Part 512 Repeal and Replace

PROS Redesign Summary of Regulatory Changes

Part 512 will be repealed and replaced with new regulations intended to align with a redesign of the PROS model and the 2024 State Plan Amendment (#23-0098). These new regulations are intended to simplify program implementation and provide clarity on program requirements, which involved restructuring the regulations into new subsections.

- Updated language throughout to conform with changes in naming conventions, including:
    - replacing gendered pronouns with gender neutral pronouns,
    - updating state agency names for the Office of Addiction Services and Supports, Adult Career and Continuing Education Services – Vocational Rehabilitation, and the Justice Center for the Protection of People with Special Needs,
    - updating program names for Health Home Care Coordination, Office for People with Development Disabilities (OPWDD) employment and habilitation programs, etc., and
    - We have removed any mention of limited license PROS programs to conform with the State Plan Amendment. It is noted that OMH has not certified any limited license PROS programs in over 10 years. We removed the word “comprehensive” before PROS, as this term was used to distinguish from limited license PROS.

- Changes to Part 512.4 Definitions:
    - Removed definition for “capacity” as this number in PROS is only used in reference to the fire capacity of the licensed space and is often confused with the monthly caseload
    - Amended definition for “collateral” to expand who qualifies as a collateral in alignment with other rehabilitative services in NYS and to support integration and coordination of care
    - Removed definition for “clinical staff” as this term will not be used in redesign. All staff will be categorized as paraprofessional or professional staff.
    - Added definition for “competent mental health professional” to clearly define who may supervise Peer Support Services
    - Amended definition of “designated mental illness diagnosis” to align with current language used in the DSM-5 and ICD-10. These edits are clarifying and will not result in any policy change in terms of who is or is not eligible for PROS.
    - Added definition for “direct supervision” in alignment with the State Plan Amendment.
    - Amended definition of “functional disability” to align with current language suggested by the Substance Abuse and Mental Health Services Administration

(SAMHSA). These edits are clarifying and will not result in any policy change in terms of who is or is not eligible for PROS.
    - Added definition for “in-person” and removed the definition for “face-to-face,” as the significance of these terms has changed since the promulgation of Part 596 and the implementation of telehealth services.
    - Amended definition for “licensed practitioner of the healing arts” to align with the State Plan Amendment. This includes adding LMHCs, LMFTs, LCATs, Licensed Psychoanalysts, and Licensed Occupational Therapists.
    - Amended definition for off-site to align with changes in the reimbursement model.
    - Added definition for “paraprofessional staff” in alignment with the State Plan Amendment. This includes adding definitions for Certified Peers and Licensed Practical Nurses.
    - Amended the definition of “professional staff” to add Certified Psychiatric Rehabilitation Practitioners and to clarify that limited permit holders also qualify as professional staff in PROS.
    - Amended the definition of “PROS unit” to align with new reimbursement methodology in the State Plan Amendment.
- Restructuring Part 512.5-8 to simply regulations for program implementation; this included moving information between sections to promote readability
    - Moved “Certification” from 512.6 to 512.5
    - Moved and updated “Service categories and requirements” from 512.5 to 512.6 (now “Components and services,” and incorporated component and service-specific information from 512.7 where relevant
    - Updated “Documentation” in 512.8 to include information previously included in 512.7; this new section has been renamed “Admission, assessment, individualized recovery planning, and documentation”
- Regulatory changes in 512.5 “Certification”
    - Eliminated the concept of “capacity” throughout and replaced with “monthly caseload” where relevant; this aligns with how programs are currently licensed
    - Updated what will be included on the operating certificate, replacing capacity with monthly caseload and including approved optional services
- Regulatory changes in 512.6 “Components and services”
    - Moving information from the previous 512.7 “Program operations” section so that all information related to components and services is found in one place
    - Clearly articulating the component and service definitions in alignment with the proposed redesign SPA
    - Adding qualified practitioners to each service definition so that programs will understand who can deliver and supervise each service; aligning staff qualifications with state scope of practice laws where necessary
    - Removing definitions for Basic Living Skills Training, Benefits and Financial Management, Community Living Exploration, Information and Education Regarding Self-Help, Structured Skill Development and Support, and Wellness Self-Management in alignment with the proposed redesign SPA; note that these services will be rolled into a single Psychosocial Rehabilitation service, also under the CRS component
    - Replaced the definition of CRS Assessment with two new services previously approved in the 2019 SPA:

        - Alcohol, Tobacco, and Other Drug Assessment
        - Psychiatric Rehabilitation Assessment
    - Adding definitions for new services as included in the proposed redesign SPA:
        - Complex Care Management
        - Peer Support
        - Psychosocial Rehabilitation
    - Recategorized Cognitive Remediation as an optional service under the Intensive Rehabilitation component, instead of CRS
    - Updating the regulations to align with Telehealth Guidance, requiring that individuals who receive IR services must be seen at least once in-person or through audio-visual telehealth during the calendar month
    - Expanding the definition of Ongoing Rehabilitation and Support component and service to include support for individuals in integrated educational programs
- Regulatory Changes to 512.7 “Program operations”:
    - Maintains the requirement that programs must have a program schedule which includes recovery-oriented activities and aligns with Telehealth Guidance, requiring programs to have daily in-person group services available.
    - Maintains requirements related to integration of rehabilitation, treatment, and support
    - Amends Staffing and Supervisory requirements to:
        - clearly describe minimum staffing requirements for different levels of staff,
        - align psychiatry and nursing coverage with MHOTRS, with coverage based on clinical needs instead of prescribed FTEs
            - allow PROS programs to use a psychiatric nurse practitioner to meet psychiatry needs without a regulatory waiver
        - include employment specialist requirement in regulation (currently this is required in programmatic guidance and under the State Spending Plan Guidelines)
        - replaces the 40% professional staff requirement with a 1:34 professional staff to participant ratio
        - requires that all PROS programs, regardless of size, have one professional staff in addition to the LPHA to allow for coverage due to staff absences
        - replaces component and attendance specific staffing ratios with a 1:14 staff to participant ratio; this ratio is inclusive of the professional staff outlined above
- Regulatory Changes to 512.8 “Admission, Assessment, Individualized Recovery Planning, and Documentation”:
    - Reorganized by combining information from the previous 512.7 and 512.8 so that all information about a specific topic can be found in one place;
    - For LPHA Recommendations by an outside provider, added flexibility to allow programs to capture NPI *or* license number instead of only license number
    - Revised required elements in an Individualized Recovery Plan to reduce administrative burden while preserving the most important elements:
        - Multiple of the required elements needed to be “identified in the summary of findings provided in each required assessment”; we changed this so that information like strengths and barriers can be included whether they

were identified in the assessment process or at any other point in services;
        - Added recovery vision
        - Removed anticipated outcomes, as it is duplicative of goals and objectives
        - Removed the requirement that individuals receiving IR, ORS, or Clinical Treatment need an additional justification for these components in their IRP;
        - Removed relapse prevention plan as a requirement;
        - Removed description of how CT and Rehabilitation services will be integrated
        - Amended signature requirements to align with the Redesign SPA
            - Added LPHA signature
            - Removed Psychiatrist/NPP signature requirement
    - Updated the service addition rules to include the signature of the supervising LPHA when a new service is added between IRP review period
    - Removed the requirement that IR and ORS services must be reviewed every three (3) months
    - Clarified current expectations related to IRP reviews and significant life events
    - Updated monthly summary note required elements to reduce administrative burden while ensuring that progress toward goals and objectives is captured in the case record
    - Replaced documentation related to program participation time with documentation requirements for individual and group-based service delivery
    - Updated the required elements in the case record to remove documentation requirements related to Integrated Treatment for Co-Occurring Disorders in order to reduce administrative burden and increase access to integrated treatment services
    - Removed the requirement for tracking program participation time as part of the case record
- Changes to 512.9 “Organization and administration”:
    - Clarified the requirement related to promoting the competency of the workforce to indicate that organizations are responsible for ensuring that staff complete required trainings as specified by OMH
- No changes to 512.10 “Rights of PROS participant”
- Changes to 512.11 “Medicaid reimbursement”:
    - Removed a reference to NYS VESID that is out of date
    - Replaced the language related to units, tiers, service frequency, and program participation time with the new reimbursement methodology
    - Removed the list of medically necessary services in PROS to align with the Redesign SPA
    - Updated the reimbursement for add-on components to increase flexibility for ORS to be provided in shorter sessions of no less than 15 minutes each
    - Clarified the 50% IR cap, which applies to paid CRS claims not submitted CRS claims
    - Updated Clinic Treatment add-on component rules so that the psychiatrist or PNP only needs to see individuals receiving medication management

specifically, creating more flexibility for participants to receive other clinical treatment services
    - Updated co-enrollment restrictions to include updated program names and models, including:
        - Changed OMH Clinic to MHOTRS
        - Added Health Home Care Management
        - Updated OPWDD program names to include current habilitation and employment programs
    - Allows for co-enrollment between PROS with Clinical Treatment and OPWDD Article 16 Clinic to improve flexibility and access to services
    - Allows for co-enrollment between PROS with Clinical Treatment and OASAS Article 32 Clinic to improve flexibility and access to services
- Changes to 512.12 “Rates of payment”:
    - Replaced table with outdated rates and tiers with information on where providers can find current information
- Changes to 512.13 “Premises”:
    - Changed “capacity” to “monthly caseload”
- No changes to 512.14 “Quality improvement”
- Changes to 512.15 “Waivers”:
    - Removed language related to waivers for psychiatry coverage due to changes we made in Part 512.7; there will no longer be a need for this type of regulatory waiver
- No changes to 512.16 “Transition to Part 512”
- No changes to 512.17 “Enforcement”
- No changes to 512.18 “Audits”
- Struck 512.19 “Behavioral health organizations” as this is outdated and no longer applicable due to the Medicaid managed care carve-in for behavioral health

PROS Redesign Regulations

Repeal and Replace Current Part 512

14 CRR-NY XII 512

Proposed Regulation

(Please note we have color coded the regulation for ease of review: Color Coding:

No Highlight = No Change to Language

Yellow Highlight = Minor Change to Language but no change to policy

Blue Highlight = New language or change to regulations that aligns with SPA and Redesign)

512.1 Background and intent.
(a) This Part establishes certification standards for personalized recovery-oriented services (PROS) programs. The purpose of PROS programs is to assist individuals in recovering from the disabling effects of mental illness.

(b) It is the intention of this Part to provide for a person-centered process, which, to the maximum extent possible, an individual participates in the planning of their services and makes informed choices about the services and supports that they receive. Compliance with this Part shall ensure that services are collaborative in nature and based on the individual's interests, preferences, strengths, and needs, are designed to empower the individual by fostering skills to achieve desired personal relationships, community participation, dignity, and respect and that the individual is satisfied with activities, supports, and services.

(c) The Office of Mental Health shall issue operating certificates to programs that meet the standards set forth in this Part. Certification in and of itself does not confer eligibility to receive financial support from any governmental source. In order to qualify for reimbursement under the medical assistance program, PROS programs must comply with the standards specified in section 512.11 of this Part.

(d) In order to be eligible for payments pursuant to title 11 of article 5 of the Social Services Law, a PROS program must be certified to provide services by the Office of Mental Health in addition to meeting the requirements of title XIX of the Social Security Act.

(e) This Part establishes rates of payment made by government agencies pursuant to title 11 of article 5 of the Social Services Law for the participation of individuals in an eligible PROS program.

(f) The rates of payment established pursuant to this Part are intended to be adequate to meet the costs of an efficiently and economically operated program.

512.2 Legal base.
(a) Sections 7.09(b) and 31.04(a) of the Mental Hygiene Law give the commissioner the power and responsibility to plan, establish and evaluate programs and services for the benefit of individuals with mental illness, and to adopt regulations that are necessary and proper to implement matters under their jurisdiction.

(b) Section 41.05 of the Mental Hygiene Law provides that a local governmental unit shall direct and administer a local comprehensive planning process for its geographic area in which all providers of service shall participate and cooperate through the development of integrated systems of care and treatment for people with mental illness.

(c) Subdivision (a) of section 43.02 of the Mental Hygiene Law provides that payments under the Medical Assistance Program for programs approved by the Office of Mental Health shall be at rates certified by the Commissioner of Mental Health and approved by the Director of the Division of the Budget.

(d) Subdivision (b) of section 43.02 of the Mental Hygiene Law gives the commissioner authority to request from operators of facilities certified by the Office of Mental Health such financial, statistical and program information as the commissioner may determine to be necessary.

(e) Subdivision (c) of section 43.02 of the Mental Hygiene Law gives the Commissioner of Mental Health the authority to adopt rules and regulations relating to methodologies used in establishment of schedules of rates for payment.

(f) Sections 364(3) and 364-a(1) of the Social Services Law give the Office of Mental Health responsibility for establishing and maintaining standards for medical care and services in facilities under its jurisdiction, in accordance with cooperative arrangements with the Department of Health.

512.3 Applicability.
This Part shall apply to any provider of service that has been certified to operate or proposes to operate a PROS program that must be certified by the Office of Mental Health.

512.4 Definitions.
(a) *Admission date* is the day that the PROS program completes and submits a PROS registration form on behalf of a PROS participant, using the registration system approved by the office.

(b) *Adult* means an individual 18 years of age or older.

(c) *Collateral* means a person who is the individual's family, family of choice, and others significant in their life or integral to their PROS goal, who provide a direct benefit to the participant. Services may be delivered to collateral in accordance with the individualized recovery plan, and for the purpose of advancing their goals and for coordination of services with other community behavioral health and medical providers.

(d) *Commissioner* means the Commissioner of the New York State Office of Mental Health.

(e) *Competent mental health professional* means professional staff and certified peer specialists or certified youth peer advocates with at least three years of direct experience providing peer support services.

(f) *Comprehensive psychiatric rehabilitation assessment* means the process of identifying the skills and supports necessary for an individual to be successful in their chosen life roles. Such assessment is intended to focus on the individual's living, learning, working, parenting and social goals, and to identify barriers, due to the individual's mental illness, that are preventing achievement of the individual's recovery goals. The assessment should also identify the individual's strengths that can be utilized in the achievement of their recovery goals.

(g) *Designated mental illness diagnosis* means a Diagnostic and Statistical Manual of Mental Disorders (DSM) diagnosis or International Classification of Diseases (ICD) equivalent other than:

(1) substance-related and addictive disorders in the absence of other mental health conditions defined in the DSM or ICD;

(2) neurodevelopmental disorders in the absence of other mental health conditions defined in the DSM or ICD, except Attention-Deficit/Hyperactivity Disorder and Tic Disorders;

(3) neurocognitive disorders, including traumatic brain injury, or mental disorders due to another medical condition; or

(4) V-Codes. Other conditions that may be a focus of clinical attention (commonly described with Z codes).

(h) *Direct supervision* means that the appropriate professional staff must be available at all times to furnish assistance and direction to paraprofessional staff for the purpose of addressing issues in the provision of any PROS service component. This does not require that the supervisor be present in the room at the time the service is rendered.

(i) *Due diligence* means the exercise of reasonable and appropriate efforts to comply with the standards set forth in this Part.

(j) *Employment specialist* means a member of the PROS staff who meets the qualifications of a paraprofessional staff and whose primary responsibility is delivery of evidence-based supported employment services.

(k) *Evidence-based practice* means an intervention for which there is consistent, scientific evidence showing that it improves recipient outcomes.

(l) *Functional disability* means a deficit caused by the designated mental illness that rises to the level of impairment in one or more major life activities, such as activities of daily living, instrumental activities of daily living, or participating in family, school, or workplace.

(m) *In-person* means contact between a PROS participant and a member of the PROS staff, in the same physical location, for the purpose of providing a medically necessary service for the PROS participant's benefit.

(n) *Licensed practitioner of the healing arts (LPHA)* means the following professional staff, as defined in this Part:

(1) nurse practitioner;

(2) physician;

(3) physician assistant;

(4) psychiatric nurse practitioner;

(5) psychiatrist;

(6) licensed psychologist;

(7) registered professional nurse;

(8) licensed mental health counselor;

(9) licensed marriage and family therapist;

(10) licensed creative arts therapist;

(11) licensed psychoanalyst;

(12) licensed occupational therapist;

(13) licensed clinical social worker (LCSW); and

(14) licensed master social worker (LMSW) if supervised by an LCSW, licensed psychologist, or psychiatrist employed by the agency.

(o) *Local governmental unit (LGU)* means the unit of government given the authority in accordance with article 41 of the Mental Hygiene Law to plan and provide for local or unified services.

(p) *Month* means any time between and including the first and last days of any calendar month in a given year.

(q) *Monthly caseload* means the maximum number of individuals who can be registered to receive services from the PROS program in any given month.

(r) *New York Employment Support System (NYESS)* is a secure computer-based case management tool developed by OMH and New York State Department of Labor used by PROS providers to provide employment services and as a data-reporting instrument.

(s) *Office* means the New York State Office of Mental Health (OMH).

(t) *Off-site,* for purposes of providing PROS services, means any appropriate location in the community, other than a licensed PROS site, where an individual may receive services. Off-site does not include any space that is co-located at the same address as the licensed PROS site.

(u) *Paraprofessional staff* means PROS staff members who are not professional staff, as specified below. Paraprofessional staff include the following:

(1) Certified Peers means individuals who have are certified or credentialed by the New York Peer Specialist Certification Board as a Certified Peer Specialist (CPS), including those with provisional certification (CPS-P), and individuals who have been credentialed by the Families Together in New York State as a Youth Peer Advocate (YPA-C), including those with provisional credentials (YPA-PC) and are supervised by a competent mental health professionals, including professional staff or by a CPS or YPA-C with three years of experience providing direct peer support services;

(2) Licensed Practical Nurses (LPN) means individuals who are currently licensed or permitted as an LPN by the New York State Education Department and are supervised by a registered professional nurse, licensed physician, or physician's assistant; and,

(3) Other individuals who are at least 18 years old, possess at least a High School diploma or high school equivalency certificate, and demonstrate six (6) months professional and/or personal experience in a mental health or human services field.

(v) *Person-centered process* shall mean that an individual participates to every extent possible, in the planning of their services and empowers the individual to make choices about the services and supports that they receive.

(w) *Pre-admission status* means the time period that begins when an individual first receives a PROS pre-admission service and ends on the individual's PROS admission date.

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

(1) *certified psychiatric rehabilitation practitioner*, which means an individual who is currently certified as a Psychiatric Rehabilitation Practitioner by the Psychiatric Rehabilitation Association;

(2) *creative arts therapist,* which means an individual who is currently licensed or has a limited permit to practice as a creative arts therapist by the New York State Education Department, or who has a master's degree in a mental health field from a program approved by the New York State Education Department and registration or certification by the American Art Therapy Association, American Dance Therapy Association, National Association of Music Therapy or American Association for Music Therapy;

(3) *credentialed alcoholism and substance abuse counselor,* which means an individual who is currently credentialed by the New York State Office of Addiction Services and Supports in accordance with Part 853 of Title 14 of the NYCRR;

(4) *marriage and family therapist,* an individual who is currently licensed or has a limited permit to practice as a marriage and family therapist by the New York State Education Department;

(5) *mental health counselor,* which means an individual who is currently licensed or has a limited permit to practice as a mental health counselor by the New York State Education Department;

(6) *nurse practitioner,* which means an individual who is currently certified or has a limited permit to practice as a nurse practitioner by the New York State Education Department;

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

(8) *occupational therapist,* which means an individual who is currently licensed or has a limited permit to practice as an occupational therapist by the New York State Education Department;

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

(10) *physician,* which means an individual who is currently licensed or has limited permit to practice as a physician by the New York State Education Department;

(11) *physician assistant,* which means an individual who is currently registered or has a limited permit to practice as a physician assistant or a specialist's assistant by the New York State Education Department;

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

(13) *psychoanalyst,* which means an individual who is currently licensed or has a limited permit to practice as a psychoanalyst by the New York State Education Department;

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

(15) *registered professional nurse,* which means an individual who is currently licensed or has a limited permit to practice as a registered professional nurse by the New York State Education Department;

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

(17) *social worker*, which means an individual who is currently licensed or has a limited permit to practice as a master social worker (LMSW) or clinical social worker (LCSW) by the New York State Education Department. LMSWs must be supervised by a LCSW, licensed psychologist, or

psychiatrist employed by the agency. Social workers who do not meet this criteria may not be considered licensed practitioners of the healing arts; and

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

(y) *PROS unit* is defined as 15 continuous minutes of service provided to an individual or collateral, or 30 continuous minutes of service provided to an individual or collateral in a group setting.

(z) *Provider of service* means the entity that is legally responsible for the operation of a PROS program. Such entity may be an individual, partnership, association, limited liability corporation, or corporation.

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

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

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

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

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

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

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

512.5 Certification.
(a) A provider of service intending to operate a PROS program must obtain an initial operating certificate issued by the office in accordance with Part 551 of this Title. Renewals of such operating certificates shall be issued for terms of up to three years.

(b) PROS programs shall be licensed as one of the following program types:

(1) PROS with clinical treatment, or

(2) PROS without clinical treatment.

(c) Each PROS program shall be authorized by a discrete operating certificate. In addition, if a PROS program is operating at multiple sites, each site shall be authorized by a discrete operating certificate. For each site, the operating certificate shall specify:

(1) the program type to be operated;

(2) the location of the program;

(3) the hours of operation of the program;

(4) the program's monthly caseload;

(5) the population to be served;

(6) any approved optional services to be provided; and

(7) the term of the operating certificate.

(d) The initial operating certificate issued pursuant to subdivision (a) of this section shall be for a term of up to one year.

(1) A provider shall not exceed the monthly caseload identified in its operating certificate unless the provider receives approval pursuant to Part 551 of this Title.

(e) A PROS provider may offer services identified in section 512.6 of this Part pursuant to an agreement with another provider. Such agreements require prior approval of the office as clinical services contracts or management contracts in accordance with Part 551 of this Title.

(f) Establishment of a new PROS site or changes to the operating certificate, other than changes in the hours of operation as described in subdivision (g) of this section, require prior approval of the office in accordance with Part 551 of this Title. Such changes include, but are not limited to, the following:

(1) changes in the physical space or location, use of additional sites, or change in the provider's monthly caseload;

(2) termination of the program; or

(3) changes in the powers or purposes set forth in the certificate of incorporation of the provider of service.

(g) Changes in the hours of operation of a program may be made upon approval of the office, in consultation with the local governmental unit.

(h) No PROS program site shall be located within the operating space of a residential program licensed by the office.

(i) An operating certificate may be limited, suspended or revoked by the office pursuant to Part 573 of this Title. The operating certificate is the property of the office and as such shall be returned to the office if it should be revoked.

(j) The commissioner, in consultation with the local governmental unit, may reduce a program's monthly caseload when it is determined that such program is not providing services at a reasonable level, or is not providing reasonable access to services in accordance with section 512.8(a)(6) of this Part. Such reduced monthly caseload may be reallocated, to another provider of service certified pursuant to this Part, in accordance with Parts 551 and 573 of this Title.

(k) The provider of service shall frame and display the operating certificate within the PROS program site in a conspicuous place that is readily accessible to the public.

(l) The commissioner is authorized to make inspections and examine all records of PROS programs. Such examination may include, but is not limited to, any medical, service, financial or contractual record. The provider of service shall cooperate with the office during any such inspection or examination.

(m) The commissioner shall have the authority to designate and approve demonstration projects for purposes of examining innovative program and administrative configurations, regulatory flexibility, and alternative funding methodologies.

(n) No renewal of an operating certificate pursuant to this Part and Part 551 of this Title shall be issued in the absence of an executed provider agreement developed in accordance with section 512.14(b) of this Part.

512.6 Components and services.
Each of the following services, offered by PROS providers in accordance with their certification category, are provided by PROS staff members for the purpose of assisting individuals to overcome the barriers caused by their mental illness that are preventing them from achieving their chosen goals.

(a) *Clinical treatment component* shall be designed to help individuals achieve and maintain recovery from mental health conditions by treating the symptoms of those conditions and restoring skills which have been lost due to the onset of mental illness and which are necessary for individuals to manage and cope with the symptoms and behaviors associated with mental health conditions and function successfully in the community. Clinical treatment interventions must be highly integrated into the support and rehabilitation focus of the PROS program. The frequency and intensity of clinical treatment services shall be commensurate with the needs of the target population. Such services shall be provided on site, off-site or through telehealth, pursuant to Part 596.4 of this Title. Clinical treatment services may only be offered by PROS programs licensed by the Office to provide such services.

(1) The clinical treatment component shall include at a minimum:

(i) *Clinical counseling and therapy*, a service designed to provide goal-oriented verbal counseling or therapy, including individual, group and family counseling or therapy, for the purpose of addressing the emotional, cognitive and behavioral symptoms of a mental health disorder or for engaging, motivating and stabilizing persons with a co-occurring mental health and substance use disorder, and the related effects on role functioning. This service is conducted by professional staff, excluding Certified Psychiatric Rehabilitation Practitioners, Occupational Therapists, Pastoral Counselors, Therapeutic Recreation Specialists, and Rehabilitation Counselors. Such service may be provided by paraprofessional staff where appropriate under state scope of practice laws, under the supervision of Professional staff, except Certified Psychiatric Rehabilitation Practitioners, Occupational Therapists, Pastoral Counselors, Therapeutic Recreation Specialists, and Rehabilitation Counselors.

(ii) *Health assessment*, a service designed to gather data concerning an individual's medical history and any current signs and symptoms and assess such data to determine their physical health status and need for referral. This includes continued measurement of specific health indicators associated with increased risk of medical illness and early death, including but not limited to, blood pressure, body mass index (BMI), substance use, and tobacco use. This service is conducted by a nurse practitioner, nurse practitioner in psychiatry, physician, physician's assistant, psychiatrist or registered professional nurse. Licensed Practical Nurses may also provide health assessment within their scope of practice under New York State law and under the supervision of a registered professional nurse, licensed physician, or physician assistant.

(iii) *Medication management*, a service designed to prescribe or administer medication to treat the primary symptoms of an individual's psychiatric condition. This service is intended to include medication trials which are adequate in dose and duration, as well as assessments of the appropriateness of the individual's existing medication regimen through record reviews, ongoing monitoring, and consultation with the PROS participant and/or collateral. Medication management may include monitoring the side effects of prescribed medications including, but not limited to, extrapyramidal, cardiac and metabolic side effects, and may include providing individuals with information concerning the effects, benefits, risks and possible side effects of a proposed course of medication. The Medication itself is reimbursable under separate State Plan authority. This service is conducted by a psychiatrist or psychiatric nurse practitioner. Registered professional nurses, and licensed practical nurses under the supervision of a registered professional nurse, licensed physician, or physician assistant, may also administer medication.

(iv) *Psychiatric assessment*, a service designed to gather data concerning an individual's psychiatric history and current mental health symptoms, assess such data for determination of the individual's current mental health status, and identify the need for clinical treatment services. This service is conducted by a psychiatrist or psychiatric nurse practitioner.

(v) *Symptom monitoring*, a service designed to identify the ongoing effects of an individual's course of care. This service involves the continuous process of monitoring a recipient's symptoms of mental illness, as identified in their individualized recovery plan, and their response to treatment, within the context of other support and rehabilitation services. This service is conducted by LPHAs, professional staff, or paraprofessionals under the supervision of an LPHA.

(2) If it is clinically appropriate to deliver a clinical treatment service in a group format, such group size shall not, on a routine and regular basis, exceed 12 members. However, on an occasional basis, group sizes of between 13 and 24 members are permissible if the group is co-facilitated by at least two staff members, and there is documentation that the expanded group size is clinically appropriate for the service being provided. Pursuant to section 512.11(b)(5) of this Part, a PROS program may, within the specified limits, still use the service to satisfy the service frequency requirement of section 512.11(c)(4)(i) of this Part for some group participants.

(3) Individuals receiving the medication management service must have, at a minimum, one contact with a psychiatrist or nurse practitioner in psychiatry every three months, or more frequently as clinically appropriate.

(b) *Community rehabilitation and support (CRS) component* shall be designed to engage and assist individuals in managing their illness and in restoring those skills and supports necessary achieve satisfaction in life roles and to live successfully in the community. Such services shall be provided on site, off-site or through telehealth, pursuant to Part 596 of this Title.

(1) A CRS component shall include, at a minimum, the following services:

(i) *Alcohol, tobacco, and other drug assessment*, an assessment service designed to gather data concerning an individual's substance-related history and current use and assess such data to determine the individual's substance abuse status, the need for substance abuse services or referral. This service is conducted by professional staff.

(ii) *Crisis intervention*, a service designed to safely and respectfully de-escalate situations of acute distress or agitation which require immediate attention. This service is conducted by professional staff or paraprofessional staff under the supervision of professional staff.

(iii) *Complex care management*, time-limited, medically necessary interventions to restore functioning and address the symptoms of mental illness. This includes skill building to help the individual to identify solutions to problems that threaten recovery and care coordination services to help the individual to connect with medical or remedial services. This service is conducted by professional staff or paraprofessional staff under the supervision of professional staff.

(iv) *Individualized recovery planning*, a continuous, dynamic process that engages each person as an active partner in developing, reviewing and modifying a care plan that supports their progress towards recovery. The individualized recovery planning process also includes working with the individual in the development of a relapse prevention plan and advance directive, where appropriate. This service is conducted by professional staff under the supervision of an LPHA or paraprofessional staff under the supervision of an LPHA.

(v) *Pre-admission screening*, a service that includes engaging, interviewing and evaluating an individual to determine whether the individual is appropriate for the program and identifying and addressing any unique circumstances and functional limitations which may impact the individual's ability and desire to receive PROS services. This service is conducted by professional staff or paraprofessional staff under the supervision of professional staff.

(vi) *Psychosocial rehabilitation*, a service designed to provide psychosocial rehabilitation, skills training, and psychoeducation services to assist the individual to overcome mental health barriers that may have interfered with the person's ability to function independently and perform normative adult roles in settings where they live, work, learn, and socialize. Rehabilitation counseling, skill building, and psychoeducational interventions are used support the attainment of person-centered recovery goals and valued life roles and restore the individual's functional level to the fullest possible and promote independence and full community participation. Psychosocial rehabilitation includes motivational interventions intended to support the individual's engagement in the recovery process, fostering therapeutic relationships to sustain active participation in services. This service is conducted by professional staff or paraprofessional staff under the supervision of professional staff.

(viii) Psychiatric rehabilitation assessment, a service designed to be done with the active involvement of the individual, the comprehensive psychiatric rehabilitation assessment process involves a review of the individual's strengths and barriers encountered as a result of their psychiatric condition and identifies life role goals to be addressed in the individual's Individualized Recovery Plan. This service is conducted by professional staff or paraprofessional staff under the supervision of professional staff.

(2) A community rehabilitation and support component may also include the following service:

(vi) *Peer support*, a service that includes psychoeducation, person-centered goal planning, demonstrating effective coping skills, and facilitating community connections and crisis support to reduce symptomology and restore functionality. Peer Support services promote recovery, self-advocacy, and the development of natural supports and community living skills. Individuals actively participate in decision-making and the delivery of services. Services are directed toward achievement of the specific, individualized, and result oriented goals contained in an Individualized Recovery Plan. This service is conducted by a Certified or provisionally Certified Peer Specialists and Credentialed or provisionally Credentialed Youth Peer Advocates under the supervision of competent mental health professionals.

(3) When CRS services are provided in a group format, such group size shall not, on a routine and regular basis, exceed 12 members. However, on an occasional basis, group sizes of between 13 and 24 members are permissible if the group is co-facilitated by at least two staff members, and there is documentation that the expanded group size is appropriate for the service being provided. Pursuant to section 512.11(b)(5) of this Part, a PROS program may, within the specified limits, still use the service to satisfy the service frequency requirement of section 512.11(b)(7) of this Part for some group participants.

(c) *Intensive rehabilitation (IR) component* shall be designed to intensively assist individuals in attaining and maintaining life roles. Individuals may require IR when they experience episodes of acute loss of functioning increasing their risk of hospitalization, loss of housing or involvement in the criminal justice system or heightened urgency and motivation to work towards a specific rehabilitation goal over a short period of time. Such services shall be provided on site, off-site or through telehealth, pursuant to Part 596.4 of this Title.

(1) An IR component, as part of a PROS program, shall include, at a minimum, the following services:

(i) *Family psychoeducation/ intensive family support*, a psychosocial education service designed to provide information, guidance, and support to collateral(s) of individuals receiving PROS as well as the individual when desired and appropriate, for the purpose of assisting and enhancing the capacity of a collateral to reduce an individual's symptomatology, restore functioning, and facilitate an individual's overall recovery. This service is conducted by professional staff or paraprofessional staff under the supervision of professional staff, who have completed training approved by the Office.

(ii) *Integrated treatment for co-occurring disorders,* a rehabilitation counseling service based on evidence-based practices that include motivational, cognitive-behavioral and harm reduction techniques designed to restore functionality and promote recovery for persons with both mental health and substance use disorders. This specialty service is integrated as the focus is to overcome barriers/impairments caused by both mental health and substance use disorders. This service is conducted by professional staff or paraprofessional staff under the supervision of professional staff, who have completed training approved by the Office.

(iii) *Goal acquisition,* a psychosocial rehabilitation service designed to assist an individual expressing heightened urgency and motivation to restore functionality and achieve a personally meaningful life role goal. This service is conducted by professional staff or paraprofessional staff under the supervision of professional staff.

(iv) *Relapse prevention*, a service designed to address an exacerbation of acute symptoms or manage existing symptoms that are not responsive to the current service formulation. This service may also include the execution of a series of predetermined steps identified in the relapse prevention plan. Individuals who are experiencing an exacerbation of symptoms that is interfering with their recovery process and that is not responding to the current plan of care are assisted in implementing their relapse prevention plan or in using other methods to either minimize their symptoms or permit the individual to continue to work towards their recovery notwithstanding their symptomatology. This service is conducted by professional staff or paraprofessional staff under the supervision of professional staff.

(2) An IR component may also include the following service:

(i) *Cognitive remediation,* a counseling service designed to improve and restore an individual's functioning by restoring the cognitive skill that is the target of the remediation task. Cognitive remediation is an optional PROS service, subject to prior review and written approval of the Office of Mental Health. This service is conducted by professional staff or paraprofessional staff under the supervision of professional staff, who have completed training approved by the Office. Cognitive remediation is optional and shall be subject to prior review and written approval of the office.

(3) When IR services are provided in a group format, such group size shall not exceed, on a regular and routine basis, eight members. However, family psychoeducation/intensive family support services provided in a group format may include up to 16 group members, if the group is co-facilitated by at least two staff members. Pursuant to section 512.11(c)(2)(ii) and (iii) of this Part, a PROS program may, within the specified limits, allow group sizes to exceed eight members, or 16 members for family psychoeducation/intensive family support groups, on an occasional basis, and still use the service to satisfy the service frequency requirement of section 512.11(c)(2)(i) of this Part for some group participants.

(4) Individuals receiving IR services must be receive at least one PROS service in-person or through audio-visual telehealth in the same calendar month in which IR is provided.

(d) *Ongoing rehabilitation and support (ORS) component* shall be designed to assist individuals in managing symptoms and overcoming functional impairments as they integrate into a competitive workplace or educational program. Such services shall be provided off-site or through telehealth. An ongoing rehabilitation and support component shall include the following service:

(1) *Ongoing rehabilitation and support*, a service designed to develop strategies for resolving workplace issues and school or training program issues and maintain other functional skills necessary to sustain competitive employment or to complete an educational program. These services are customized to the individual and necessary to help the individual achieve a rehabilitation goal defined in their individualized recovery plan. ORS is provided to individuals who are working in integrated employment settings or participating in integrated educational programs. ORS does not include tutoring, educational, vocational or job training services. This service is conducted by professional staff or paraprofessional staff under the supervision of professional staff.

512.7 Program operations.

(a) Program purpose.

(1) The purpose of PROS programs is to partner with individuals in their recovery from mental illness through the delivery of integrated rehabilitation, treatment, and support services.

(i) PROS programs shall offer individuals who are recovering from mental illness an array of personalized and integrated recovery-oriented services, which are delivered within a site-based program setting as well as in off-site locations in the communities where such individuals live, learn, work and socialize.

(ii) PROS programs shall establish a therapeutic environment which fosters awareness, hopefulness and motivation for recovery, and incorporates a harm reduction philosophy.

(b) Integration of rehabilitation, treatment, and support services.

(1) All PROS providers shall establish mechanisms regarding the coordination of rehabilitation, treatment and support services for individuals, including linkage agreements with other providers as appropriate. These mechanisms shall address:

(i) coordination among any of the PROS components as specified in Part 512.6 that are delivered by the same PROS provider;

(ii) coordination among any of the PROS components as specified in Part 512.6, which are delivered by multiple PROS providers; and

(iii) coordination of PROS services with other service providers.

(c) Program schedule.

(1) The PROS program shall maintain a program schedule that includes recovery-oriented activities and daily in-person group services.

(d) Staffing and supervision.

(1) Programs must maintain practitioner and supervisory caseloads that are clinically appropriate All PROS programs, regardless of size, must maintain a minimum of three (3) full time equivalent (FTE) staff consisting of:

(i) one full-time equivalent (FTE) LPHA,

(ii) one FTE professional staff other than the required LPHA, and

(iii) one FTE employment specialist.

(2) Programs with more than 42 participants on their census must maintain a ratio of professional staff to participants of 1:34. This ratio is inclusive of the required staff outlined in Part 512.7(d)(1) above and all additional professional staff employed on the PROS team and delivering direct services to PROS participants, excluding the Psychiatrist or Nurse Practitioner.

(3) Programs with more than 42 participants on their census must maintain a ratio of program staff to participants of 1:14. This ratio is inclusive of the required staff outlined in Part 512.7(d)(1) above and all additional paraprofessional and professional staff employed on the PROS Team and delivering direct services to PROS participants, excluding the Psychiatrist or Psychiatric Nurse Practitioner.

(4) PROS with clinical treatment must employ an adequate number of professional staff whose scope of practice includes all aspects of clinical counseling and therapy, health assessment, medication management, psychiatric assessment, and symptom monitoring to meet the needs of all participants enrolled in the clinical treatment component.

(5) PROS with clinical treatment must maintain the capacity to rapidly admit and assess individuals referred from inpatient, forensic, or emergency settings, ensuring that there is no lapse in an individual's psychiatric prescriptions.

(6) PROS programs shall ensure paraprofessional staff demonstrate competency in rehabilitation practices and PROS service components through formal and informal training practices, including job-shadowing of professional staff and experienced paraprofessional staff, as appropriate, based on the educational background and professional experience of the paraprofessional staff member. Supervision for paraprofessional staff occurs both formally, through direct supervision and consultation availability, as well as informally through regular organizational and recovery planning meetings. Professional staff must also be available at all times to address any issues related to quality of care in the provision of any PROS service components. Additionally, PROS Programs must demonstrate a formal plan for the provision of appropriate supervision of group-delivered services as a condition of program licensure.

512.8 Admission, assessment, individualized recovery planning, and documentation.

(a) Admission and registration.

(1) Admission criteria must conform to applicable State and Federal law governing non-discrimination. Admission criteria shall not exclude individuals because of past histories of incarceration or substance use. A provider of service shall not deny access to services by an otherwise appropriate individual solely on the basis of multiple diagnoses.

(2) The program's admission process, including any criteria governing participation in the program, shall be clearly described and available for review by participants, their families or significant others.

(3) Providers of service shall not use coercion in regard to program admission or discharge, referrals to other programs, or the level of service provision, provided that nothing in this paragraph shall be interpreted to affect or otherwise impact the delivery of services to an individual under a court order issued pursuant to section 9.60 of the Mental Hygiene Law.

(4) Prior to admission to a PROS program, pre-admission screening services may be provided. During such time, the individual shall be considered to be in pre-admission status.

(5) To be eligible for admission to a PROS program, a person must:

(i) be 18 years of age or older;

(ii) have a designated mental illness diagnosis;

(iii) have a functional disability due to the severity and duration of mental illness; and

(iv) be recommended for admission by an LPHA. The recommendation must be in writing, must be signed and dated, and must include an explanation of the medical need for PROS services.

(a) If the LPHA making the recommendation is not a member of the PROS program staff, the recommendation must include the LPHA license number or National Provider Identifier.

(b) If the LPHA making the recommendation is a member of the PROS program staff, the recommendation must include the identification of the PROS components that will initially meet the individual's needs and the LPHA must sign the screening and admission note.

(6) Admission of an eligible individual to a PROS program shall be based upon service availability, and not based upon an individual's ability to pay for such services.

(7) Upon a decision to admit an individual to a PROS program, a screening and admission note shall be written. Such note shall include the following:

(i) reason for admission;

(ii) primary service-related needs and services to meet those needs;

(iii) admission diagnosis, and

(iv) signature of a professional member of the PROS staff.

(8) After admission, the initial service recommendation plan shall be developed by or under the supervision of an LPHA, in partnership with the individual. The initial service recommendation plan identifies the individual's primary service needs and a list of services in which they will participate and remains valid for up to 60 days or until the IRP is completed. The initial service recommendation plan shall be considered part of the admission documentation and shall be maintained in the case record as a separate document, distinct from the IRP.

(9) When admission is not indicated, a notation shall be made of the following:

(i) the reason for not admitting the individual; and

(ii) any referrals made to other programs or services.

(10) Upon admission, the PROS program shall complete and submit a PROS registration, using the registration system approved by the office.

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

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

(11) The PROS admission date for an individual shall be the date that the PROS program submits a completed registration.

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

(13) If a registration request on behalf of an individual is denied, such individual shall be discharged from the PROS program.

(b) Assessment.

(1) PROS programs must complete the following required assessments within 60 days of admission, and prior to completion of the initial individualized recovery plan, for individuals enrolled in the CRS and IR components:

(i) Alcohol, tobacco, and other drug assessment; and,

(ii) Comprehensive psychiatric rehabilitation assessment

(2) PROS programs must complete the following required assessments within 60 days of admission, and prior to completion of the initial individualized recovery plan, for individuals enrolled in the CT component:

(i) Health assessment; and,

(ii) Psychiatric assessment.

(3) For individuals enrolled in the ORS component only, PROS programs must complete the comprehensive psychiatric rehabilitation assessment with an employment focus within 60 days, and prior to completion of the initial individualized recovery plan.

(c) Individualized recovery planning process.

(1) The individualized recovery planning process shall be carried out by, or under the direct supervision of, an LPHA. Such process is intended to be reflective of a person-centered process and shall therefore be conducted in collaboration with the individual and any persons the individual has identified for participation.

(2) The individualized recovery planning process shall include, but not be limited to, the following activities:

(i) meetings with the PROS participant and relevant others;

(ii) linkage and coordination activities with other service providers for the purpose of assessing plan progress and assuring integration of services; and

(iii) development of an individualized recovery plan (IRP).

(4) An initial IRP shall be developed after completion of all required assessments and within 60 days of the individual's admission date.

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

(i) the participant’s name;

(ii) recovery vision and PROS goal(s);

(iii) objectives and target dates;

(iv) criteria to determine when goals and objectives have been met so that the participant can move forward in their recovery process;

(v) strengths;

(vi) supports and resources;

(vii) mental health barriers and needs;

(vii) other barriers and needs as it relates to goal attainment;

(ix) specific PROS services to be provided, including type and frequency;

(x) any collaterals who will assist the participant in their recovery;

(xi) an indication of whether the participant has any advanced directives;

(xii) name, title, and credentials/qualifications of the staff member developing the IRP; and

(xiii) required signatures obtained within seven days of the date that the IRP is developed, as follows:

(a) the PROS participant's signature; in situations where the individual is out of contact with the program due to hospitalization or other issue, signature should be obtained upon their return to the program;

(b) the signature of the staff member who prepared the IRP; and,

(c) if the staff member who prepared the IRP is not an LPHA, the signature of the LPHA supervising or participating in the IRP process shall also be included.

(6) The inclusion of the licensed practitioner of the healing art's signature on the IRP is a representation that the identified PROS services are deemed to be medically necessary.

(7) An IRP is considered completed when all required staff signatures are provided. The official completion date is when the last required signature is obtained.

(8) Services may be provided on an interim basis and be considered part of the IRP by documenting the need for a new service or change in a service on a progress note. If the new or revised service continues after scheduled periodic review of the IRP, the service must be identified on the IRP. The progress note must include the following:

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

(ii) the signature of the participant and a member of the staff; and

(iii) if the staff member writing the progress note is not an LPHA, the signature of the LPHA supervising the service addition shall also be included within seven calendar days.

(9) Each individual's IRP shall be reviewed for progress as follows:

(i) Six month review and update of the IRP: programs are required to conduct a review and update of the IRP every six months. This review and update should result in a new IRP reflective of the individual's progress or lack of progress toward their goal and must be signed by all required parties within seven days of the date the IRP is updated, including:

(a) PROS participant;

(b) staff member who prepared the IRP; and,

(c) the LPHA reviewing and approving the IRP, if the staff member who developed the plan is not an LPHA.

(10) Each IRP Review should result in an IRP Review Summary. This summary provides the justification for any changes to be made within the IRP and/or justification for parts of the IRP that will remain the same for the next review period.

(11) The IRP shall be reviewed as soon as possible and within seven calendar days following the discovery of any significant life event, including but not limited to a psychiatric hospitalization or a change in housing or employment status. IRP reviews completed due to a significant life event may or may not result in an updated IRP. Significant life events and subsequent IRP reviews must be documented in the case record.

(11) If a PROS participant is receiving PROS services from multiple PROS providers:

(i) the provider of CRS services shall be responsible for forwarding copies of the IRP and related updates to the provider of IR or ORS services; and

(ii) the provider of IR or ORS services shall be responsible for developing an IR or ORS plan which shall be a component of the IRP, and which is consistent with the IRP developed by the provider of CRS services.

(d) Monthly summary notes.

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

(2) Monthly summary notes shall include, at a minimum:

(i) a brief description of the participant's engagement and participation in PROS;

(ii) a summary of the progress made towards objectives identified in the IRP, subsequent to the previous monthly summary note;

(iii) identification of any emergent needs or significant life events not otherwise documented in the chart; and

(iv) identification of any necessary changes to the IRP and services related to such needs or events.

(3) Monthly summary notes shall be completed, at a minimum, once each calendar month.

(e) Supporting documentation.

(1) Documentation of individual service delivery must include:

(i) name of individual receiving services;

(ii)component and service provided;

(iii) date of service;

(iv) duration of service;

(v) location of service;

(vi) modality;

(vii) description of service provided and how the participant responded to the service; and

(viii) the name, qualifications, and dated signature of PROS staff delivering the service.

(2) Documentation of group service delivery must include:

(i) name of individual receiving services;

(ii)component and service provided;

(iii) date of service;

(iv) duration of service;

(v) location of service;

(vi) modality; and

(viii) the name, qualifications, and dated signature of PROS staff delivering the service.

(f) Discharge.

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

(g) Case records.

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

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

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

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

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

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

(i) pre-admission screening notes;

(ii) identifying information and history, this may include information from referral sources;

(iii) mental illness diagnosis;

(iv) required assessments based on enrollment in specific PROS components;

(v) for individuals receiving clinical treatment component services from the PROS program, dated and signed records of all medications prescribed;

(vi) records of any mental and physical diagnostic exams, tests, and consultations as available;

(vii) LPHA recommendation and screening and admission note;

(viii) initial service recommendation (ISR);

(ix) individualized recovery plan, including all addendums, updated IRPs, and IRP Review Summaries;

(x) all documentation of service delivery;

(xi) all non-billable documentation;

(xii) all monthly summary notes;

(xiii) any referrals made to other programs or services;

(xiv) consent forms; and

(xv) discharge summaries.

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

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

512.9 Organization and administration.
(a) The provider of service shall identify a governing body, which shall have overall responsibility for the operation of the program. The governing body may delegate responsibility for the day-to-day management of the program to appropriate staff pursuant to an organizational plan approved by the office.

(b) In programs operated by not-for-profit corporations other than hospitals licensed pursuant to article 28 of the Public Health Law, no person shall serve as a member of the governing body and of the paid staff of the program without prior approval of the office.

(c) The governing body shall be responsible for the following duties:

(1) to meet at least four times a year;

(2) to review, approve and maintain minutes of all official meetings;

(3) to develop an organizational plan which indicates lines of accountability and the qualifications required for staff positions. Such plan may include the delegation of the responsibility for the day-to-day management of the program to a designated professional who is qualified by training and experience to supervise program staff;

(4) to review the program's compliance with the terms and conditions of its operating certificate, applicable laws and regulations;

(5) to design and operate the program consistent with and appropriate to the ethnic and cultural background of the population to be served by the PROS program;

(6) to develop a mechanism for PROS program participants, and any individuals they identify, to participate in the development and ongoing review of the IRP;

(7) to develop, approve, and periodically review and revise as appropriate, all programmatic and administrative policies and procedures. Such policies and procedures shall include, but are not limited to, the following:

(i) written personnel policies which shall prohibit discrimination on the basis of race, color, creed, disability, sex, marital status, age, national origin or sexual orientation, and the

applicable obligations imposed by: title VII of the Civil Rights Act; Federal Executive Order 11246; the Rehabilitation Act of 1973, section 504; the Vietnam Era Veteran's Readjustment Act; the Federal Age Discrimination in Employment Act of 1967; the Federal Equal Pay Act of 1963; the Americans with Disabilities Act of 1990; and the State Human Rights Law (Executive Law, article 15);

(ii) written policies, applicable to job applicants and volunteers, which shall provide for verification of employment history, personal references, work record and qualifications, as well as documentation of compliance with Part 550 of this Title— criminal history records check;

(iii) written policies and procedures, when applicable, concerning the prescription and administration of medication which shall be consistent with applicable Federal and State laws and regulations;

(iv) written policies and procedures regarding the confidentiality of individuals' records consistent with applicable Federal and State laws and regulations, and the appropriate retention of such records;

(v) written criteria for admission and discharge from the program;

(vi) written policies and procedures regarding the mandatory reporting of child abuse or neglect;

(vii) written policies and procedures describing an incremental grievance process that addresses the timely review and resolution of individuals' complaints, including documentation thereof, and which provides a process enabling individuals to request review by the provider's governing body, and ultimately the Office of Mental Health, when resolution is not satisfactory; and

(viii) standards of conduct which shall be delineated for all staff in regard to relationships with PROS participants consistent with OMH guidance.

(d) Restraint and seclusion shall not be utilized in programs governed by this Part. Each PROS program must have ongoing education and training and must demonstrate competence in techniques and alternative methods of safely handling crisis situations. In situations in which alternative procedures and methods not involving the use of physical force cannot reasonably be employed, nothing in this section shall be construed to prohibit the use of reasonable physical force when necessary to protect the life and limb of any person.

(e) Individuals' participation in research shall only occur in accordance with applicable Federal and State requirements.

(f) A provider of service shall report, investigate, review, monitor and document incidents in accordance with section 29.29 of the Mental Hygiene Law and Part 524 of this Title.

(g) There shall be an emergency evacuation plan and staff shall be trained about its procedures.

(h) There shall be a written utilization review procedure to monitor the appropriateness of service provision.

(i) The provider of service shall participate as required with the local governmental unit in local planning processes pursuant to sections 41.05 and 41.16 of the Mental Hygiene Law. At a minimum, such participation shall include:

(1) provision of budget and planning data as requested by the local governmental unit;

(2) identification of the population being served by the program;

(3) identification of the geographic area being served by the program;

(4) description of the program's relationship to other providers of service including, but not limited to, a description of all written agreements entered into pursuant to this Part; and

(5) provision of copies to the local governmental unit of any plans or documents submitted to the office for approval pursuant to this Part at the time of such submission to the office. The provider of service shall consult with the local governmental unit prior to the submission of any such plans or documents and, to the extent practicable, prior to any changes or alterations to the PROS program not otherwise addressed in such plans or documents.

(j) In programs that are not operated by a unit of New York State government, there shall be an annual audit, pursuant to a format prescribed by the office, of the financial condition and accounts of the program performed by a certified public accountant who is not a member of the governing body or an employee of the program. Government-operated programs shall comply with applicable laws concerning financial accounts and auditing requirements.

(k) The provider of service shall establish mechanisms for the meaningful participation of current or former recipients of service either through direct participation on the governing body, or through the creation of an advisory board. If an advisory board is used, the provider of service shall establish a mechanism for the advisory board to make recommendations to the governing body.

(l) The provider of service shall establish mechanisms for priority access by individuals, referred to the provider, who are enrolled in an assisted outpatient treatment program established pursuant to section 9.60 of the Mental Hygiene Law. Prior to the discharge by a provider of service of an individual who is also enrolled in an assisted outpatient treatment program, the provider of service shall notify the individual's case manager and the director of the assisted outpatient treatment program.

(m) The provider of service shall establish mechanisms that promote the competency of its workforce, including completion of required trainings as established by the Office.

(n) The provider of service shall maintain adequate information in personnel files concerning the scope of activities for workforce development, additional certificate or academic programs which staff have engaged in while employed, and special credentialing that staff have achieved to obtain necessary competencies.

(o) PROS programs with clinical treatment shall consider the full range of atypical antipsychotic medications, available at the time when prescribing medication. Such providers shall conduct, or arrange for, any associated blood analysis, when so indicated.

(p) PROS programs with clinical treatment shall have a mechanism to provide, or arrange for, contact with individuals enrolled in the program who need assistance when the program is not in operation. Such plan shall be subject to approval by the office.

(q) PROS programs without clinical treatment shall develop a plan for appropriately responding to individuals enrolled in the program who need assistance when the program is not in operation. Such plan shall be subject to approval by the office.

(r) The PROS program shall develop a plan that addresses continuity of care within the mental health system and other service systems (*e.g.,* social services, health care, alcoholism and substance abuse services, local correctional systems). The plan shall be included in the case record and must include a protocol for the development and monitoring of coordination and integration between the PROS provider and outside service providers. Such plan shall be subject to approval by the office.

(s) Upon the request of the office, or upon the request of the local governmental unit with which the provider has an agreement in accordance with section 512.14(b) of this Part, each provider of service shall furnish any and all information and records concerning the operation and administration of the program including, but not limited to, information regarding the program or services, person-specific services, performance indicators, contracts or other agreements and statistical, administrative and fiscal operations.

(t) Providers shall comply with applicable data submission requirements identified by the office.

512.10 Rights of PROS participants.

(a) Individuals participating in a PROS program certified pursuant to this Part are entitled to the rights defined in this subdivision. A provider of service shall be responsible for the protection of these rights.

(1) Individuals participating in a PROS program have the right to an individualized recovery plan and to participate to the fullest extent consistent with their capacity in the establishment and revision of that plan.

(2) Individuals have the right to a full explanation of the services provided in accordance with their IRP.

(3) Participation in a PROS program is voluntary and individuals are presumed to have the capacity to consent to such participation. The right to participate voluntarily in and to consent to participation in a PROS program shall be limited only pursuant to a court order in accordance with applicable provisions of law.

(4) The confidentiality of individuals' clinical records shall be maintained in accordance with section 33.13 of the Mental Hygiene Law and applicable Federal law and regulations.

(5) PROS participants and other qualified persons shall be assured access to their clinical records consistent with section 33.16 of the Mental Hygiene Law and applicable Federal law and regulations.

(6) Individuals have the right to receive clinically appropriate care and treatment that is suited to their needs and skillfully, safely and humanely administered with full respect for their dignity and personal integrity.

(7) Individuals have the right to receive services in a non-discriminatory manner, and to be treated in a way that acknowledges and respects their cultural environment.

(8) Individuals have the right to a maximum amount of privacy consistent with the effective delivery of services.

(9) Individuals have the right to freedom from abuse and mistreatment by staff.

(10) Individuals have the right to be informed of the provider's grievance policies and procedures, and to initiate any questions, complaints or objections accordingly.

(b) A provider of service shall provide a notice of rights as described in subdivision (a) of this section to each individual upon admission to a PROS program. Such notice shall be provided in writing and explained to the participant in a person-centered manner. These rights must be posted in a conspicuous location easily accessible to the public. The notice shall include the address and telephone number of the Justice Center for the Protection of People with Special Needs, the nearest regional office of the Protection and Advocacy for Individuals with Mental Illness Program, the nearest chapter of the National Alliance for Individuals with Mental Illness - New York State, the local governmental unit, and the Office of Mental Health.

512.11 Medicaid reimbursement.

(a) General reimbursement requirements for PROS providers.

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

(i) are in pre-admission status pursuant to section 512.8(a)(4) of this Part;

(ii) are registered in a PROS program pursuant to section 512.8(a)(13) of this Part; or

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

(2) Unless an individual is registered with a PROS program pursuant to section 512.8 (c) of this Part, reimbursement is limited to the pre-admission monthly base rate, consistent with the most recent Office Fee Schedule.

(b) Reimbursement of the monthly base rate.

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

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

(i) monthly base rate;

(ii) IR component add-on;

(iii) ORS component add-on; and

(iv) clinical treatment component add-on.

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

(4) A maximum of five units may be accumulated onsite per calendar day. For purposes of calculating the monthly base rate, service each unit provided off-site for the same duration will be counted as 2 units instead of one. A maximum of ten units may be accumulated off-site per calendar day.

(5) When a medically necessary CRS or CT service is provided in a group format, such service shall not accrue units toward the base rate for more than 12 members of the group per each participating staff member.

(6) To determine the monthly base rate, the daily PROS units accumulated during the calendar month are aggregated and translated into one of three payment levels, in accordance with the most recent Office Fee Schedule.

(7) A minimum of four units of CRS services must be accrued for an individual during a calendar month in order to bill the monthly base rate.

(a) The four units of CRS services necessary to bill the monthly base rate may be accrued through any combination of individual and group-based services, onsite or off-site, including:

(i) four 15-minute individual services,

(ii) four 30-minute group services,

(iii) one 15-minute individual service and three 30-minute group services,

(iv) two 15-minute individual services and two 30-minute group services, or

(v) three 15-minute individual services and one 30-minute group service.

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

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

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

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

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

(2) Intensive rehabilitation.

(i) In order to bill the IR component add-on, an individual must have received at least one PROS unit in-person or through audio-visual telehealth and must have received at least six PROS units during the month, including at least one IR service, as identified in section 512.6(c)(1) of this Part.

(*a*) The six units necessary to bill the IR component add-on may be accrued through any combination of individual and group-based services, onsite or off-site, including:

(1) six 15-minute individual services,

(2) six 30-minute group services,

(3) one 15-minute individual service and five 30-minute group services,

(4) two 15-minute individual services and four 30-minute group services

(5) three 15-minute individual services and three 30-minute group service,

(6) four 15-minute individual services and two 30-minute group services, or

(7) five 15-minute individual services and one 30-minute group service.

(ii) When a medically necessary IR service, other than family psychoeducation/intensive family support, is provided in a group format, such service shall not be used to satisfy the IR service requirement of subparagraph (i) of this paragraph, for more than eight members of the group.

(iii) When a medically necessary family psychoeducation/intensive family support IR service is provided in a group format, such service shall not be used to satisfy the IR service requirement of subparagraph (i) of this paragraph, for more than 16 members of the group.

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

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

(3) Ongoing rehabilitation and support.

(i) PROS programs may only bill the ORS component add-on for individuals who work in an integrated competitive job or who are participating in an integrated educational program.

(ii) A minimum of four units of ongoing rehabilitation and support per month, which must occur on a minimum of two separate days. At least one service per month must be with the individual only.

(iii) In instances where a PROS program provides ORS services to an individual, but CRS services are provided by another provider of service or no CRS services are provided in the month, the PROS provider shall submit an ORS-only bill.

(4) Clinical treatment.

(i) In order to bill the clinical treatment add-on, a minimum of one clinical treatment service, as identified in section 512.6(a)(1) of this Part, must be provided during the month.

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

(iii) The clinical treatment component may only be reimbursed in conjunction with the monthly base rate.

(iv) If it is clinically appropriate to deliver a clinical treatment service in a group format, the group size limitations in sections 512.6(a)(2) and 512.11(b)(5) of this Part shall apply.

(d) Reimbursement for pre-admission program participation.

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

(i) If pre-admission occurs in the month preceding the month of admission and registration, reimbursement cannot exceed the pre-admission monthly base rate pursuant to the most recent Office Fee Schedule.

(2) If pre-admission occurs during the month of admission, all units accrued during the calendar month may be included in the aggregate total that determines the monthly base rate.

(3) In no event shall the use of the pre-admission monthly base rate exceed two consecutive months per individual.

(e) Co-enrollment limitations.

(1) General rules.

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

(ii) If an individual is in pre-admission status pursuant to section 512.8(a)(4) of this Part, the co-enrollment limitations described in this subdivision are not applicable. This exception shall be limited to two consecutive calendar months for each pre-admission episode.

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

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

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

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

(3) OMH-licensed continuing day treatment (CDT) program and PROS program.

(i) Medicaid shall not reimburse for services provided to an individual in both a PROS program and CDT program, licensed pursuant to Part 587 of this Title, in a given month except as described in sub-paragraph (ii) below.

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

(4) OMH-licensed partial hospitalization (PH) program and PROS program.

Medicaid may reimburse for services provided to an individual in a given month in both a PROS program and a PH program licensed pursuant to Part 587 of this Title.

(5) OMH-licensed assertive community treatment (ACT) program and PROS program.

(i) Medicaid may reimburse for services provided to an individual in both a PROS program and an ACT program for no more than three months within any 12-month period.

(ii) Medicaid reimbursement of the PROS provider shall be limited to level 1 or 2 of the PROS monthly base rate.

(iii) Medicaid reimbursement of the ACT provider shall be limited to the partial stepdown payment rate, pursuant to Part 508 of this Title.

(6) OMH-licensed mental health outpatient treatment and rehabilitation services (MHOTRS) and PROS program.

(i) Medicaid may reimburse for services provided to an individual in a given month in both a PROS program and a MHOTRS program licensed pursuant to Part 599 of this Title.

(ii) Medicaid reimbursement of the PROS providers shall be limited to the monthly base rate and IR or ORS component.

(7) Health home care management and PROS program. Medicaid may reimburse for services in a given month provided in both a PROS program and a health home program or specialty mental health care management program.

(8) Targeted case management (TCM) program and PROS program. Medicaid may reimburse for services in a given month provided in both a PROS program and a TCM program.

(9) OPWDD-sponsored Article 16 Clinic and PROS program. Medicaid may reimburse for services in a given month provided in both a PROS program and an OPWDD-sponsored Article 16 Clinic.

(i) If the individual is enrolled in the clinical treatment component of PROS, Medicaid shall not reimburse for duplicative psychotherapy services in both programs.

(10) OASAS-sponsored Article 32 Clinic and PROS program. Medicaid may reimburse for services in a given month provided in both a PROS program and an OASAS-sponsored Article 32 Clinic.

(11) OPWDD-sponsored pathway to employment services, pre-vocational services, or supported employment services and PROS program.

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

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

(12) OPWDD-sponsored day habilitation and PROS program. When medically necessary, Medicaid may reimburse for services provided to an individual in a given month in both OPWDD-sponsored day habilitation services pursuant to section Part 635 of this Title and a PROS program. Medicaid reimbursement of a PROS provider shall be limited to level 1 or 2 of the PROS monthly base rate.

(13) OPWDD-sponsored community habilitation and PROS program. When medically necessary, Medicaid may reimburse for services provided to an individual in a given month in both OPWDD-sponsored community habilitation programs pursuant to Part 635 of this Title and a PROS program. Medicaid reimbursement of a PROS provider shall be limited to level 1 or 2 of the PROS monthly base rate.

(14) DOH-licensed outpatient program and PROS program.

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

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

(f) Post-payment audits and recoveries.

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

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

(3) If Medicaid provided reimbursement to a PROS program and/or a MHOTRS program that was not authorized pursuant to paragraph (e)(6) of this section, and both the PROS program and the MHOTRS program are operated by the same sponsor:

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

(4) If Medicaid provided reimbursement to both a PROS program and a CDT program operated by the same sponsor that was not authorized pursuant to paragraph (e)(3) of this section, the CDT program is not entitled to retain any of the funds paid to the CDT program in a given month on behalf of the same individual.

(6) If Medicaid provided reimbursement to a PROS program and an ACT program that are not authorized pursuant to paragraph (e)(5) of this section, such providers are not entitled to retain such reimbursement as follows:

(i) If reimbursement to the PROS provider exceeds three months within a 12-month period, the PROS provider is not entitled to retain any reimbursement in excess of three months.

(ii) If reimbursement to the PROS provider exceeds level 2 of the monthly base rate, the PROS provider is not entitled to retain any amounts in excess of level 2 of the monthly base rate.

(iii) If reimbursement to the ACT provider exceeds the partial stepdown payment rate, the ACT provider is not entitled to retain any funds paid to the ACT provider in excess of the allowable payment.

(8) If Medicaid provided reimbursement to a PROS program and an OPWDD-sponsored pathway to employment services, pre-vocational services, or supported employment program that was not authorized pursuant to paragraph (e)(11) of this section, the PROS provider is not entitled to retain the IR or ORS component add-on.

(9) If Medicaid provided reimbursement to a PROS program and an OPWDD-sponsored day habilitation program that was not authorized pursuant to paragraph (e)(12) of this section, the PROS provider is not entitled to retain any amounts in excess of level 2 of the monthly base rate.

(10) If Medicaid provided reimbursement to a PROS program and an OPWDD-sponsored community habilitation program that was not authorized pursuant to paragraph (e)(13) of this section, the PROS provider is not entitled to retain any amounts in excess of level 2 of the monthly base rate.

(10) If Medicaid provided reimbursement to a PROS program and a DOH-licensed program that was not authorized pursuant to paragraph (e)(14) of this section, the DOH-licensed program is not entitled to retain any of the funds paid to the DOH-licensed program for mental health services on behalf of that individual.

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

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

(b) Each rate of payment established pursuant to this section shall be a monthly rate determined by the commissioner and approved by the Division of the Budget. The monthly base rate and component add-on schedules for PROS Programs shall be in accordance with the most recent Office Fee Schedule.

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

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

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

(1) For PROS programs operated by providers licensed pursuant to article 28 of the Public Health Law, there shall be added an allowance for the cost of capital, which shall be determined by the application of the principles of cost-finding for the Medicare program. No capital expenditure for which approval by the office is required under the applicable provisions of the Mental Hygiene Law or Part 551 of this Title shall be included in allowable capital costs for purposes of rate computation unless such approval has been secured.
(2) Allowable capital expenditures shall not include costs specifically excluded pursuant to section 2807-c of the Public Health Law.
(3) The capital payment per service month for a provider's PROS licensed outpatient mental health programs shall be determined by dividing all allowable capital costs of the provider's PROS programs, after deducting any exclusions, by the annual number of service months for all enrollees of the PROS program.

512.13 Premises.
(a) The provider of service shall maintain premises that are adequate and appropriate for the safe and effective operation of a PROS program in accordance with the following:

(1) A PROS program shall allocate adequate space for the number of persons served by the program.

(2) All PROS programs shall provide for sufficient types and arrangements of spaces to provide individual and group activities consistent with the program's monthly caseload and purpose.

(3) All PROS programs offering clinical treatment shall provide for controlled access to and maintenance of medication and supplies in accordance with applicable Federal and State laws and regulations.

(4) All PROS programs shall provide for controlled access to and maintenance of records.

(5) All PROS programs shall provide for appropriate furnishings and equipment consistent with the purpose of the program.

(b) The provider of service shall possess a certificate of occupancy in accordance with the Building Code of New York State and the Property Maintenance Code of New York State (19 NYCRR Chapter XXXIII, Subchapter A, Parts 1221 and 1226) or comparable local codes.

(c) The provider of service shall consider the use of appropriate features and equipment that enable the accessibility of persons with physical disabilities, consistent with the population being served by the program.

512.14 Quality improvement.

(a) The provider of service shall establish a process to collect and analyze data on program and individual outcomes. A process shall be established for the routine use of such data for decision-making purposes. In association with the achievement of individual outcomes and reviews of related processes, providers of service are encouraged to use evidence-based practices.

(b) The office, in conjunction with local governmental units, will develop a plan regarding oversight and evaluation criteria for PROS programs, including the development of performance indicators.

(1) Each local governmental unit shall decide the level of its participation in the oversight and evaluation of PROS programs. Such participation shall include the execution of signed agreements between the local governmental unit and each PROS program in the geographic area served by the local governmental unit. Such provider agreements may include performance indicators specified by the local governmental unit and approved by the office.

(2) If the local governmental unit and the PROS provider are unable to execute an agreement in accordance with paragraph (1) of this subdivision, the office shall review the situation and, if warranted, may execute an agreement directly with the PROS provider. If the office determines that such an agreement will be executed, it will so notify the local governmental unit.

(3) In the event that the PROS program is operated by the local governmental unit, the PROS program shall execute a provider agreement with the office.

(c) Provider agreements executed pursuant to subdivision (b) of this section may include provisions authorizing a withholding of up to 20 percent of the provider's monthly Medicaid payment if the provider fails to comply with applicable data and reporting requirements, operational requirements, or performance indicators. Such withholding of Medicaid payments may be continued until the provider attains compliance, at which time previously withheld funds shall be released to the provider.

(1) In regard to performance indicators which are related to the outcome of individual usage of PROS services, no withholding of Medicaid revenue for an individual PROS provider pursuant to this subdivision shall occur earlier than the 12th month following the month in which the operating certificate issued for that provider becomes effective, or the 12th month following the effective date of the initial agreement developed pursuant to subdivision (b) of this section, whichever is later.

(2) Any withholding of Medicaid payments pursuant to this subdivision does not obviate the authority of the office to initiate other administrative sanctions authorized pursuant to this Title or applicable provisions of the Mental Hygiene Law.

512.15 Waivers.
(a) Providers shall apply for waivers in such form as the commissioner shall require. Waivers shall run concurrently with the term of the program's operating certificate. The office, in consultation with the local governmental unit, may renew such waivers based upon a determination that conditions continue to warrant the granting of such waivers.

512.16 Transition to Part 512.
(a) PROS programs shall be implemented in accordance with a schedule established by the Office of Mental Health, in consultation with the local governmental unit.

(b) Outpatient providers which are certified as a continuing day treatment pursuant to Part 587 of this Title, and are obtaining certification pursuant to this Part, may continue to operate pursuant to the requirements of Part 587 until four months after the effective date of the PROS provider's initial operating certificate issued pursuant to Part 551 of this Title. Notwithstanding this transition period, applicable co-enrollment reimbursement limitations pursuant to section 512.11(e) of this Part shall become effective upon the effective date of the PROS provider's initial operating certificate issued pursuant to Part 551 of this Title. In accordance with the licensure category under which individual reimbursement claims are submitted, providers shall adhere to the applicable documentation and service requirements of either this Part, or Parts 587 and 588 of this Title.

(d) To allow a period of adjustment to the professional staffing requirements established pursuant to this Part, staff employed by a provider at the time of its application for an operating certificate pursuant to Part 551 of this Title shall be deemed to have met the requirements of section 512.7(d) of this Part, during the provider's first 18 months of operation, subject to the following conditions:

(1) such staffing plan shall be described in the application for an operating certificate pursuant to Part 551 of this Title;

(2) programs must employ at least one full-time professional staff member; and

(3) when a staff member included in the staffing plan pursuant to paragraph (1) of this subdivision leaves the provider's employment, they shall be replaced with an individual who will bring the program closer to compliance with section 512.7(d) of this Part.

512.17 Enforcement.
(a) A provider of service shall exercise due diligence in complying with the requirements of this Part.

(b) The office shall review the program and practices of the provider of service in order to facilitate determinations as to whether providers are exercising the requisite due diligence and are otherwise in compliance with this Part.

(c) If, based on a review of the program and practices of a provider of service, the office determines that a provider of service is not exercising due diligence in complying with the requirements of this Part, the office shall give notice of the deficiency to the provider of service and may also initiate the following:

(1) request that the provider of service prepare a plan of correction, which plan shall be subject to approval by the office; and

(2) provide such technical assistance as the office deems necessary to assist the provider of service in developing and implementing an appropriate plan of correction.

(d) If the provider of service fails to prepare an acceptable plan of correction within a reasonable time or refuses to permit the office to provide technical assistance or fails to promptly or effectively implement a plan of correction which has been approved by the office, it shall be determined that the provider of service is in violation of this Part.

(e) Upon a determination that a provider of service is in violation of this Part, or upon a determination that a provider of service has failed to otherwise comply with the terms of its operating certificate or with the provisions of any applicable statute, rule or regulation, the commissioner may revoke, suspend or limit the provider's operating certificate or impose fines in accordance with applicable provisions of law or regulation.

(f) Nothing in this section shall limit or preclude the commissioner from taking whatever immediate measures may be necessary, including the exercise of their authority under Mental Hygiene Law, sections 31.16(b) and 31.28, in the event that an individual's health or safety is in imminent danger or there exists any condition or practice which poses imminent danger to the health or safety of any PROS participant or the public.

512.18 Audits.

(a) Each provider of services shall comply with Part 552 of this Title—audits of Office of Mental Health licensed or operated facilities, programs or units, which established standards for the administration of audits.

(b) Providers of service shall cooperate during the performance of audits conducted by the New York State Department of Health, and shall provide access to any such records and reports requested.

14 NYCRR Part 512

Regulatory Impact Statement

1. Statutory Authority: Section 7.07(c) of the Mental Hygiene Law charges the Office of Mental Health with the responsibility for seeing that persons with mental illness are provided with care and treatment, and that such care, treatment and rehabilitation is of high quality and effectiveness.

Sections 7.09 and 31.04 of the Mental Hygiene Law grant the Commissioner of Mental Health the power and responsibility to adopt regulations that are necessary and proper to implement matters under their jurisdiction, and to set standards of quality and adequacy of facilities, equipment, personnel, services, records and programs for the rendition of services for adults diagnosed with mental illness or children diagnosed with emotional disturbance, pursuant to an operating certificate.

Sections 364 and 364-a of the Social Services Law give the Office of Mental Health responsibility for establishing and maintaining standards for medical care and services in facilities under its jurisdiction, in accordance with cooperative arrangements with the Department of Health.

Section 43.01 of the Mental Hygiene Law gives the Commissioner authority to set rates for outpatient services at facilities operated by the Office of Mental Health. Section 43.02 of the Mental Hygiene Law provides that payments under the medical assistance program for outpatient services at facilities licensed by the Office of Mental Health shall be at rates certified by the Commissioner of Mental Health and approved by the Director of the Budget.

2. Legislative Objectives: Articles 7 and 31 of the Mental Hygiene Law reflect the Commissioner's authority to establish regulations regarding mental health programs.

The proposed rule furthers the legislative policy of providing high quality outpatient mental health services to individuals with mental illness in a cost-effective manner. The amendments to 14 NYCRR Part 512, ensure that individuals with serious mental illness receive effective services to address their illness and that providers receive adequate reimbursement to pay for such care.

3. Needs and Benefits: On November 22, 2019 the New York State Plan Amendment (SPA) #16-0041 was approved for adoption into the State Medicaid Plan with an effective date of April 1, 2016. The SPA comprehensively describes the methodology and service components for Personalized Recovery Oriented Services (PROS). Included in the SPA were programmatic and billing changes intended to expand the eligible staffing qualifications, add new services, and better define service components of existing PROS services. The new language reflects changes made by the NYS Department of Education, of four new titles added to the definitions for Licensed Practitioners of the Healing Arts (LPHA): Licensed Mental Health Counselor, Licensed Creative Arts Therapist, Licensed Marriage and family Therapist, and Licensed Psychoanalyst. Changes were made in the SPA to offer regulatory relief and increased access to services for PROS participants including the removal of the restriction that previously prohibited co-enrollment of an individual in a PROS with Clinic and an OMH licensed (Part 599) Clinic operated by the same organization.

Over the last three years, OMH has worked closely with PROS programs and participants to engage in a programmatic and reimbursement redesign of the model. These efforts included multiple workgroups, focus groups, listening sessions, and

surveys. The goal of the redesign is to improve outcomes, enhance flexibility for providers and participants, and to ensure fiscal viability of the model in a changing environment post-pandemic. On December 28, 2023, New York State submitted an updated State Plan Amendment (#23-0098) that is currently pending approval with CMS. The updated SPA includes significant programmatic and billing changes that are intended to increase flexibility and reduce administrative burden, streamline reimbursement, and simplify the program model. The updated SPA add new services (Peer Support and Complex Care Management) that contribute to the comprehensiveness of the PROS model, combines multiple psychosocial rehabilitation services into a single psychosocial rehabilitation service to reduce confusion, identifies additional rehabilitative staff qualifications to ease the impact of the workforce crisis, and increases our flexibility to address future workforce issues.

4. Costs:

(a) Cost to State government: Any costs associate with these amendments are Medicaid eligible and shared with the Federal Government.

(b) cost to local government: These regulatory amendments will not result in any additional costs to local government.

(c) cost to regulated parties: These regulatory amendments will not result in any additional costs to those regulated parties.

5. Local government mandates: These regulatory amendments will not result in any additional imposition of duties or responsibilities upon county, city, town, village, school or fire districts.

6. Paperwork: No substantial increase in paperwork is anticipated as a result of the amendments to 14 NYCRR Part 512.

7. Duplication: These regulatory amendments do not duplicate existing State or federal requirements.

8. Alternatives: No alternatives were considered, as these amendments seek to conform regulations to the State Plan Amendment and CMS guidelines to ensure that PROS programs remain in compliance. Not conforming to the state plan amendment will cause confusion in the field regarding both service delivery and payment.

9. Federal standards: The regulatory amendments do not exceed any minimum standards of the federal government for the same or similar subject areas.

10. Compliance schedule: This rulemaking will be effective upon publication of a Notice of Adoption in the State Register.