d) Section 19.20 of the Mental Hygiene Law (Protection of People with Special Needs Act, added by Chapter 501 of the Laws of 2012) authorizes the Office to receive and review criminal history information related to certain prospective employees and volunteers

(e) Section 19.20-a of the Mental Hygiene Law (Protection of People with Special Needs Act, added by Chapter 501 of the Laws of 2012) authorizes the Office to receive and review criminal history information related to persons seeking to be credentialed or applicants for an operating certificate issued by the Office.

(f) Section 19.21(b) of the Mental Hygiene Law requires the Commissioner to establish and enforce certification, inspection, licensing and treatment standards for [~~alcoholism, substance abuse and chemical dependence~~] **addiction services** facilities and staff.

(g) Section 19.40 of the Mental Hygiene Law authorizes the Commissioner to issue operating certificates for the provision of [~~chemical dependence~~]**addiction** services.

(h) Section 22.07(c) of the Mental Hygiene Law authorizes the Commissioner to promulgate rules and regulations to ensure that the rights of individuals who have received, and are receiving, [~~chemical dependence~~]**addiction** services are protected.

(i) Section 32.01 of the Mental Hygiene Law authorizes the Commissioner to adopt any regulation reasonably necessary to implement and effectively exercise the powers and perform the duties conferred by Article 32 of the Mental Hygiene Law.

(j) Section 32.02 of the Mental Hygiene Law authorizes the Commissioner to adopt regulations necessary to ensure quality services to those suffering from compulsive gambling.

(k) Section 32.07(a) of the Mental Hygiene Law authorizes the Commissioner to adopt regulations to effectuate the provisions and purposes of Article 32 of the Mental Hygiene Law.

(l) Sections 33.16(a)(6) and 33.16(b)(4) of the Mental Hygiene Law define a "qualified person" as an individual receiving services, [~~his or her~~]**their** legal guardian, or a parent, spouse or adult child who has authority to provide consent for care and treatment.

(m) Section 33.23 of the Mental Hygiene Law requires directors of facilities certified by OASAS to provide telephone notification to a "qualified person" of an incident involving a client within **twenty-four (**24**)** hours of the initial report.

(n) Section 33.25 of the Mental Hygiene Law requires facilities to release records to "qualified persons", upon request, relating to allegations and investigations of client abuse or mistreatment.

(o) Section 491 of the Executive Law requires mandated reporters to immediately report allegations of reportable incidents to the Vulnerable Persons' Register upon discovery.

(p) Section 492 of the Social Services Law establishes the Vulnerable Persons' Register to which reports of allegations of reportable incidents must be submitted in a manner and on forms approved by the executive director of the Justice Center.

(q) Article 6, Title 6 of the Social Services Law requires the reporting of suspected abuse or maltreatment of persons under 18 years of age to the New York Statewide Central Register of Child Abuse and Maltreatment (hereinafter, "Statewide Central Register").

(r) Section 413 of the Social Services Law identifies persons required to report cases of suspected child abuse or maltreatment to the Statewide Central Register.

(s) Section 415 of the Social Services Law requires suspected child abuse or maltreatment to be reported immediately by telephone and to be followed by a written report on a form supplied by the commissioner of the Office of Children and Family Services, and further describes procedures for reporting.

(t) Section 495 of the Executive Law establishes the "Register of Substantiated Category One Cases of Abuse and Neglect" as a statewide register maintained by the Justice Center.

(u) Chapter 501 of the Laws of 2012 establishes the Justice Center.

§836.3 Applicability

This Part applies to facilities and provider agencies certified, licensed, funded, or operated by the Office, and custodians thereof in the following manner:

(a) Facilities and provider agencies certified, licensed or operated by the Office are subject to the jurisdiction of the Justice Center and shall follow provisions consistent with Justice Center law and regulations; and

(b) Providers funded, but not certified or licensed, by the Office are subject to the provisions of this Part solely applicable to such providers as indicated herein.

(c) To the extent that federal requirements conflict with any of the provisions in this Part, the federal requirements shall supersede the conflicting provisions in this Part with respect to any such facility or provider agency.

§836.4 Definitions

As used in this Part, unless otherwise indicated, the terms listed below shall have the following meanings:

(a) (1) "Incident" means an event or happening, accident or injury during the conduct of any program activity which involves a client, a custodian, or damage to the facility in which the program operates and which has, or may have, an adverse or endangering effect on the life, health or welfare of clients or custodians and is

required to be reported, investigated and recorded to designated parties according to Article eleven of the social services law and procedures approved by the Office, reviewed by an Incident Review Committee, and acted upon in an appropriate manner to safeguard the well-being of clients and custodians and to bring the matter to closure.

(2) Incidents are either "reportable" to the Justice Center or "non-reportable."

(3) "Non-reportable" incidents need not be reported to the Justice Center, or if they are reported may be determined as not within the jurisdiction of the Justice Center; nevertheless, these incidents may require documentation in a patient's clinical record or as an incident related to the program or facility which must be maintained by the service provider for review by the provider's Incident Review Committee, or by the Office or the Justice Center, upon request.

(b) "Reportable incident" means an incident of "abuse or neglect" or a "significant incident" as defined in subdivision (c) or (d) of this section; **or the death of service recipient as defined in subdivision (c) of section 836.8 of this part which must be reported in accordance with the requirements of that subsection** [some patient deaths are also a reportable incident].

(c) "Abuse or neglect" means a reportable incident described by the following conduct that a mandated reporter is required to report to the Vulnerable Persons' Central Register ("VPCR") via a toll-free hotline **or reporting online.**

(1) "Physical abuse" means conduct by a custodian intentionally or recklessly causing, by physical contact, physical injury or serious or protracted impairment of the physical, mental or emotional condition of a service recipient or causing the likelihood of such injury or impairment. Such conduct may include but shall not be limited to: slapping, hitting, kicking, biting, choking, smothering, shoving, dragging, throwing, punching, shaking, burning, cutting or the use of corporal punishment. Physical abuse shall not include reasonable emergency interventions necessary to protect the safety of any person. In addition, a hotline call shall be made immediately when an injury cannot be explained, and investigation is needed because of the:

(i) Extent and/or location of the injury;

(ii) Number of injuries at one time; or

(iii) Frequency of injuries over time.

(2) "Sexual abuse" means any conduct by a custodian that subjects a person receiving services to any offense defined in article one hundred thirty or section 255.25, 255.26 or 255.27 of the penal law; or any

conduct or communication by such custodian that allows, permits, uses or encourages a service recipient to engage in any act described in articles two hundred thirty or two hundred sixty-three of the penal law.

(3) "Psychological abuse" means conduct by a custodian intentionally or recklessly causing, by verbal or non-verbal conduct, a substantial diminution of a service recipient's emotional, social or behavioral development or condition, supported by a clinical assessment performed by a physician, psychologist, psychiatric nurse practitioner, licensed clinical or master social worker or licensed mental health counselor, or causing the likelihood of such diminution. Such conduct may include but shall not be limited to intimidation, threats, the display of a weapon or other object that could reasonably be perceived by a service recipient as a means for infliction of pain or injury, in a manner that constitutes a threat of physical pain or injury, taunts, derogatory comments or ridicule. Such conduct shall be reported to the Justice Center when a mandated reporter has reasonable cause to suspect that it occurred, even though no clinical assessment has been undertaken to determine its impact on the service recipient.

(4) "Deliberate inappropriate use of restraints" means the use of a restraint when the technique, the amount of force or the situation in which the restraint is used is deliberately inconsistent with a service recipient's individual treatment/recovery plan, generally accepted treatment practices and/or applicable federal or state laws, regulations or policies, except when the restraint is used as a reasonable emergency intervention to prevent imminent risk of harm to a person receiving services or to any other person. For purposes of this Part a "restraint" shall include the use of any manual, pharmacological or mechanical measure or device to immobilize or limit the ability of a person receiving services to freely move **their**[~~his or her~~] arms, legs or body. A deliberate inappropriate restraint may include, among other things, a finding that a restraint was used as a punishment or for the convenience of staff.

(5) "Use of aversive conditioning" means the application of a physical stimulus intended to induce pain or discomfort in order to modify or change the behavior of a person receiving services in the absence of a person-specific authorization by the Office pursuant to law, regulations and clinical guidance. Aversive conditioning may include but is not limited to, the use of physical stimuli such as noxious odors, noxious tastes, blindfolds, the withholding of meals and the provision of substitute foods in an unpalatable form and movement limitations used as punishment, including but not limited to helmets and mechanical restraint devices.

(6) "Obstruction of reports of reportable incidents" means conduct by a custodian that impedes the discovery, reporting or investigation of the treatment of a service recipient by falsifying records related to the

safety, treatment or supervision of a service recipient, actively persuading a mandated reporter from making a report of a reportable incident to the Vulnerable Persons' Register with the intent to suppress the reporting or the investigation of such incident, intentionally making a false statement or intentionally withholding material information during an investigation into such a report; intentional failure of a supervisor or manager to act upon such a report in accordance with Office regulations, policies or procedures; or, for a mandated reporter who is a custodian as defined in subdivision (d) of this section, failing to report a reportable incident upon discovery.

(7) "Unlawful use or administration of a controlled substance" means any administration by a custodian to a service recipient of: a controlled substance as defined by article thirty-three of the public health law, without a prescription; or other medication not approved for any use by the federal food and drug administration. It also shall include a custodian unlawfully using or distributing a controlled substance as defined by article thirty-three of the public health law, at the workplace or while on duty.

(8) "Neglect" means any action, inaction or lack of attention that breaches a custodian's duty and that results in or is likely to result in physical injury or serious or protracted impairment of the physical, mental or emotional condition of a service recipient. Neglect shall include, but is not limited to:

(i) failure to provide proper supervision, including a lack of proper supervision that results in conduct between persons receiving services that would constitute abuse as described in paragraphs (1) through (7) of this subdivision if committed by a custodian; or

(ii) failure to provide adequate food, clothing, shelter, medical, dental, optometric or surgical care, consistent with the rules or regulations promulgated by the Office, provided that the facility or provider agency has reasonable access to the provision of such services and that necessary consents to any such medical, dental, optometric or surgical treatment have been sought and obtained from the appropriate individuals; or

(iii) failure to provide access to educational instruction, by a custodian with a duty to ensure that an individual receives access to such instruction in accordance with the provisions of part one of article sixty-five of the education law and/or the individual's individualized education program.

(d) "Significant incident" means a reportable incident, other than an incident of abuse or neglect as defined in subdivision (c) of this section, which because of its severity or the sensitivity of the situation, may result in, or has the reasonably foreseeable potential to result in, harm to the health, safety or welfare of a person receiving services and shall include but is not limited to:

(1) conduct between persons receiving services that would constitute abuse as described in paragraphs (1) through (7) of subdivision (c) of this section, if committed by a custodian; and

(2) conduct on the part of a custodian, inconsistent with a service recipient's individual treatment/recovery plan, generally accepted treatment practices and/or applicable federal or state laws, regulations or policies and which impairs or creates a reasonably foreseeable potential to impair the health, safety or welfare of a person receiving services, including but not limited to:

(i) unauthorized seclusion, which shall mean the placement of a person receiving services in a room or area from which **they**[~~he or she~~] cannot, or perceives that **they**[~~he or she~~] cannot, leave at will;

(ii) unauthorized use of time-out, which shall mean the use of a procedure in which a person receiving services is removed from regular programming and isolated in a room or area for the convenience of a custodian, or as a substitute for programming but shall not include the use of a time-out as an emergency intervention to protect the health or safety of the individual or other persons;

(iii) except as provided for in paragraph (7) of subdivision (c) of this section, the administration of a prescribed or over-the-counter medication, which is inconsistent with a prescription or order issued for a service recipient by a licensed, qualified health care practitioner, and which has an adverse effect on a service recipient. For purposes of this subparagraph, "adverse effect" shall mean the unanticipated and undesirable side effect from the administration of a particular medication which unfavorably affects the well-being of a service recipient;

(iv) inappropriate use of restraints, which shall mean the use of a restraint when the technique, the amount of force or the situation in which the restraint is used are inconsistent with a service recipient's individual treatment/recovery plan, generally accepted treatment practices and/or applicable federal or state laws, regulations or policies; or

(3) Other significant incidents, including but not limited to:

(i) An event that is, or appears to be, a crime under New York state or federal law involving custodians, clients, or others, including children of service recipients in a residential program, as victims or perpetrators;

(ii) Body cavity search; must be with client consent;

(iii) Any violation of a client's rights to confidentiality pursuant to 42 CFR Part 2 or the Health Insurance Portability and Accountability Act (HIPAA).

(iv) Missing client as defined in subdivision (u) of this section;

(v) Suicide attempt whether or not preceded by statements of intent; statement of intent alone is not a suicide attempt; statements of intent should be recorded in a patient's clinical record;

(vi) Death of a custodian or mandated reporter during the course of his/her job duties related to the provider facility; shall also be reported to any other appropriate entity;

(vii) Death of an outpatient client if death occurs on program premises or during the course of program activities.

(e) "Custodian" means a director, operator, employee or volunteer of a facility or provider agency; or a consultant or an employee or volunteer of a corporation, partnership, organization or governmental entity which provides goods or services to a facility or provider agency pursuant to contract or other arrangement that permits such person to have regular and substantial contact with individuals who are cared for by the facility or provider agency.

(f) "Facility" or "provider agency" shall mean a facility or program in which services are provided and which is operated, licensed or certified by the Office. Such facilities and provider agencies are within the jurisdiction of the Justice Center for purposes of reporting reportable incidents to the Justice Center's Vulnerable Persons' Central Register.

(g) "Mandated reporter" means a custodian or a human services professional but shall not include a service recipient.

(h) "Human services professional" means any: physician; registered physician assistant; surgeon; medical examiner; coroner; dentist; dental hygienist; osteopath; optometrist; chiropractor; podiatrist; resident; intern; psychologist; registered nurse; licensed practical nurse; nurse practitioner; social worker; emergency medical technician; licensed creative arts therapist; licensed marriage and family therapist; licensed mental health counselor; licensed psychoanalyst; licensed behavior analyst; certified behavior analyst assistant; licensed speech/language pathologist or audiologist; licensed physical therapist; licensed occupational therapist; hospital personnel engaged in the admission, examination, care or treatment of persons; Christian Science practitioner; school official, which includes but is not limited to school teacher, school guidance counselor, school psychologist, school social worker, school nurse, school administrator or other school personnel required to hold a teaching or administrative license or certificate; full or part-time compensated school employee required to hold a temporary coaching license or professional coaching certificate; social services worker; any other child care or foster care worker; mental health professional; person credentialed by the Office; peace officer;

police officer; district attorney or assistant district attorney; investigator employed in the office of a district attorney; or other law enforcement official.

(i) "Physical injury" and "impairment of physical condition" means any confirmed harm, hurt or damage resulting in a significant worsening or diminution of an individual's physical condition.

(j) "Delegate investigatory entity" means a facility or provider agency, or any other entity authorized by regulations of the Office or the Justice Center to conduct an investigation of a reportable incident.

(k) "Justice Center" means the Justice Center for the Protection of People with Special Needs established pursuant to Chapter 501 of the Laws of 2012.

(l) "Person receiving services," or "service recipient" means a client who receives or has received services from a facility or provider agency.

(m) "Personal representative" means a person authorized under state, tribal, military or other applicable law to act on behalf of a vulnerable person in making health care decisions, or a service recipient's parent, guardian or other person legally responsible for the service recipient.

(n) "Subject of the report" means a custodian, as defined in subdivision (e) of this section, who is reported to the vulnerable persons' central register for the alleged abuse or neglect of a vulnerable person as defined in subdivision (q) of this section.

(o) "Other persons named in the report" means and is limited to the following persons who are named in a report to the Vulnerable Persons' Register other than the subject of the report: the service recipient whose care and treatment is the concern of a report to the Vulnerable Persons' Central Register, and the personal representative, if any, as defined in subdivision (m) of this section.

(p) "Vulnerable Persons' Central Register" means the statewide central register of reportable incidents involving vulnerable persons, which shall operate in accordance with section four hundred ninety-two of Article 11 of the social services law.

(q) "Vulnerable person" means a person who, due to physical or cognitive disabilities, or the need for services or placement, is receiving services from a facility or provider agency.

(r) "Intentionally" and "recklessly" shall have the same meanings as provided in subdivisions one and three of section 15.05 of the penal law.

(s) "Clinical records" means information concerning or related to the examination or treatment of a person receiving services from a provider agency.

(t) “Incident management program” means a plan developed and maintained by service providers pursuant to section 836.5 of this Part including specifications for the identification, investigation, reporting and appropriate response to any incident and review by the provider’s Incident Review Committee.

(u) “Missing client” means a client (1) over the age of eighteen in a residential facility who has not been accounted for when and where such client is expected to be present and, after **forty-eight (48)** [~~24~~] hours, whose location has not been determined by means of immediate and appropriate diligent efforts (a client is accounted for and not missing if staff has received information regarding the patient’s intention to leave treatment against medical advice or to remove **themselves**[~~himself/herself~~] to a specific location outside of the facility with or without an approved pass); or

(2) under the age of eighteen in a residential facility who has not been accounted for when and where such client is expected to be present and, after **twenty-four (**24**)** hours, whose location has not been determined by means of immediate and appropriate diligent efforts (a client is accounted for and not missing if staff has received information regarding the patient’s intention to leave treatment against medical advice or to remove **themselves**[~~himself/herself~~] to a specific location outside of the facility with or without an approved pass, or is known to be in the custody of a parent or guardian).

(v) “Qualified person” means an individual receiving services or [~~his or her~~] **their** personal representative as defined in subdivision (l) of this section.

(w) “Staff” means custodians identified as an administrator, licensed clinician, contractor, employee, consultant, volunteer, intern, peer advocate, agent, or counselor trainee affiliated with a program certified, licensed, funded, or operated by the Office.

(x) “Incident Review Committee” means a committee required by a facility Incident management program and established pursuant to section 836.5 of this Title.

§836.5 Incident management plan and incident review committee

(a) The governing authority of every facility or provider agency certified, licensed, funded, or operated by the Office must establish and maintain written policies and procedures constituting an incident management program for responding to, reporting, investigating and evaluating incidents. All incident management programs are subject to review by the Office and must be consistent with patient rights provisions of Part 815 of this Title and with the requirements of the Justice Center.

(b) At a minimum, an incident management program must be consistent with Justice Center Incident Reporting regulations and incorporate the following:

(1) identification of staff responsible for administration of the incident management program;

(2) provisions for annual review by the governing authority;

(3) specific internal recording and reporting procedures applicable to all incidents observed, discovered or alleged;

(4) procedures for monitoring overall effectiveness of the incident management program;

(5) minimum standards for investigation of incidents observed, discovered or alleged, including, but not limited to:

(i) physical or medical examination, as indicated by circumstances; name of examiner; written findings;

(ii) identification and interviews with any witnesses (interviews conducted separately by qualified, objective persons); written documentation of such interviews;

(iii) review of pertinent physical evidence; documentation (photos, expert assessments) and retention by facility Incident Review Committee, facility executive or other appropriate person;

(iv) documentation of investigative steps taken.

(6) procedures for the implementation of corrective action plans if required;

(7) establishment of an Incident Review Committee pursuant to subdivision (f) of this section;

(8) required periodic training in mandated reporting obligations of custodians and the Justice Center code of conduct, in addition to any other training as may be required by the Office and consistent with Justice Center regulations;

(9) provision for retention of records, review and release pursuant to Justice center regulations and section 33.25 of the mental hygiene law.

(c) Any provider of services dually certified, licensed, funded, or operated by the Office and another New York State agency may substitute the other agency's required incident reporting program for the requirements of this section provided such program meets or exceeds the scope and requirements of this Part and such substitution has been previously approved by the Office and is consistent with Justice Center regulations. As a condition of such approval, a provider must comply with any other provisions relevant to incidents as required by the Office and have a current operating certificate that is not subject to any limitations.

(d) Upon admission to a program, clients, and others when appropriate and subject to applicable confidentiality laws, must be informed that a program maintains an incident management program.

(e) Upon clearance for employment any custodian must be informed of the service provider's incident management program, custodian obligations as a mandated reporter, and an original signed attestation by such custodian that they have received and understand such obligations. Custodian attestation to receiving and understanding the Code of Conduct must be renewed annually.

(f) Incident Review Committee. Each provider's incident management program must provide for the establishment of an Incident Review Committee. Such committee may also perform other review functions for the facility or service provider, including but not limited to, quality improvement and/or utilization review, however minimum requirements include, but are not limited to:

(1) Each Incident Review Committee must include members of the governing body of the provider agency and other persons identified by the director, including members from the following: direct support staff, licensed health care practitioners, service recipients and representatives of family, consumer and other advocacy organizations (if appropriate, based on the size of the facility or provider agency, the Office may authorize an exemption from this requirement or portions of this requirement upon review of a written request). The executive director of a provider may not serve as an incident review committee member.

(2) Services not requiring medical staff may substitute a Qualified Health Professional for the medical staff.

(3) In a service co-located within a general hospital or a certified hospital for mental illness, or a service that is part of a larger human services agency, the functions of the Incident Review Committee may be performed by a hospital-wide committee or an agency-wide committee, provided a representative from the [~~chemical dependence or compulsive gambling~~] **addiction services** unit serves on the committee and confidentiality is maintained pursuant to 42 CFR Part 2, and the functions of the committee meet or exceed the requirements of this Part.

(4) Members of the committee shall be trained in confidentiality laws and regulations and shall comply with section 74 of the Public Officers Law (code of ethics).

(5) Committee functions and responsibilities. At a minimum, each Incident Review Committee must:

(i) review and evaluate all incidents;

(ii) determine the facts, review and evaluate ongoing practices and procedures in relation to such incidents, and recommend any indicated changes in practices and procedures to improve the provider's response to all incidents;

(iii) determine whether there are patterns or common causes of incidents and make recommendations for changes to prevent recurrence;

(iv) meet as often as necessary to properly execute its functions, but in no event less than quarterly;

(v) keep written minutes of its deliberations and submit bi-annual reports to the governing authority;

(vi) prepare a summary of incidents reviewed and recommendations made, if any, at each meeting; and

(vii) take any action necessary to follow up on recommendations made.

(6) Incident Review Committees are responsible for reviewing individual incidents and incident patterns to determine the timeliness, thoroughness and appropriateness of the program's response. The committee may make recommendations to the governing body regarding the implementation of any preventive or corrective action.

(7) Incident Review Committees are responsible for monitoring the compliance of the program's incident management practices and the implementation of any corrective action taken by the provider. Any corrective action required must be endorsed, in writing, by the facility director or [~~his/her~~]**their** designee, identify a monitoring date and person responsible for assessing the efficacy of the corrective action.

(8) The Incident Review Committee must quarterly compile a collective report of the total number of incidents by type, its findings and recommendation; such reports shall be maintained by the governing authority to be available for inspection or review by the Office for purposes of recertification or by the Justice Center for such purposes as it may designate.

§836.6 Incident reporting, notice, and investigations in facilities and provider agencies certified, licensed or operated by the Office

(a) Unless otherwise indicated herein, all reportable incidents as defined in this Part shall be reported to the Vulnerable Persons' Register.

(b) A custodian of any service provider who personally observes, is advised of, or otherwise becomes aware of an incident must take immediate and appropriate action to intervene and attempt to prevent or limit injury or potential injury to any person to the greatest extent possible.

(c) In accordance with a provider's incident management program, a written incident report must be initiated or a call made by a mandated reporter as defined in this Part to the Vulnerable Persons' Register toll-free hotline immediately after a reportable incident is discovered.

(1) Every mandated reporter who has direct knowledge of an incident and has reasonable cause to suspect that a person receiving services has been subjected to a reportable incident is required to make a report to the VPCR unless:

(i) **they have**[~~he or she has~~] actual knowledge that the reportable incident has been reported to the VPCR; and

(ii) that **they have**[~~he or she has~~] been named as a person with knowledge of the incident in such prior report.

(2) For purposes of this reporting obligation, "discovery" occurs when a mandated reporter has "reasonable cause to suspect" that a service recipient has been subjected to a reportable incident. This may occur either:

(i) when a mandated reporter witnesses a suspected reportable incident; or

(ii) when another person, including a service recipient, comes before the mandated reporter, in the mandated reporter's professional or official capacity, and provides the mandated reporter with reasonable cause to suspect that a service recipient has been subjected to a reportable incident.

(3) For purposes of this reporting obligation, "reasonable cause to suspect" does not require conclusive evidence that the incident occurred; a rational or sensible suspicion is sufficient and may be based on the mandated reporter's observations, training and experience, and the mandated reporter's disbelief of an explanation provided for an injury.

(d) In addition to those reports of reportable incidents that must be made to the Justice Center, an initial incident report must be forwarded to the director or designee for investigation immediately after an incident is discovered. Such an initial incident report shall, at a minimum, contain the following information:

(1) The exact date and time of the incident if known; and

(2) a description of the incident, including location, and actions taken in response to it; and

(3) the name(s), address(es), and telephone number(s) of the victim(s), witness(es), and any other persons involved; and

(4) the presence of injuries, if any, and first aid provided to address such injuries.

(e) The Justice Center shall determine whether a reportable incident shall be investigated by the Justice Center or delegated to the Office for investigation. If an incident is delegated to the Office by the Justice Center, the Office may investigate such reportable incident itself, or may delegate such an investigation to the facility or provider agency. For any investigation of a reportable incident of abuse or neglect that is not conducted by the Justice Center, the final report of such investigation of abuse or neglect must be provided to the Justice Center no later than fifty (50) days after the Justice Center accepts the initial report of the incident, unless an extension of time is granted for documented good cause. Any final report of a delegated significant incident must be provided to the Justice Center within sixty (60) days after the Justice Center accepts the initial report of the incident, unless an extension of time is granted for documented good cause.

(f) All incidents must be recorded by the service provider and all incident reports and other relevant records made available for inspection by the Office and the Justice Center, when appropriate.

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(g) Upon notice to the Office, service providers may delay [~~"discovery," as such term is defined in paragraph (2) of subdivision (c) of this section, and immediate~~] reporting for no more than twenty-four (24) hours in order to conduct a preliminary review of an allegation of abuse or neglect**, where a service provider does not have reasonable cause to suspect that the allegation has occurred because**[~~ under circumstances in which~~]:

(1) the person making the allegation of abuse or neglect has a documented history of making false reports of abuse or neglect and no other person has come forward as a witness to such allegation; or

(2) the person making the allegation of abuse or neglect has a documented behavioral or psychological condition that would tend to cause such person to make a false report of abuse or neglect and no other person has come forward as a witness to such allegation.

(h) Any delayed discovery of an allegation pursuant to subdivision (g) of this section must be documented, such documentation including:

(1) the reasons identified above for such delay in any subsequent report to the Justice Center; or

(2) the basis for a determination not to report; such documentation shall be available to the Justice Center or the Office upon request.

§836.7 Incident reporting, notice, and investigations in programs funded but not certified or licensed by the Office

(a) Prevention programs and other services funded, but not certified or licensed by the Office, shall report incidents to the Office, and not the Justice Center. Reports shall be made to the OASAS bureau of Patient Advocacy. The initial report of such an incident, in such a program, must, at a minimum, contain:

(1) The exact date and time of the incident if known; and

(2) a description of the incident, including location, and actions taken in response to it; and

(3) the name(s), address(es), and telephone number(s) of the victim(s), witness(es), and any other persons involved; and

(4) the presence of injuries, if any, and first aid provided to address such injuries.

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(b) All other provisions of this Part are applicable to prevention programs and other services funded but not certified or licensed by the Office.

§836.8 Additional notice and reporting requirements for reportable incidents

(a) Subject to the provisions of 42 CFR Part 2, in addition to any other notice provisions required in this Part, notification of reportable incidents involving a client must be made pursuant to section 33.23 of the Mental Hygiene Law by the director or designee to the client's family or significant other, designated emergency contact, or other qualified person. Such notification must be made by telephone or secure electronic method immediately after an incident is discovered.

(b) If it appears that a crime may have been committed against any custodian or service recipient, the provider must immediately make such reports as are necessary to provide notification to the appropriate law enforcement agency of the incident. A provider may disclose client-identifying information to the appropriate law enforcement agency only when such disclosure:

(1) is directly related to a client's commission of a crime on the premises of the program or a threat to commit such a crime; and

(2) is limited to the circumstances of the incident, including the status of the individual committing or threatening to commit the crime, and such individual's name and address.

(c) In the event of a client's death in an inpatient or residential program under any circumstances or within 30 days of such client's discharge, immediate notification must be made to **both** the VPCR **and the Justice Center's Mortality Review Unit** (subject to the provisions of 42 CFR Part 2), **the process for which can be found here: https://www.justicecenter.ny.gov/mortality-review,** the local coroner or medical examiner, or any other state or local agency identified under state laws requiring the collection of health or other vital statistics.

(d) In addition to reporting requirements of subdivision (a) of this section, in the case of a missing client the provider's policies and procedures and missing client reports must indicate that the appropriate supervisory staff member was notified immediately. If such supervisor deemed it necessary, a diligent search must be made by staff of the physical plant, grounds and surroundings. Telephone inquiries may be made to the person's home or any other appropriate

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location, provided such calls are made in such manner so as not to violate confidentiality requirements of 42 CFR Part 2. Incident reports of a missing client must state the efforts made to locate the client as well as the outcome of such efforts.

(e) Nothing herein shall require staff to submit a report to a provider's director or designee if such director or designee is alleged to have committed the reportable or significant incident or to be directly involved in the alleged reportable or significant incident. If the director or director's designee is alleged to have committed the reportable or significant incident or to be directly involved in the alleged reportable or significant incident, staff members as mandated reporters as defined in section 836.4 of this Part must report such allegations only to the VPCR and the Office.

§836.9 Recordkeeping and release of records to qualified persons

(a) A copy of each incident report including identifying information must be kept on file at the program for a minimum of six (6) years and must be subject to inspection and review by the Office or the Justice Center.

(b) Copies of the minutes and summaries of the Incident Review Committee must be kept on file at the program for a minimum of six (6) years and must be subject to inspection and review by the Office or the Justice Center.

(c) Subject to the provisions of 42 CFR Part 2, records and reports released in accordance with this Part shall be released to qualified persons pursuant to subdivision (b) of section 33.23 of the Mental Hygiene Law, section 33.25 of the Mental Hygiene Law, and shall include a statement that such records and reports shall not be further disseminated by the recipient except as provided by law.

(d) Subject to the provisions of 42 CFR Part 2, upon the written request of a qualified person, the director of the program must:

(1) promptly provide to such qualified person a copy of the written incident report, provided the names and other personally identifying information of clients and employees shall not be included unless such clients and employees authorize such disclosure;

(2) offer to hold a meeting with such qualified person to further discuss the incident; and

(3) provide such qualified person with a written report on the actions taken to address the incident within 10 days of discovery of the incident;

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(4) release, within 21 days of the conclusion of any investigation, records and documents pertaining to allegations and investigations into client abuse or mistreatment at a program.

(e) Providers are required to cooperate with Justice Center investigations of abuse or neglect and significant incidents by making related records available upon the request of authorized investigators.

(f) Providers are required to cooperate with the Justice Center in making records relating to abuse and neglect available for disclosure pursuant to subdivision (6) of section 490 of the social services law.

§836.10 Duty to cooperate and inspection of facilities

(a) Subject to the provisions of 42 CFR Part 2, as part of an investigation of abuse or neglect, a service provider must cooperate with any investigation or inspection conducted by the Office or the Justice Center, or any representative thereof to the extent necessary to carry out the functions, power, and duties of the Justice Center. Such cooperation shall include at a minimum to allow the Office and/or the Justice Center to inspect its facility and all relevant books, data and records, including but not limited to, client or resident records, kept by such provider, to submit to the Justice Center any relevant records requested pursuant to Justice Center regulations, and to interview and examine any client or resident at its facility except that no such client or resident shall be examined without their consent. Such data includes:

(i) for the subject of an investigation of abuse or neglect, the alleged subject's name, date of birth, social security number or alien registration number, physical or residential address and, if different, his or her mailing address;

(ii) for a service recipient alleged to be the victim of an allegation of abuse or neglect, the alleged victim's date of birth and mailing address; whether the alleged victim is a self-advocate or has a personal representative as defined in this Part and the mailing address of any such personal representative.

(b) Failure of a service provider to provide requested data, records or information shall be reported to the Office which may impose a fine, and/or suspend, revoke or limit the provider's operating certificate and/or take any other appropriate action in accordance with applicable law or regulation.

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§ 836.11 Severability

If any provision of this Part or the application thereof to any person or circumstance is held invalid, such invalidity shall not affect other provisions or applications of this Part that can be given effect without the invalid provision or applications, and to this end the provisions of this Part are declared to be severable.

Summary
Notice of Proposed Rulemaking

REPEAL and REPLACE 14 NYCRR Part 841
Medical Assistance For Addiction Services

Due to the amount of changes in this regulation, OASAS is repealing old Part 841 and replacing it with new Part 841. The reason that OASAS chose to repeal and replace rather than just make amendments throughout is that the amendments were substantial and it was more efficient to repeal and replace the language. This changes in this rule remove outdated and irrelevant language and reflect the new State Plan Amendment. Medicaid rules (and therefore the OASAS State Plan) have updated the way OASAS Providers bill for services, and the regulatory language was updated to reflect this. These changes will allow for rate methodologies that promote efficiency, meaning fees rather than cost based rates, for inpatient services. Overall, the changes provider for more accurate and fair reimbursement, as well as add simplicity to the entire regulation.

Justification
Notice of Proposed Rulemaking

REPEAL and REPLACE 14 NYCRR Part 841
Medical Assistance For Addiction Services

The proposed rule repeals the old Part 841 and replaces it with the new Part 841. The reason that OASAS chose to repeal and replace rather than just make amendments throughout is that the amendments were substantial and it was more efficient to repeal and replace the language. This amendment removes outdated and irrelevant language reflects the new State Plan Amendment. Medicaid rules (and therefore the OASAS State Plan) have updated the way OASAS Providers bill for services, and the regulatory language was updated to reflect this. These changes will allow for rate methodologies that promote efficiency, meaning fees rather than cost based rates, for inpatient services. Overall, the changes provider for more accurate and fair reimbursement, as well as add simplicity to the entire regulation.

REPEAL and REPLACE 14 NYCRR PART 841:

MEDICAL ASSISTANCE FOR ADDICTION SERVICES

(Statutory Authority: Mental Hygiene Law Sections 19.07(e), 19.09(b), 19.40, 32.01, 32.07(a), 43.01, and 43.02; Social Services Law Section 364; Executive Law Article 15; 10 NYCRR Part 86-8)

Sec.

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841.11 Medical assistance payments for children and family treatment and support services
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Section 841.1 Background and intent.

(a) The purpose of this Part is to establish standards for reimbursement and participation in the Medical Assistance Program, as authorized by title 11 of article 5 of the Social Services Law, for services provided by addiction services providers certified or co-certified by the Office. This Part does not apply to programs dually licensed by Article 28 of the public health law and Article 32 of the mental hygiene law.

(b) The payments determined under the standards and methods established by this Part are intended to be reasonable and adequate to meet the costs that must be incurred

by efficiently and economically operated programs in order to provide addiction services in conformity with applicable State and Federal laws, regulations and safety standards.

841.2 Legal basis.

(a) Section 19.07(e) of the Mental Hygiene Law authorizes the Commissioner to adopt standards including necessary rules and regulations pertaining to addiction services.

(b) Section 19.09(b) of the Mental Hygiene Law authorizes the Commissioner to adopt regulations necessary and proper to implement any matter under their jurisdiction.

(c) Section 32.01 of the Mental Hygiene Law authorizes the Commissioner to adopt any regulation reasonably necessary to implement and effectively exercise the powers and perform the duties conferred by Article 32 of the Mental Hygiene Law.

(d) Section 32.07(a) of the Mental Hygiene Law authorizes the Commissioner to adopt regulations to effectuate the provisions and purposes of Article 32 of the Mental Hygiene Law.

(e) Sections 43.01 and 43.02 of the Mental Hygiene Law grant the Commissioner the power and responsibility to adopt regulations that are necessary and proper to implement matters under his/her jurisdiction and to establish standards and methods of payment made by government agencies pursuant to title 11 of article 5 of the Social Services Law for eligible addiction services certified by the Office.

(f) Section 364 of the Social Services Law provides that each office within the Department of Mental Hygiene shall be responsible for establishing and maintaining standards for medical care and services in institutions serving Medicaid patients.

(g) Pursuant to section 23 of Part C of chapter 58 of the laws of 2009, the Commissioner is authorized, with the approval of the Commissioner of Health and the Director of the Budget, to promulgate regulations pursuant to Article 32 of the Mental Hygiene Law utilizing the Ambulatory Patient Group (APG) methodology for the purpose of establishing standards and methods of payments made by government agencies pursuant to title 11 of article 5 of the Social Services Law for addiction services otherwise subject to the provisions of this Part.

(h) Article 15 of the executive law defines the protected classes included in the state human rights law.

(i) Title 10 of the New York Code of Rules and Regulations Part 86-8 defines reporting and rate certifications for outpatient services ambulatory patient group.

841.3 Applicability.

This Part is applicable to any eligible provider as defined herein and as certified, approved or otherwise authorized pursuant to this Title.

841.4 Definitions.

(a) "Medicaid program" shall mean the medical assistance program, under Title XIX of the federal Social Security Act, in accordance with a state plan approved by the United States Department of Health and Human Services.

(b) "Eligible provider" shall operate an addiction services program and shall be approved by the single state agency to provide services and operate as a Medicaid provider; and is one of the following:

(1) a substance use disorder withdrawal and stabilization services program which is certified under Part 816 of this Title; or

(2) a substance use disorder residential rehabilitation services for youth program certified under Part 817 of this Title; or

(3) a substance use disorder inpatient rehabilitation services program which is certified under Part 818 of this Title; or

(4) a residential services program certified under Part 820 of this Title by the Office; or

(5) a substance use disorder outpatient program certified under Part 822 of this Title; or

(6) a children and family treatment and support services program certified or designated under Part 823 of this Title.

(c) "Single state agency" shall mean the New York State Department of Health.

(d) “Allowable costs” shall mean those costs incurred by an eligible inpatient provider which are eligible for payment by government agencies in accordance with title

11 of article 5 of the Social Services Law. To be allowable, costs must be reasonable and necessary for efficient provision of addiction services, related to patient care, and approved by the commissioner.

(e) "Per diem" or "patient day" shall mean the unit of measure denoting services rendered to one patient between the census taking hours on two successive days. In computing patient days, the day of admission shall be counted but not the day of discharge. When a patient is admitted and discharged on the same day, this period shall be counted as one patient day.

(f) "Base year" shall mean the cost reporting period for which fiscal and patient data are utilized to calculate rates of payment.

841.5 Provisions applicable to all eligible providers

(a) Limits on Compensation. The maximum reimbursable costs for salaries for positions/titles shall be consistent with the requirements of the limits on executive compensation in this Title.

(b) Financial and Statistical Reporting:

(1) Each eligible provider shall maintain financial records and records relative to numbers and types of services provided and shall prepare and submit to the Office financial and statistical reports in accordance with the requirements of the Office.

(2) All financial reports to be prepared and submitted to the Office shall:

(i) be prepared in accordance with generally acceptable accounting principles;

(ii) be certified by an independent certified public accountant or an independent licensed accountant and shall include a statement of opinion on the data therein, unless this requirement is otherwise waived or modified by the Office; and

(iii) be accompanied by a complete copy of the eligible provider's certified financial statements.

(3) All reports to be prepared and submitted to the Office shall:

(i) be certified by the chief administrative officer or director of the eligible provider;

(ii) be on forms prescribed by the Office; and

(iii) include financial and statistical data for each service for which rates or fees are established.

(4) Reporting Requirements. Reports required to be submitted by this section shall be submitted within 120 days after the close of the eligible provider's fiscal year. Extensions of time for filing reports may be granted by the commissioner upon application received prior to the due date of the report and only in circumstances where the eligible provider establishes by documentary evidence that the reports cannot be filed by the due date for reasons beyond the control of the eligible provider.

(5) If the eligible provider determines that the information on reports filed is inaccurate, incomplete or incorrect, the eligible provider shall immediately file with the Office the corrected reports which comply with the requirements of this section.

(6) If the required financial and statistical reports are determined by the Office to be incomplete, inaccurate or incorrect, the eligible provider has 30 days from the date of receipt of notification from the office to provide the correct or additional data.

(7) Penalties for Non-compliance. (i) If an eligible provider fails to file the required financial and statistical reports, in accordance with this Part, on or before the due date, or Office approved extended due date, the Office may, at its discretion, reduce said eligible provider's existing Medicaid payments by up to twenty (20) percent, beginning the first day of the month following the original due date or approved extended due date and continuing until the first day of the month in which the reports are received by the Office. If the eligible provider fails to file the required financial and statistical reports by the end of the rate period during which the reports were due, such reduction may be increased in each subsequent month by up to ten (10) percent until receipt of the required information. All funds shall be returned to the provider once the provider is determined by the Office to be in compliance.

(8) Revocation of operating certificate. If, after a period of non-compliance resulting in reduced Medicaid payments, the Office determines that a program will likely be unable to meet its financial obligations, the Office may request the program voluntarily surrender its operating certificate or take action to revoke the operating certificate in accordance with this Title.

(c) Record keeping. An eligible provider shall furnish to the Office any information that it may request regarding payments claimed by the provider for furnishing services.

(d) Billing.

(1) The eligible provider shall levy no additional charges to patients for services paid for by the Medicaid Program.

(2) Claims for payment by the Medicaid Program shall be submitted at rates and/or fees established by the Office and approved by the Director of the Budget. Such billings shall be net of any individual or third-party liability.

(3) Claims shall be submitted only for services which were actually furnished to eligible persons and for which documentation of medical necessity is available at the time the services were furnished.

(4) Claims shall be submitted on officially authorized claim forms in formats and in accordance with the Department of Health standards and procedures for claims submission.

(5) All information provided in relation to any claim for payment shall be true, accurate and complete.

(e) Compliance with general medical assistance program requirements. Each eligible provider shall comply with all applicable medical assistance program requirements of the Department of Health.

(f) Calculation of allowable costs.

(1) General. To be considered as allowable, costs must be properly chargeable to necessary patient care as determined by the Office and rendered in accordance with the operating, financial and reporting requirements of the Office pursuant to this Title, and as such may be amended from time to time. The allowability of costs shall be determined in accordance with the following:

(i) Except where specific rules concerning allowability of costs are stated herein, the Office shall use as its major determining factor in deciding on the allowability of costs, the most recent edition of the Medicare Provider Reimbursement Manual, commonly referred to as HIM15, published by the U.S. Department of Health and Human Services' Centers for Medicaid and Medicare Services.

(ii) Where specific rules stated herein or in HIM15 are silent concerning the allowability of costs, the Office shall determine allowability of costs based on reasonableness and relationship to patient care and generally accepted accounting principles.

(2) Services. Allowable operating costs shall include the costs of all services necessary to meet the operating requirements of the Office pursuant to this Title and the special needs of the patient population to be served by an eligible provider.

(3) Capital expenditures. No capital expenditures for which approval by the Office is required in accordance with this Part shall be included in allowable capital costs for purposes of computation of the rate of payment unless such approval shall have been secured. Reimbursement for capital and start-up costs will be limited to those costs determined by the Office to be both reasonable and necessary.

(g) Application Procedures. To qualify for medical assistance payments, an eligible provider, with a current operating certificate issued by the office, shall apply for enrollment as a Medicaid provider on application forms as required by the NYS Department of Health.

(h) Approval of rates. Payment rates established in accordance with the provisions of this Part will remain in effect until such time as they are revised with the approval of the NYS Division of the Budget and the Centers for Medicare and Medicaid Services (where Federal share is applicable).

841.6 Medical assistance payments for inpatient substance use disorder withdrawal and stabilization services

(a) The provisions of this section are applicable to programs certified as substance use disorder inpatient withdrawal and stabilization services pursuant to Part 816.

(b) Rates of Payment.

(1) Rates will be calculated using a cost-based fee methodology inclusive of operating costs and capital reimbursement. There shall be no capital add-on to these fees, nor any separate Medicaid reimbursement for capital costs.

(2) Fees will be established using a regression model based on the relationship between normalized cost and program capacity, recognizing both regional cost differentials and

economies of scale. The calculated statewide fees based on program capacity, will then be adjusted using regional cost factors (based on the county in which the facility is located).

(3) Fees will be deemed to be inclusive of all service delivery costs and will be considered payment in full for fee-for-service Medicaid reimbursed services.

(4) Fee schedules used to determine rates will be posted on the Office website. Fee schedules used to determine rates include:

(i) Statewide OASAS Medically Supervised Inpatient Withdrawal (MSIW) fee chart based on bed size; and

(ii) Geographic region and regional cost factor chart.

(c) Bed size.

(1) New facilities: Bed size for new facilities used for the fee calculation shall be based on 80% of the certified capacity rounded to the nearest integer. After the first full year of operation, the fee calculation shall be revised based on 90% of certified capacity rounded to the nearest integer. If the certified capacity changes for any MSIW program, including programs that have been in operation for less than one year, the fee shall be revised based on 90% of the new certified capacity, effective on the date of the capacity change.

(2) Minimum and maximum standards: Facilities with fewer than six (6) beds shall use the six (6) bed fee. Facilities with an excess of 120 beds (meaning "bed size" as calculated above) shall use the 120-bed fee.

(d) Appeals of Medically Supervised Inpatient Withdrawal Fees.

(1) Fee adjustment for underutilization. MSIW providers may request retroactive fee adjustments based on documented low service volume relative to certified capacity that resulted in an overall net loss in the program. These adjustments are approvable solely at the discretion of the Office and will require compelling justification relative to the program's underutilization. MSIW beds that were used as "swing beds" for other programs (e.g., Medically Monitored Inpatient Withdrawal) do not constitute underutilization and will not justify a fee increase.

(2) Other items of appeal. MSIW providers may also request retroactive fee adjustments based on significant financial losses in the program that resulted from programmatic expenses that were significantly out of proportion to the established level of reimbursement. The provider must fully and properly demonstrate that the fee adjustment requested in the appeal is necessary

to ensure efficient and economic operation of the facility. The final determination as to the extent, if any, of a fee adjustment shall be made solely at the discretion of the Office.

(e) Base year. From time to time, and at the discretion of the Office, the fee calculation may be revised using new base year data. The base year for new fee calculations will be the most recent, substantially complete Consolidated Fiscal Report period available at the time of the calculation.

841.7 Medical assistance payments and utilization review for substance use disorder residential rehabilitation services for youth

(a) The provisions of this section are applicable to programs certified under Part 817.

(b) Rates of Payment.

(1) Rates will be calculated using a cost-based fee methodology inclusive of operating costs and capital reimbursement. There shall be no capital add-on to these fees, nor any separate Medicaid reimbursement for capital costs. There shall be no admission review team add-on.

(2) Fees will be established using a regression model based on the relationship between normalized cost and program capacity, recognizing both regional cost differentials and economies of scale. The calculated statewide fees based on program capacity, will then be adjusted using regional cost factors (based on the county in which the facility is located).

(3) Fees will be deemed to be inclusive of all service delivery costs and will be considered payment in full for fee-for-service Medicaid reimbursed services.

(4) Fee schedules used to determine rates will be posted on the Office website. Schedules used to determine fees include:

(i) Statewide OASAS Residential Rehabilitation Services for Youth (RRSY) fee chart based on bed size; and

(ii) Geographic region and regional cost factor chart.

(c) Bed size.

(1) For existing and new inpatient rehabilitation facilities, the bed size will be based on the certified capacity of the program site.

(2) If the certified bed size changes, the fee will be revised accordingly and will be effective on the date of the bed size change.

(3) Facilities with fewer than fourteen (14) certified beds will use the fourteen-bed fee. Facilities with sixty (60) or more certified beds will use the sixty-bed fee.

(4) Bed size is determined at certification and listed on the program operating certificate issued by the Office.

(d) Base year. The base year for new fee calculations will be the most recent, substantially complete Consolidated Fiscal Report period available at the time of the calculation.

(e) Certification for treatment, utilization review and control.

(1) For an individual who is a Medicaid recipient when admitted to the residential rehabilitation services for youth program, certification of services must be made by an independent team as defined in Part 817 of this Title.

(2) For individuals who apply for Medicaid after admission to the residential rehabilitation for youth program, or for emergency admissions, certification of services must be made by the multidisciplinary team as defined in Part 817 of this Title. This team must include a physician. Emergency admission certification must be made within 14 days after admission. Certification must be made at the time of admission or, if an individual applies for Medicaid while in the facility, at the time of application.

(3) The utilization review plan of an eligible residential rehabilitation services for youth provider shall include the following:

(i) provision for review of each Medicaid recipient's need for services furnished in accordance with the criteria of Part 817 of this Title;

(ii) provisions to ensure that utilization review of a Medicaid recipient's treatment plan and services shall be performed by a multidisciplinary team that includes a physician as defined in Part 817 of this Title.

(iii) procedures to be used by the committee to ensure that staff of the eligible residential rehabilitation services for youth provider take needed corrective action;

(iv) provisions to ensure that the patient's record includes all information required by Part 817 of this Title, as well as the name of the patient's physician, the dates of Medicaid application and authorization if made after admission, initial and subsequent continued stay review dates, the reasons and plan for continued stay if continued stay is necessary, and other supporting material found necessary and appropriate by the multidisciplinary team;

(v) specification of records and reports to be made by the utilization review group;

(vi) provisions for maintaining the confidentiality of the identities of patients in the records and reports of the utilization review group; and

(vii) written criteria to assess the need for continued stay which conform to the requirements of Part 817 of this Title.

(4) The group performing utilization review shall ensure that subsequent reviews for continued stay of a recipient in an eligible residential service for youth program are conducted no later than each thirty-day period following the initial continued stay review. The date assigned for each subsequent continued stay review shall be noted in the patient's record.

(5) Continued stay reviews shall be performed in accordance with the following:

(i) Review for continued stay shall be conducted by the multidisciplinary team defined in Part 817 of this Title.

(ii) The review shall be conducted on or before the review date assigned.

(iii) The multidisciplinary team shall review and evaluate the documentation referred to in this Part in relation to the criteria established in this Part.

(iv) If the multidisciplinary team finds that a recipient's continued stay is needed, the multidisciplinary team shall assign a new continued stay review date in accordance with paragraph (4) of this subdivision.

(v) Any decision of the multidisciplinary team that continued stay is unnecessary shall be provided in writing within two days to the director, the attending physician, the primary counselor, and the patient; and Medicaid billing shall cease as of the day of notification. However, any decision to discharge or retain the patient shall be made on clinical grounds independent of the utilization review group's determination.

(vi) A multidisciplinary team must certify that the services continue to be needed by each recipient.

(vii) If the multidisciplinary team finds that a continued stay is not needed, it shall notify the recipient's attending physician and primary counselor within one working day and provide them two working days to present their views before a final decision.

841.8 Medical assistance payments for substance use disorder inpatient rehabilitation services

(a) The provisions of this section are applicable to programs certified under Part 818.

(b) Rates of Payment.

(1) Rates will be calculated using a cost-based fee methodology inclusive of operating costs and capital reimbursement. There shall be no capital add-on to these fees, nor any separate Medicaid reimbursement for capital costs.

(2) Fees will be established using a regression model based on the relationship between normalized cost and program capacity, recognizing both regional cost differentials and economies of scale. The calculated statewide fees based on program capacity, will then be adjusted using regional cost factors (based on the county in which the facility is located). Geographic region and regional cost factor charts will be posted on the OASAS website.

(3) Fees will be deemed to be inclusive of all service delivery costs and will be considered payment in full for fee-for-service Medicaid reimbursed services.

(4) Fee schedules used to determine rates will be posted on the Office website. Schedules used to determine fees include:

(i) Statewide OASAS Freestanding Inpatient Rehabilitation fee chart based on bed size; and

(ii) Geographic region and regional cost factor chart.

(c) Bed size.

(1) For existing and new inpatient rehabilitation facilities, the bed size will be based on the certified capacity of the program site.

(2) If the certified bed size changes, the fee will be revised accordingly and will be effective on the date of the bed size change.

(3) Facilities with fewer than 14 certified beds will use the 14-bed fee. Facilities with 120 or more certified beds will use the 120-bed fee.

(4) Bed size is determined at certification and listed on the program operating certificate issued by the Office.

(d) Base year. From time to time, and at the discretion of the Office, the fees may be revised using new base year data. The base year for new fee calculations will be the most recent, substantially complete Consolidated Fiscal Report period available at the time of the calculation.

841.9 Medical assistance payments for residential services

(a) The provisions of this section are applicable to programs certified to provide residential services under Part 820.

(b) The program's services are provided in three elements: Stabilization, rehabilitation, and reintegration. Only elements that are approved for federal financial participation are eligible for Medicaid reimbursement. Each reimbursable element shall have regional fees established and posted on the website of the Office. The regions include Downstate and Upstate. The Downstate region shall consist of New York City, as well as the counties of Nassau, Suffolk, Westchester, Rockland, Orange, Putnam, and Dutchess. Upstate shall consist of all other counties in the state. Any annual or periodic fee adjustments shall be published on the Office's website. The initial fees shall be effective July 1, 2016.

(c) Allowable treatment costs shall be determined by the application of principles developed for determining reasonable cost payments for direct and indirect costs. Room and board related costs are not included in the rate.

(d) The fee development methodology shall consider each component of provider cost, as necessary to comply with requirements regarding economy, efficiency, and quality of care. Provider enrollment and retention will be reviewed periodically to ensure that access to care and adequacy of payments are maintained. The fee development methodology will primarily consist of provider cost modeling, though provider compensation studies, cost data, available funding, and comparable fees of other States' residential Medicaid programs may be considered as well. The fees shall be established using the ratio of the calculated or estimated total annual allowable provider cost to the estimated annual billable per diem units.

(e) Periodic fee updates may be performed using provider cost modeling, reported actual cost, and/or any of the factors listed in the prior paragraph. Fee updates will require federal approval and will be posted to the Office website.

841.10 Medical assistance payments for substance use disorder outpatient programs

(a) Applicability. The provisions of this section are applicable to programs certified or co-certified to provide ambulatory care services provided by the following:

(1) substance use disorder outpatient clinics certified or co-certified pursuant to Part 822 of this Title;

(2) opioid treatment programs providing opioid full agonist treatment medications and certified under Part 822 of this Title;

(3) substance use disorder outpatient rehabilitation programs certified or co-certified pursuant to Part 822 of this Title; and

(4) substance use disorder medically supervised outpatient withdrawal and stabilization services certified under Section 816.8 of this Title; and

(5) integrated outpatient programs certified pursuant to Part 825.

Each program shall contain two peer groups, one upstate and one downstate.

(b) Billable services requirements and limitations must be delivered in accordance with the provisions of the Ambulatory Patient Groups (APG) Clinical and Medicaid Billing Guidance, as incorporated by reference in this Title (hereinafter referred to as the APG Manual), in effect at the time the service(s) was delivered.

(c) Definitions. All applicable definitions and rules covering standardized APG pricing logic for New York State's Medical Assistance program are found at Title 10 NYCRR Part 86-8.

(d) APGs and associated weights.

(1) APGs shall be subject to periodic revision; the most current listing shall be published in the APG Manual available on the Office website.

(2) The Department of Health, in consultation with the office, shall assign weights associated with all CPT and HCPCS procedure codes that can be used to bill under the APG methodology.

The office shall maintain and update a list of weights associated with APGs as published in the "APG Policy and Medicaid Billing Guidance" manual on the OASAS website. Such list may include APGs not specifically associated with addiction outpatient and

opioid treatment services, but which may appropriately be billed by providers subject to this Part.

(e) Base Rates. Base rates for addiction outpatient services shall be developed by the Office, and subject to the approval of the Department of Health, in accordance with the following:

(1) Separate base rates shall be established for each peer group. Base rates shall reflect differing regional cost factors, variations in patient population and service delivery, available funding levels, and capital expenditures;

(2) Additional discrete base rates may be developed by the Office for such peer groups as may be established by regulation in this Part; and

(3) Base rates may be periodically adjusted to reflect changes in provider case mix, service costs and other factors as determined by the Office.

(4) All base rates established by the Office shall be published on the Office's website.

(f) System Updating. The following elements of the APG rate-setting system shall be reviewed at least annually, with all changes posted on the New York State Department of Health's website:

(1) The listing of reimbursable APGs and associated weights,

(2) The applicable International Statistical Classification of Diseases and Related Health Problems, as incorporated by reference in this Title (ICD),-10 codes, or subsequent ICD categorization, utilized in the APG software system,

(3) The Applicable CPT/HCPCS codes utilized in the APG software system; and

(4) The APG software system's grouping and pricing logic.

(g) Bundled payment for opioid treatment program (OTP) services

(1) OASAS will establish regional weekly bundled payments for freestanding opioid treatment programs. Such payments will be available as an alternative to the reimbursement under the Ambulatory Patient Group (APG) fee methodology already in place for OTPs. Programs may bill any given week of OTP service for any given patient under either methodology (APGs or the bundled payment methodology), but not both. The initial bundled fees shall be effective March 16, 2020.

(2) For purposes of these bundled payments there will be two regions, downstate and upstate, with the regional assignment based on program location. The downstate region includes the following counties: New York, Kings, Queens, Richmond, Bronx, Nassau, Suffolk, Westchester, Rockland, Putnam, Dutchess and Orange. The upstate region includes all other counties in the State.

(3) The proposed bundled payments are based on service delivery that mirrors a subset of the Medicare OTP bundles in terms of both services and practitioners, as well as in terms of cost by practitioner for each service. Services covered by the bundled payment include: FDA-approved opioid agonist and antagonist treatment medications, dispensing and administering medications, substance use disorder counseling, individual and group therapy, toxicology testing, intake activities, and periodic assessments.

(4) Weekly fees shall be established in the following rate code classifications:

(i) Methadone Dispensing and/or Counseling – This code covers all of the services listed above for a patient being treated with Methadone.

(ii) Methadone Take Home – This code is billable when the patent has a supply of take-home medication in their possession for the week being billed. It cannot be billed for the same week as the dispensing and/or counseling code.

(iii) Buprenorphine Dispensing and/or Counseling – This code covers all of the services listed above for a patient being treated with Buprenorphine.

(iv) Buprenorphine Take Home – This code is billable when the patent has a supply of take-home medication in their possession for the week being billed. It cannot be billed for the same week as the dispensing and/or counseling code.

(5) The initial bundled payments, effective March 16, 2020, shall be calculated by using the unregionalized Medicare fees for the same services, meaning those fees shall not vary by region.

(6) Effective August 2, 2021 the fees shall be regionalized using the OASAS OTP regional factor of 1.1700 (Downstate relative to Upstate) for freestanding facilities. The regional factor shall be applied on a budget neutral basis assuming that the Downstate region would have 94.41% of the methadone bundle service volume based on a historical volume calculation by the Office. The medication take home fees shall

continue to be identical to those used by Medicare, and, as with Medicare, not regionalized.

(7) The Office, may, at its discretion, periodically update the bundled fees using trends, actual cost, Medicare benchmarking, program modeling, or some combination of these techniques – subject to available funding, Federal approval, and NYS Division of the Budget approval.

841.11 Medical assistance payments for children and family treatment and support services

(a) The provisions of this section are applicable to rehabilitative health and behavioral health services provided by programs or providers certified or designated pursuant to Part 823 to provide Children and Family Treatment and Support Services (CFTSS).

(b) Billable Services: Billable services are those authorized and defined in the Children and Family Treatment Support Services Manual posted on the Department of Health website:

(1) Crisis Intervention (CI);

(2) Other Licensed Practitioners (OLP);

(3) Community Psychiatric Support and Treatment (CPST);

(4) Psychosocial Rehabilitation (PSR);

(5) Family Peer Support Services (FPSS); and

(6) Youth Peer Support and Training (YPST).

(c) Approved Modality and Setting. (1) Modality. Unless otherwise authorized, services should include face-to-face interaction with the child/youth and their family, as appropriate. Any such interactions, or the reason(s) such interaction could not be completed, should be documented in the patient treatment/recovery plan and case record.

(2) Setting. Services may be provided in a variety of settings, including an emergency room, health or behavioral health clinic setting, or other community location where the child/youth lives, attends school, works or engages in social activities. Services should be offered in the best setting suited for the desired outcomes and as referenced in the *Manual*.

(d) Rate Setting. Rate of reimbursement is as posted on the Department of Health website. The rate development methodology is composed of provider cost modeling, provider compensation studies and cost data. The following list outlines components which may be used in determining rate development:

(1) Staffing assumptions and staff wages;

(2) Employee-related expenses;

(3) Program-related expenses; and

(4) Program billable units.

841.12 Capital costs.

(a) This section shall apply to programs with Medicaid reimbursement calculated pursuant to this Part.

(b) No program or service governed by this Part shall have its own facility specific or program specific capital add-on. Instead, capital costs from submitted cost reports shall be reviewed by the Office and a regional, and not separately identifiable, capital component shall be built into the operating fees. Such fees shall constitute payment in full for all costs of operating the program, including capital costs, unless otherwise specified.

(c) Allowable Costs. (1) Allowable capital costs means the costs to a program operated by an applicant with respect to the acquisition of real property estates, interests, and cooperative interests in realty, their design, construction, reconstruction, rehabilitation and improvement, original furnishings and equipment, site development, and appurtenances of a facility and as otherwise identified in this Title.

(2) Unless otherwise specified in this Part, costs of ownership of real property shall be allowable in the following categories; depreciation, interest, and closing costs on the purchase and financing of real property, including fees related to loans from the Dormitory Authority of the State of New York (DASNY). Providers should not report costs that were not actually incurred by the provider (e.g., debt service or fees on DASNY loans that were paid by the State of New York or refunded to the provider by the State of New York).

(3) Costs related to Dormitory Authority loans shall be allowable, unless otherwise paid by the State of New York, as follows:

(i) Interest cost accruing from Dormitory Authority mortgage loans pursuant to subdivision 13-d of section 5 of the Facilities Development Corporation Act, net of the portion of such interest cost attributable to operating costs, is an allowable cost. That portion of the interest cost attributable to allowable start-up costs is also allowable. That portion of the loan principal that is attributable to depreciable or amortizable costs, under the rules of HIM 15, is an allowable cost and shall be reimbursed as depreciation or amortization in accordance with any requirements and conditions. Any portion of the loan principal that is attributable to costs that are not depreciable or amortizable under the rules of HIM 15 is not allowable for reimbursement.

(ii) Fees imposed by the office and annual administrative fees imposed by the Dormitory Authority in connection with Dormitory Authority mortgage loans shall be allowable costs.

(iii) Interest payments on Dormitory Authority loans pursuant to this subdivision for capital indebtedness and start-up costs will be considered allowable where such interest expense results from approved capital indebtedness and/or start-up costs in accordance with this Title.

(iv) Interest payment on Dormitory Authority loans pursuant to the provisions of this Part are allowable in excess of the amount associated with the outstanding principal balance prior to refinancing only if the purpose of the additional debt is to acquire assets to be used for care of the persons served by the program and all other applicable requirements of this Part are met.

(v) The Office may recoup, in full or in part, the interest and fee reimbursement for DASNY loans attributable to a particular service. The office may also recoup, in full or in part, the annual depreciation or amortization reimbursement for costs financing through DASNY mortgage loans. The amount of Dormitory Authority mortgage loan interest, fee, depreciation, and amortization recoupments shall be equal to or less than the provider's actual reimbursement for such costs. In no case shall these recoupments exceed such reimbursement.

(d) Start-up costs. Upon the approval by the office, the approved start-up costs of new programs shall be amortized and reimbursed to the provider over a period not to exceed five years.

816.13 Utilization Review

(a) Except as otherwise specified, programs shall provide that:

(1) An Office approved tool was utilized to identify the appropriate level of care for treatment delivered to the patient.

(2) A practitioner must certify for each Medicaid recipient that services of the type provided are or were needed in accordance with the controlling Part under this Title.

(3) The utilization review plan of an eligible provider shall ensure that each provider have policies and procedures to address:

(i) Patients continue to require services furnished in accordance with the applicable criteria of the controlling Part of this Title and review of treatment planning and progress notes;

(ii) Patients are receiving care consistent with psychosocial needs and diagnosis for which they are receiving treatment; and,

(iii) patients have been referred for additional services consistent with their health and physical.

(4) Providers shall have policies and procedures for a utilization management team charged with meeting at least twice annually. Such team shall review the results of audits, utilization management process and other quality assurance activities that are related to charting and to create a comprehensive corrective action plan as needed to ensure compliance with state and federal laws, regulations and guidance issued by the Office.

841.14 Severability.

If any provision of this Part or the application thereof to any person or circumstance is held invalid, such invalidity shall not affect other provisions or applications of this Part which can be given effect without the invalid provisions or applications, and to this end the provisions of this Part are declared to be severable.

Summary
Notice of Proposed Rulemaking

Tobacco-Limited Services
14 NYCRR PART 856

The proposed amendments to Part 856 simply change tobacco-free services to tobacco-limited services, allowing for very limited use of tobacco products in designated areas in programs organized and operating pursuant to Title 14 and certified, funded, or otherwise authorized by OASAS as a provider of prevention, treatment, or recovery substance use disorder services. The reason for this change is to ensure that a completely "tobacco-free environment" is no longer a deterrent to those seeking treatment, while also ensuring that use is very limited to specific settings within the program so as to maintain the health and safety of all staff and patients. The changes throughout the regulation simply replace "tobacco free" with "tobacco-limited" and also clearly state the settings in which those who wish to use tobacco may do so. The language also adds a provision stating that tobacco-cessation shall be available to those who may wish to stop using tobacco products (available to both patients and staff). Minor changes throughout update the language in the regulation to use the new terminology for the office: The Office of Addiction Services and Supports.

Justification
Notice of Proposed Rulemaking

Tobacco-Limited Services
14 NYCRR PART 856

Currently, Part 856 is written as “Tobacco-Free Services” and does not allow for the limited use of tobacco products by those entering treatment. OASAS has recognized that a tobacco-free environment may lead prospective patients to not seek out treatment and therefore has been identified as a major barrier to treatment. The amendments to Part 856 simply change tobacco-free services to tobacco-limited services, allowing for very limited use of tobacco products in designated areas in programs organized and operating pursuant to Title 14 and certified, funded, or otherwise authorized by OASAS as a provider of prevention, treatment, or recovery substance use disorder services. The reason for this change is to ensure that a completely “tobacco-free environment” is no longer a deterrent to those seeking treatment, while also ensuring that use is very limited to specific settings within the program so as to maintain the health and safety of all staff and patients.

TOBACCO-LIMITED SERVICES [~~TOBACCO-FREE SERVICES~~]
14 NYCRR PART 856

[Statutory Authority: Mental Hygiene Law Sections 19.07(e), 19.09(b), 19.21(b), 19.21(d), 32.01, & 32.07(a) **and Public Health Law Section 1399-O**]
Notice: The following regulations are provided for informational purposes only. The Office of Alcoholism and Substance Abuse Services makes no assurance of reliability. For assured reliability, readers are referred to the Official Compilation of Rules and Regulations.

Sec.

Sec. 856.1 Background and Intent
Sec. 856.2 Legal Base
Sec. 856.3 Applicability
Sec. 856.4 Definitions
Sec. 856.5 Policy and Procedures
Sec. 856.6 Severability
Sec. 856.7 Effective Date

Section 856.1 Background and intent

(a) To reduce addiction, illness and death caused by tobacco products.

(b) To provide a healthy **and supportive** environment for staff, patients, volunteers and visitors to entities organized and operating pursuant to the provisions of this Title and certified and/or funded by the **Office of Addiction Services and Supports** [~~Office of Alcoholism and Substance Abuse Services~~] ("the Office") as a provider of prevention, treatment or recovery services for **substance use disorders and problem gambling** [~~alcoholism, substance abuse, chemical dependence and/or gambling~~].

(c) To establish **tobacco-limited services in a tobacco-limited environment** [~~tobacco-free services in a tobacco-free environment~~].

Section 856.2 Legal base

(a) Section 19.07(e) of the Mental Hygiene Law authorizes the Commissioner of the **Office of Addiction Services and Supports** [~~Office of Alcoholism and Substance Abuse Services~~] ("the Commissioner") to adopt standards including necessary rules and regulations pertaining to **substance use disorder** [~~chemical dependence~~] services.

(b) Section 19.09(b) of the Mental Hygiene Law authorizes the Commissioner to adopt regulations necessary and proper to implement any matter under his or her jurisdiction.

(c) Section 19.21(b) of the Mental Hygiene Law requires the Commissioner to establish and enforce certification, inspection, licensing and treatment standards for **substance use disorder treatment** [~~alcoholism, substance abuse, and chemical dependence~~] facilities.

(d) Section 19.21(d) of the Mental Hygiene Law requires the Commissioner to promulgate regulations which establish criteria to assess **substance use disorder** [~~alcoholism, substance abuse, and chemical dependence~~] treatment effectiveness and to establish a procedure for reviewing and evaluating the performance of providers of services in a consistent and objective manner.

(e) Section 32.01 of the Mental Hygiene Law authorizes the Commissioner to adopt any regulation reasonably necessary to implement and effectively exercise the powers and perform the duties conferred by Article 32 of the Mental Hygiene Law.

(f) Section 32.07(a) of the Mental Hygiene Law authorizes the Commissioner to adopt regulations to effectuate the provisions and purposes of Article 32 of the Mental Hygiene Law.

(g) Section 1399-O of the Public Health Law regulates smoking and vaping in certain public areas.

Section 856.3 Applicability

(a) This Part applies to any **program organized and operating pursuant to the provisions of this Title and certified, funded, or otherwise authorized by the Office as a provider of substance use disorder prevention, treatment, or recovery services**[~~entity ("the service") organized and operating pursuant to the provisions of this Title and certified and/or funded by the Office of Alcoholism and Substance Abuse Services ("the Office") as a provider of prevention, treatment or recovery services for chemical dependence and/or gambling~~].

Section 856.4 Definitions

(a) **Tobacco-limited means prohibiting the use of all tobacco products in facilities and in vehicles owned or operated by the program subject to this Part, while allowing for limited use of tobacco products in designated areas on facility grounds** [~~Tobacco-free means prohibiting the use of all tobacco products in facilities, on grounds and in vehicles owned or operated by the service subject to this Part~~].

(b) Facility means **certain parts of the program that are utilized by patients, staff, volunteers, or visitors. This shall include the programs' buildings which are under the direct control of the facility and vehicles that are owned and operated by the program** [~~any part of the service that is utilized by patients, staff, volunteers or visitors. This shall include the service buildings and grounds which are under the direct control of the facility and vehicles that are owned and operated by the facility~~].

(c) Facility grounds means any part of the program that is outdoors, is utilized by patients, staff, volunteers, or visitors, and is under direct control of the program.

(d) [~~(c)~~] Tobacco products include but are not limited to cigarettes, cigars, pipe tobacco, chewing or dipping tobacco.

(e) [~~(d)~~] Patient means any recipient of services in a facility certified**, funded, or otherwise authorized** [~~or funded~~] by the Office.

Section 856.5 Policy and procedures

(a) The governing authority of the **program** [service] shall determine and establish written policies, procedures and methods governing the provision of a **tobacco-limited environment.** [~~tobacco-free environment~~]. These policies, procedures and methods should at a minimum include the following:

(1) Defines the **parts of the facility and vehicles where tobacco use is not permitted** [~~facility, vehicles and grounds which are tobacco-free~~];

(2) Defines designated areas on facility grounds where limited use of tobacco products by patients, families, and other visitors are permitted in accordance with Public Health Law Section 1399-O;

(3) Limits tobacco products that family members, and other visitors can bring to patients, admitted to the program to closed and sealed packages of cigarettes. [~~(2) Prohibits patients, family members, and other visitors from bringing tobacco products and paraphernalia to the service~~];

(4) [~~(3)~~] Requires all patients, staff, volunteers and visitors be informed of the **tobacco-limited** [~~tobacco-free~~] policy including posted notices and the provision of copies of the policy;

[~~(4) Prohibits staff from using tobacco products while at work, during work hours;~~]

(5) Establishes a **policy prohibiting staff from using tobacco products during work hours except in designated areas of the facility grounds, from purchasing tobacco products for or giving tobacco products to patients, and from using tobacco products with patients** [~~tobacco-free policy for staff while they are on the site of the service~~];

(6) **Describes employee assistance programs and other programs that will be made available to staff who want to stop smoking** [~~Establishes treatment modalities for patients who use tobacco~~];

(7) Establishes evidence-based harm reduction and cessation treatment modalities for patients who use tobacco products, in accordance with guidance from the Office;
(8) Establishes a policy prohibiting patients from using tobacco products during program hours except in designated areas of the facility grounds at designated times;

(9) Describes required annual training for staff, including clinical, non-clinical, administrative, and volunteers about tobacco products, nicotine dependence, and tobacco use disorder that is sufficient for the program to operate a holistic approach to tobacco use disorder that is evidenced in progress notes, policies and procedures, perception of care, and outcomes [~~(7) Describes training on tobacco use and nicotine dependence available to staff including clinical, non-clinical, administrative and volunteers~~];

(10) [~~(8)~~] Describes tobacco and nicotine prevention and education programs made available by the service to patients, staff, volunteers and others;

(11) Establishes procedures, including a policy to address the treatment needs of patients who return to the use of tobacco products. This policy shall be incorporated into the policies and procedures as required by all programs certified, funded, or otherwise authorized by this Title and every effort shall be made to provide appropriate treatment services to all persons in need of substance use disorder treatment services. Additionally, each facility shall address staff resumption of tobacco use consistent with the employment procedure of that facility.

[~~(9) Establishes procedures, including a policy to address patients who relapse on tobacco products. This policy shall incorporate the policy and procedures contained in 816.5 (g), 817.4 (o), 818.4 (o), 819.4 (o), 820.7 (a), 821.4 (v), 822.4 (u), 828.14 (b),(c) & (d), and every effort shall be made to provide appropriate treatment services to all persons in need of alcohol and drug addiction services. Additionally, each facility shall address staff relapse consistent with the employment procedure of that facility~~.]

Section 856.6 Severability

If any provision of this Part or the application thereof to any person or circumstance is held invalid, such invalidity shall not affect other provision**s** or applications of this Part which can be given effect without the invalid provision or applications, and to this end the provisions of this Part are declared to be severable.

Section 856.7 Effective Date

[~~This regulation will be effective July 24, 2008.~~]

Summary
Notice of Proposed Rulemaking

Amend 14 NYCRR PART 857
Problem Gambling Treatment and Recovery Services

Overall, The proposed rule amends Part 857 to update language consistent with agency statutory and regulatory provisions; removes references to "waiver" programs which no longer exist. The changes in the rule amend Part 857 to update language consistent with agency statutory and regulatory provisions; removes references to "waiver" programs which no longer exist; removes, consolidates and updates regulatory definitions; expands the provisions of the regulation to all certified, funded or otherwise authorized programs rather than those that provide "gambling only" services; requires use of the level of care tool developed for provision of gambling services in OASAS programs and requires the use of a mental health screening for individuals seeking gambling services. Such amendments are consistent with agency guidance and the provision of problem gambling treatment and recovery services as well as mandating use of the OASAS created tool to determine level of care for gambling services. Provision of problem gambling services are optional services which require certified, funded or otherwise authorized programs to seek a designation pursuant to Part 857 in order to provide. Additionally, there no longer exist any "waiver" programs, all such programs are now certified pursuant to Parts 822 or 824.

Office of Alcoholism and Substance Abuse Services

Andrew M. Cuomo
Governor

Arlene González-Sánchez, M.S., L.M.S.W.
Commissioner

Justification
Notice of Proposed Rulemaking

Amend 14 NYCRR PART 857
Problem Gambling Treatment and Recovery Services

The proposed rule amends Part 857 to update language consistent with agency statutory and regulatory provisions; removes references to "waiver" programs which no longer exist; removes, consolidates and updates regulatory definitions; expands the provisions of the regulation to all certified, funded or otherwise authorized programs rather than those that provide "gambling only" services; requires use of the level of care tool developed for provision of gambling services in OASAS programs and requires the use of a mental health screening for individuals seeking gambling services. Such amendments are consistent with agency guidance and the provision of problem gambling treatment and recovery services as well as mandating use of the OASAS created tool to determine level of care for gambling services. Provision of problem gambling services are optional services which require certified, funded or otherwise authorized programs to seek a designation pursuant to Part 857 in order to provide. Additionally, there no longer exist any "waiver" programs, all such programs are now certified pursuant to Parts 822 or 824.

14 NYCRR Part 857 AMENDED to read as follows:

PROBLEM GAMBLING TREATMENT AND RECOVERY SERVICES
(Statutory Authority: Mental Hygiene Law, Section**s 19.07(a); 19.09(b); 19.20, 19.20(a), 32.01**
32.02**; 32.07**)

Sec.
857.1 Background and intent
857.2 Legal authority
857.3 Applicability
857.4 Definitions
857.5 Designations
857.6 Medicaid/Insurance claims
857.7 General program standards
857.8 Severability

857.1 Background and intent.

(a) Regulation of compulsive gambling (also known as "gambling disorder" or "problem gambling" as such terms are defined herein) was transferred by statute in 2005 from the Office of Mental Health (OMH) to OASAS.

(b) OASAS is directed to define treatment, develop access to prevention, treatment and recovery services, develop minimum standards for treatment, establish core competencies for treatment professionals and service providers, and educate providers of other addictive disorder treatment and mental health services.

857.2 Legal authority.

(a) Section 19.07(a) of the Mental Hygiene Law charges the Office of **Addiction Services and Supports** [~~Alcoholism and Substance Abuse Services~~] (OASAS or "Office") with assuring the development of comprehensive plans, programs and services for research, prevention, care, treatment, rehabilitation, education and training related to substance use disorder and compulsive gambling.

(b) Section 19.09 (b) of the Mental Hygiene Law allows the commissioner to adopt regulations necessary and proper to implement any matter under the commissioner's jurisdiction.

(c) Section 19.20 of the Mental Hygiene Law authorizes the Office to receive and review criminal history information from the Justice Center related to employees or volunteers of treatment facilities certified, licensed or operated by the Office.

(d) Section 19.20-a of the Mental Hygiene Law authorizes the Office to receive and review criminal history information from the Justice Center related to persons seeking to be credentialed by the Office or applicants for an operating certificate issued by the Office.

(e) Section 32.01 of the Mental Hygiene Law states the commissioner may adopt any regulation reasonably necessary to implement and effectively exercise the powers and perform the duties conferred by Article 32 of the Mental Hygiene Law.

(f) Section 32.02 of the Mental Hygiene Law states the commissioner may adopt regulations necessary to ensure quality services to those suffering from compulsive gambling.

(g) Section 32.07 of the Mental Hygiene Law states the commissioner may adopt regulations to effectuate the provisions and purposes of article 32 of the Mental Hygiene Law.

857.3 Applicability

(a) The provisions of this Part apply to providers certified, funded or otherwise authorized by the Office that[~~:~~

~~(1) provide gambling treatment [as a secondary diagnosis to a substance use disorder]; or~~

~~(2) have received a waiver to provide gambling-only treatment services prior to the effective date of this regulation; or~~

~~(3)~~] have received a "designation" pursuant to the provisions of this Part to provide gambling [~~only~~] treatment services.

857.4 Definitions

[(a) ~~"Addiction disorder" means substance use disorder, as defined in Part 800 of this Title, gambling disorder as defined in the most recent edition of the Diagnostic and Statistical Manual (DSM), or problem gambling as defined in this Part.~~

~~(b) "Addiction services" means services delivered by a certified or authorized provider or program for the prevention, treatment and recovery from an addiction disorder.]~~

[~~(c)~~]**(a)**"Designated program" means an OASAS certified program that has been designated pursuant to the requirements of this Part to provide **gambling treatment.** [~~"gambling-only treatment."~~]

[~~(d)~~]**(b)** "Problem gambling" means gambling behavior**s that negatively affect functioning and relationships but meet less than four (4) criteria for gambling disorder as defined by the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) or International Classification of Diseases (ICD).** [~~meeting less than four (4) of the DSM criteria for gambling disorder.~~]

(c) "Gambling disorder" means persistent and recurrent problematic gambling behavior leading to clinically significant impairment or distress as defined by the most recent the most recent edition of the DSM.

[~~(e)~~]**(d)**"Gambling treatment" means treatment for gambling disorder or problem gambling [~~as a secondary diagnosis to substance use disorder, or if context indicates, "gambling-only treatment" without a primary diagnosis of substance use disorder~~].

[~~(f)~~]**(e)** "Qualified Problem Gambling Professional (QPGP)" means any of the following professionals who can document either a minimum of one year of experience in the treatment and/or clinical research of problem gambling, or have completed a formal training program in the treatment of problem gambling as required by the Office and available on the Office website:

(1) Qualified Health Professional (QHP) as listed in Part 800 of this Chapter; for purposes of this subdivision only such QHP is not required to meet the minimum one year of experience in substance use disorders;

(2) Credential Alcoholism and Substance Abuse Counselor with a Gambling designation (CASAC-G);

(3) Credentialed problem gambling counselor (CPGC) who has a current valid credential issued by the Office;

(4) National Certified Gambling Counselor (Level I and II);

(5) Board Approved Clinical Consultant who is currently registered as such by the National Council on Problem Gambling;

(6) Pastoral Counselor certified by the American Association of Pastoral Counselors or is a Fellow of the American Association of Pastoral Counselors.

857.5 Designation to provide gambling[~~-only~~] treatment services

(a) OASAS certified providers seeking to provide gambling[~~-only~~] treatment services must receive authorization pursuant to the requirements of this section.
(b) *Designation.* (1) Requests for designation to provide gambling[~~-only~~] treatment services shall be in the form of an application submitted to the Bureau of Certification and to the appropriate Regional Office.

(2) Office approval will be based on a review of the written plan addressing the following criteria available on the Office website and including, but not limited to:

(i) admission criteria and screening tools;

(ii) confidentiality;

(iii) staffing, supervision and staff training;

(iv) reporting and recordkeeping;

(v) programming **available** [~~specific to gambling-only treatment services~~], such as financial counseling and planning; individual, group and family counseling;

(vi) policies and procedures addressing potential conflicts of interest involving staff with outside employment.

(c) *Regulatory compliance.* "Designated providers" are subject to all regulations applicable to their operating certificate. If terms of such regulation conflict with corresponding terms of the approved designation plan related to the provision of gambling[~~-only~~] services, the terms of the designation plan and the provisions of this Part applicable to gambling[~~-only~~] services shall govern.
[~~(d) *Previous waivers.* Providers who have previously received a waiver to provide gambling-only treatment services must apply for designation pursuant to this Part.~~]

857.6 Medicaid/Insurance claims

(a) *Third Party Reimbursement.*

(1) No Medicaid claim may be submitted by an OASAS program for **provision of problem gambling or gambling disorder treatment**[~~gambling-only services (addiction services)~~] unless such program has been **designated [**~~approved~~] to provide such services and the service has been approved by CMS.

(2) Private insurance may be billed for gambling disorder services.

857.7 General Program Standards

(a) *Policies and Procedures.* In addition to the policies and procedures required by a program's certification, programs offering gambling treatment [~~(as secondary to SUD or as gambling-only)~~] must develop policies and procedures specific to the level of gambling treatment provided including, but not limited to:

(1) standards of conduct for staff related to providing clinical treatment, self-help support or any other professional service in another independent program, community and/or private practice setting;

(2) provisions to admit without a [~~full~~] diagnosis [~~for a~~] **of** gambling disorder;

(3) services must include financial counseling and planning (on site or by referral);

(b) *Staffing.* (1) Programs providing gambling treatment must have a clinical supervisor and designated counseling staff deemed qualified to provide gambling treatment services. If at any time a program does not meet the staffing requirements the program must immediately report this to their [~~Field~~]**Regional** Office manager.

(2) Staffing requirements include:

(i) Clinical Supervisor. The Clinical Supervisor must be a Qualified Problem Gambling Professional[~~s~~] (QPGP) as defined in **this Part**[~~section 857.4 of this Part~~] and be currently acting in a clinical supervisory role. If the Clinical Supervisor is not a QPGP at the time of the application, they must document they are pursuing the requirements and submit proof of completion within one year of application approval. During this time, the direct counseling staff providing gambling treatment must be receiving supervision as approved by OASAS.

(ii) Counselors. Counselors providing direct gambling treatment must be a QPGP.

(3)[~~(iii)~~] Training. All clinical staff should be provided with, and document, training related to gambling disorder and problem gambling.

(4)[~~(iv)~~] Continuing education. Qualified Health Professionals (QHP) as defined in Part 800 of this **Title** [~~Chapter~~], and Pastoral Counselors **providing gambling treatment**, must submit documentation of ten (10) hours of advanced clinical problem gambling training every three years.

(c) *Admission, initial services, transfers and readmissions.* (1) The program must document that the individual is determined to have met the criteria for problem gambling (meets **fewer than four (4)** [~~1-4~~] criteria of Gambling Disorder) or Gambling Disorder based on the criteria in the most recent version of the [~~Diagnostic and Statistical Manual (DSM)~~] **DSM** or the **ICD**[~~International Classification of Diseases (ICD)~~].

(2) The program must have used a gambling screening **instrument** [~~tool~~] that has been approved by the Office.

(3) **The program must document level of care determination using an Office approved level of care protocol for admission.**

(4) If clinically indicated:

(i) The program must use OASAS approved, validated screening instruments for co-occurring mental health conditions and behavioral health risk, including suicide risk, and refer individuals for evaluation of associated mental health conditions.

(ii) The program must use OASAS approved, validated screening instruments for co-occurring substance use disorders, and refer individuals for evaluation of associated substance use disorders, if clinically indicated.

(5) The decision to admit an individual must be made by the clinical supervisor defined in subdivision (b) of this section and must be documented by such supervisor's dated signature (physical or electronic signature) and include the basis for admitting the patient.

(d) **Patient** *Case Records and Confidentiality.* (1) The following must be included in records for patients admitted for gambling treatment:

(i) A completed gambling screening tool approved by OASAS;

(ii) A completed gambling level of care determination using an OASAS approved tool;

(iii) If clinically indicated, a suicide, co-occurring mental health and/or substance use disorder screening instrument approved by the OASAS.

(2) [~~If admitted for gambling as a secondary diagnosis, patient records can be kept together subject to all federal and state confidentiality laws and regulations. If admitted for gambling-only treatment services, patient records must be kept separate from records for patients receiving substance use disorder treatment.~~] **Patient records are subject to all applicable federal and state confidentiality laws and regulations.**

857.8 Severability

Severability. If any provision of this Part or the application thereof to any person or circumstance is held invalid, such invalidity shall not affect other provisions or applications of this Part which can be given effect without the invalid provision or application, and to this end the provisions of this Part are declared to be severable.