



1. Part 512.11(f)(3)(ii) of Title 14 NYCRR is amended to read as follows:

SUB-PART 512

Personalized Recovery Oriented Services

Statutory authority: Mental Hygiene Law §§7.09(b), 31.04, 41.05, 43.01, 43.02;

Social Services Law §§364(3), 364-a (1), 365-m

§ 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 512.7(c)(4) of this Part;
 - (ii) are registered in a PROS program pursuant to section 512.7(c)(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 512.7(c) of this Part, reimbursement is limited to the pre-admission monthly base rate, consistent with section 512.12(e) of this Part.
 - (3) For purposes of reimbursement for individuals enrolled in Medicaid managed care, a PROS program is considered to be a carved-out service.
 - (4) When available and appropriate, PROS providers shall maximize the use of funding from the Office of Vocational and Educational Services for Individuals with Disabilities (VESID). Time spent in such funded activities shall not be included in the duration of program participation pursuant to paragraph (b)(4) of this section.
 - (5) In order to be eligible for reimbursement, any PROS service provided to a PROS participant in the participant's employment setting and any ORS service shall be on a one-to-one basis.
- (b) Reimbursement for comprehensive PROS programs.
 - (1) comprehensive PROS program shall be reimbursed on a monthly case payment basis.

- (2) The reimbursement structure for a comprehensive PROS program consists of the following four elements:
 - (i) monthly base rate;
 - (ii) IR component add-on;
 - (iii) ORS component add-on; and
 - (iv) clinical treatment component add-on.
- (3) The basic measure for the PROS monthly base rate is the PROS unit. PROS units are accumulated during the course of each day that the individual participates in the PROS program, and are aggregated up to a monthly total to determine the amount of the PROS monthly base rate that can be billed for the individual during a particular month.
- (4) The PROS unit is determined by the duration of program participation, which includes a combination of on-site and off-site program participation and service frequency as defined in section 512.4 of this Part.
- (5) Program participation is measured and accumulated in 15 minute increments. Increments of less than 15 minutes must be rounded down to the nearest quarter hour to determine the program participation for the day.
- (6) Medically necessary PROS services include:
 - (i) assessment services;
 - (ii) crisis intervention services;
 - (iii) engagement services;
 - (iv) individualized recovery planning services;
 - (v) pre-admission screening services provided during pre-admission status and documented in a pre-admission screening note;
 - (vi) services delineated in the screening and admission note pursuant to section 512.7(c)(7) of this Part, which are provided subsequent to the individual's admission date, but prior to the completion of the initial IRP, and documented in the progress note; and
 - (vii) services identified in, and provided in accordance with, the individual's IRP.
- (7) If a recipient employee provides a medically necessary service to other participants in the PROS program, such service may be included in the calculation of PROS units for such participants, as applicable. However, such service may not be included in the calculation of PROS units for the recipient employee.
- (8) In order to accumulate any PROS units for a day, a PROS program must deliver a minimum of one medically necessary PROS service to an individual or collateral during the course of the day.
- (9) PROS units are accumulated in intervals of 0.25. The maximum number of PROS units per individual per day is five.

- (10) The formula for accumulating PROS units during a program day is as follows:
 - (i) If one medically necessary PROS service is delivered, the number of PROS units is equal to the duration of program participation, rounded down to the nearest quarter hour, or two units, whichever is less.
 - (ii) If two medically necessary PROS services are delivered, the number of PROS units is equal to the duration of program participation, rounded down to the nearest quarter hour, or four units, whichever is less.
 - (iii) If three or more medically necessary PROS services are delivered, the number of PROS units is equal to the duration of program participation, rounded down to the nearest quarter hour, or five units, whichever is less.
 - (11) To satisfy the service frequency requirement of this Part, services must be provided in accordance with the following:
 - (i) services provided in a group format shall be at least 30 minutes in duration; and
 - (ii) services provided in an individual modality shall be at least 15 minutes in duration.
 - (12) When a medically necessary CRS service is provided in a group format, such service shall not be used to satisfy the service frequency requirement of this Part for more than 12 members of the group per each participating staff member.
 - (13) To determine the monthly base rate, the daily PROS units accumulated during the calendar month are aggregated and translated into one of five payment levels, in accordance with section 512.12(e) of this Part.
 - (14) A minimum of two PROS units must be accrued for an individual during a calendar month in order to bill the monthly base rate.
- (c) Reimbursement for component add-ons in comprehensive PROS programs.
- (1) The three component add-ons pursuant to paragraph (b)(2) of this section are provided in recognition that certain activities involve increased costs due to their intensity or the need for specialized staff expertise.
 - (i) Up to two component add-ons may be billed per individual per month.
 - (ii) In no event shall an ORS component add-on and an IR component add-on be billed in the same month for the same individual.
 - (iii) Component add-ons shall not be billed prior to the calendar month in which the individual is registered with the PROS program.
 - (2) Intensive rehabilitation.
 - (i) In order to bill the IR component add-on, an individual must have received at least six PROS units during the month, including at least one IR service, as identified in section 512.7(b)(4) of this Part.

- (ii) When a medically necessary IR service, other than family psychoeducation/intensive family support, is provided in a group format, such service shall not be used to satisfy the service frequency requirement of this Part, or 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 service frequency requirement of this Part, or 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 submitted annually.
 - (v) In instances where a comprehensive PROS program provides IR services to an individual, but CRS services are provided by another provider of service or no CRS services are provided in the month, the comprehensive PROS provider shall submit an IR-only bill. When an IR-only bill is submitted, the minimum six PROS units required pursuant to subparagraph (i) of this paragraph shall be limited to the provision of IR services.
- (3) Ongoing rehabilitation and support.
- (i) PROS programs may only bill the ORS component add-on for individuals who work in an integrated competitive job for a minimum of 10 hours per week. However, to allow for periodic absences due to illness, vacations, or temporary work stoppages, individuals who are scheduled to work at least 10 hours per week and have worked at least one week within the month for 10 hours qualify for reimbursement.
 - (ii) A minimum of two face-to-face contacts with the individual and/or identified collateral, which include ongoing rehabilitation and support services, must be provided per month. A minimum contact is 30 continuous minutes in duration. At least two of the face-to-face contacts must occur on separate days. A contact may be split between the individual and the collateral. At least one visit per month shall be with the individual only.
 - (iii) In instances where a comprehensive PROS program provides ORS services to an individual, but CRS services are provided by another provider of service or no CRS services are provided in the month, the comprehensive PROS provider shall submit an ORS-only bill. Notwithstanding paragraph (b)(15) of this section, the minimum service requirement for submission of an ORS-only bill shall be consistent with subparagraph (ii) of this paragraph.
- (4) Clinical treatment.
- (i) In order to bill the clinical treatment add-on, a minimum of one clinical treatment service, as identified in section 512.7(b)(9) of this Part, must be provided during the month.

- (ii) Individuals receiving clinical treatment must have, at a minimum, one face-to-face contact with a psychiatrist or 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 and/or the intensive rehabilitation or ongoing rehabilitation and support add-on.
 - (iv) If it is clinically appropriate to deliver a clinical treatment service in a group format, the group size limitations for CRS services in sections 512.7(b)(3) and 512.11(b)(13) of this Part shall apply.
- (d) Reimbursement for limited license PROS programs.
- (1) A limited license PROS program shall be reimbursed on a monthly case payment basis.
 - (2) A limited license PROS program may be reimbursed in a given month for either one monthly IR component or one monthly ORS component per individual.
 - (3) To bill the IR component on behalf of an individual, the individual must participate in at least six units of IR services per month.
 - (4) To bill the ORS component on behalf of an individual, notwithstanding paragraph (b)(15) of this section, a minimum of two face-to-face contacts per month must be provided. A minimum contact is 30 continuous minutes in duration. At least two of the face-to-face contacts must occur on separate days.
 - (5) PROS programs may only bill the ORS component for individuals who work in an integrated competitive job for a minimum of 10 hours per week. However, to allow for periodic absences due to illness, vacations, or temporary work stoppages, individuals who are scheduled to work at least 10 hours per week and have worked at least one week within the month for 10 hours qualify for reimbursement.
- (e) 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 program participation occurs in the month preceding the month of admission, reimbursement cannot exceed the pre-admission monthly base rate pursuant to section 512.12(e) of this Part.
 - (ii) If pre-admission program participation occurs during the month of admission, but the individual has not been registered in the PROS program during that month, reimbursement cannot exceed the pre-admission monthly base rate pursuant to section 512.12(e) of this Part.
- (2) If pre-admission program participation occurs during the month of admission, the pre-admission program participation may be included in the total number of PROS units accumulated during the calendar month.
 - (3) In no event shall the use of the pre-admission monthly base rate exceed two consecutive months per individual.
- (f) Co-enrollment limitations.
- (1) General rules.
 - (i) When an individual is registered in a PROS program, Medicaid reimbursement for participation in other community-based programs may be limited, depending upon the level of PROS participation and the category of the community-based program. This subdivision describes the conditions under which Medicaid will pay for those services.
 - (ii) If an individual is in pre-admission status pursuant to section 512.7(c) of this Part, the co-enrollment limitations described in this subdivision are not applicable. This exception shall be limited to two consecutive calendar months for each pre-admission episode.
 - (iii) When co-enrollment is otherwise permitted by this Part, participation in multiple programs may occur on the same day.
 - (iv) In some instances, the PROS registration system can be used to enforce the co-enrollment rules described in this subdivision. In those circumstances, the registration system precludes initial payment to providers other than the PROS provider with whom an individual is registered. In circumstances in which the PROS registration system cannot be used to enforce the co-enrollment rules described in this subdivision, any post-payment recoveries will be conducted pursuant to subdivision (g) of this section.
 - (v) If an individual is registered in a Medicaid-eligible program that has a restriction/ exception code or a Medicaid coverage code in the Welfare Management System and the New York State Department of Health has designated the program as not eligible for co-enrollment with the PROS program, the PROS program shall not receive reimbursement.
 - (2) Multiple PROS programs. Medicaid may reimburse for unduplicated components of service provided to an individual in a given month in multiple PROS programs.

However, Medicaid shall not reimburse an IR component and an ORS component in a given month for the same individual.

- (3) OMH-licensed or Office for People With Developmental Disabilities (OPWDD)-licensed clinic and PROS program.
 - (i) Medicaid shall not reimburse for both clinical treatment services provided to an individual in a given month in the clinical treatment component of a comprehensive PROS program and a clinic licensed pursuant to Part 599 or Part 679 of this Title.
 - (ii) Medicaid may reimburse for services provided to a PROS participant in a given month in a clinic, as long as the individual is not registered in the PROS clinical treatment component.
 - (iii) Medicaid may reimburse for services provided to an individual in a given month in both a limited license PROS program and a clinic licensed pursuant to Part 599 or Part 679 of this Title.

- (4) OMH-licensed continuing day treatment (CDT) program and PROS program.
 - (i) Medicaid shall not reimburse for both services provided to an individual in a given month in a comprehensive PROS program and a CDT program licensed pursuant to Part 587 of this Title.
 - (ii) Medicaid may reimburse for the IR or ORS components of service provided to an individual in a given month in a limited license PROS program and for services provided in a CDT program licensed pursuant to Part 587 of this Title only if the CDT provider and the PROS provider are not operated by the same sponsor.

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

- (6) OMH-licensed intensive psychiatric rehabilitation treatment program (IPRT) and PROS program. Medicaid shall not reimburse for both services in a given month provided in a PROS program and an IPRT.

- (7) OMH-licensed assertive community treatment (ACT) program and PROS program.
 - (i) Medicaid may reimburse for services provided to an individual in both a comprehensive PROS program and an ACT program for no more than three months within any 12-month period.
 - (ii) Medicaid reimbursement of the PROS provider shall be limited to level 1, 2 or 3 of the PROS monthly base rate.
 - (iii) Medicaid reimbursement of the ACT provider shall be limited to the partial stepdown payment rate, pursuant to Part 508 of this Title.

- (8) Intensive, supportive or blended case management (ICM/SCM/BCM) program and PROS program. Medicaid may reimburse for services in a given month provided in both a PROS program and an ICM/SCM/BCM program.
 - (9) Pre-paid mental health plan (PMHP) program and PROS program. Medicaid shall not reimburse for both services in a given month provided in a PROS program and a PMHP program.
 - (10) OPWDD-sponsored pre-vocational or supported employment services and PROS program.
 - (i) Medicaid shall not reimburse for both services provided to an individual in a given month in the IR component of a PROS program and pre-vocational or supported employment services pursuant to section 635-10.4(c) of this Title.
 - (ii) Medicaid shall not reimburse for both services provided to an individual in a given month in the ORS component of a PROS program and pre-vocational or supported employment services pursuant to section 635-10.4(c) of this Title.
 - (11) OPWDD-sponsored day services and PROS program. When medically necessary, Medicaid may reimburse for services provided to an individual in a given month in both OPWDD-licensed day treatment programs pursuant to Part 690 of this Title or OPWDD-sponsored day habilitation services pursuant to section 635-10.4(b)(2) of this Title and a PROS program. Medicaid reimbursement of a comprehensive PROS provider shall be limited to level 1 or 2 of the PROS monthly base rate.
 - (12) DOH-licensed outpatient program and PROS program.
 - (i) Medicaid shall not reimburse for any mental health services provided in a given month in an outpatient program licensed pursuant to article 28 of the Public Health Law to an individual who is registered in a PROS program.
 - (ii) This paragraph is not applicable to outpatient programs that are licensed by both OMH and DOH.
- (g) Post-payment audits and recoveries.
- (1) In circumstances in which the PROS registration system cannot be used to enforce the co-enrollment rules pursuant to subdivision (f) of this section, or other reimbursement limitations described in this Part, providers will be subject to post-payment audits and recoveries in accordance with this subdivision.
 - (2) If Medicaid provided reimbursement to a PROS program that was not authorized pursuant to subparagraph (c)(2)(iv) of this section, the program is not entitled to retain Medicaid reimbursement for the IR component add-on in excess of the 50 percent limit.

- (3) If Medicaid provided reimbursement to a PROS program and/or a clinic program that was not authorized pursuant to paragraph (f)(3) of this section, and both the PROS program and the clinic program are operated by the same sponsor:
 - (i) If both programs received reimbursement for the same individual, the clinic program is not entitled to retain any of the funds paid to the clinic program on behalf of that individual.
 - (ii) If only the clinic program received reimbursement for an individual who is registered in the PROS program, the clinic program is not entitled to retain any of the funds paid to the clinic program on behalf of that individual in excess of the amount of the PROS clinical treatment component add-on, described in section 512.12(e)(1) of this Part.
- (4) If Medicaid provided reimbursement to both a PROS program and a CDT program operated by the same sponsor that was not authorized pursuant to paragraph (f)(4) of this section, the CDT program is not entitled to retain any of the funds paid to the CDT program in a given month on behalf of the same individual.
- (5) If Medicaid provided reimbursement to both a PROS program and an IPRT program operated by the same sponsor that was not authorized pursuant to paragraph (f)(6) of this section, the IPRT program is not entitled to retain any of the funds paid to the IPRT program in a given month on behalf of the same individual.
- (6) If Medicaid provided reimbursement to a PROS program and an ACT program that are not authorized pursuant to paragraph (f)(7) of this section, such providers are not entitled to retain such reimbursement as follows:
 - (i) If reimbursement to the PROS provider exceeds three months within a 12-month period, the PROS provider is not entitled to retain any reimbursement in excess of three months.
 - (ii) If reimbursement to the PROS provider exceeds level 3 of the monthly base rate, the PROS provider is not entitled to retain any amounts in excess of level 3 of the monthly base rate.
 - (iii) If reimbursement to the ACT provider exceeds the 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.
- (7) If Medicaid provided reimbursement to a PROS program and a PMHP program that was not authorized pursuant to paragraph (f)(9) of this section, the PMHP program is not entitled to retain the equivalent of any funds paid to the PROS provider, up to the amount paid to the PMHP provider on behalf of the same individual.
- (8) If Medicaid provided reimbursement to a PROS program and an OPWDD-sponsored pre-vocational or supported employment program that was not authorized pursuant to paragraph (f)(10) of this section, the PROS provider is not entitled to retain the IR or ORS component add-on.

- (9) If Medicaid provided reimbursement to a PROS program and an OPWDD-sponsored day program that was not authorized pursuant to paragraph (f)(11) of this section, the PROS provider is not entitled to retain any amounts in excess of level 2 of the monthly base rate.
- (10) If Medicaid provided reimbursement to a PROS program and a DOH-licensed program that was not authorized pursuant to paragraph (f)(12) of this section, the DOH-licensed program is not entitled to retain any of the funds paid to the DOH-licensed program for mental health services on behalf of that individual.
- (11) In the event that the PROS registration system fails to enforce the reimbursement limitations pursuant to this Part, the State reserves the right to recover any duplicative or improper payments.