NEW YORK STATE | Office of Mental Health

Express Terms (14 NYCRR Part 512)

Pursuant to the authority granted §§ 7.09 (b), 31.04 (a), 41.05, 43.02(a), 43.02(b), 43.02 (c) of the Mental Hygiene Law and §§ 364(3) and 364-1(1) of the Social Services Law, Title 14 of the Official Compilation of Codes, Rules, and Regulations of the State of New York is amended as follows:

Part 512 is amended to read as follows:

PART 512

PERSONALIZED RECOVERY ORIENTED SERVICES

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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) 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.

(c) 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.

(d) 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.

(e) 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 [~~his or her~~]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.

[(g) Section 365-m of the Social Services Law authorizes the Commissioner of the Office of Mental Health and the Commissioner of the Office of Alcoholism and Substance Abuse Services, in consultation with the Department of Health, to contract with regional behavioral health organizations to provide administrative and management services for the provision of behavioral health services.]

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) Behavioral health organization or BHO means an entity selected by the Commissioner of the Office of Mental Health and the Commissioner of the Office of Addiction Services and Supports pursuant to section 365-m of the New York State Social Services Law to provide administrative and management services for the purposes of conducting concurrent review of behavioral health admissions to inpatient treatment settings, assisting in the coordination of behavioral health services, and facilitating the integration of such services with physical health care.]

(c[d]) Capacity means the maximum number of people to whom a PROS program can provide services on-site at any given time.

(d[e]) Carved-out services means those special care services that are not included in the benefit package of a managed care provider, for all managed care enrollees, regardless of aid category.

~~[(f) Clinical staff means all staff members, including any recipient employees, who provide services directly to individuals admitted to PROS programs or their collaterals. Students and trainees may qualify if they are participating in a program leading to a degree or certificate appropriate to the goals, objectives and services of the PROS program, are supervised in accordance with the policies governing the training program, and are approved as part of the staffing plan by the Office of Mental Health.]~~

([g]e) Collateral means a person who is:

> (1) a significant other or member of the PROS participant's family or household, academic, workplace or residential setting, who regularly interacts with the individual and is directly affected by, or has the capability of affecting, [~~his or her~~] their condition; and
>
> (2) identified in the individualized recovery plan, and approved by the individual, as having a role in services and/or is identified in the pre-admission notes as being necessary for participation in the evaluation and assessment of the individual prior to admission; and
>
> (3) not a staff member of the PROS program or any other mental health service provider except when the staff member is participating in services in [~~his or her~~] their role as the recipient's collateral, and not in [~~his or her~~]their staff member role.

([h]f) Commissioner means the Commissioner of the New York State Office of Mental Health.

[~~(i) Comprehensive PROS program, unless otherwise specified, means a comprehensive PROS program with clinical treatment or a comprehensive PROS program without clinical treatment~~.]

[~~(j) Comprehensive psychiatric rehabilitation assessment means the process of identifying the skills and supports necessary for an individual to be successful in his or her 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 his or her recovery goals~~.]

[~~(k) Concurrent review means the review of the clinical necessity for continued inpatient behavioral health services, resulting in a non-binding recommendation regarding the need for such continued inpatient services~~.]

([l]g) Designated mental illness diagnosis means a DSM-[~~I~~]V diagnosis (or ICD-[~~9~~]10-CM equivalent) other than:

(1) alcohol or drug disorders;

(2) developmental disabilities;

(3) organic brain syndromes; or

(4) social conditions (V-codes).

ICD-[9]10-CM categories and codes that do not have an equivalent in DSM-[I]V are not included as designated mental illness diagnoses.

([m]h) Due diligence means the exercise of reasonable and appropriate efforts to comply with the standards set forth in this Part.

([n]i) Evidence-based practice means an intervention for which there is consistent, scientific evidence showing that it improves recipient outcomes. Those services identified in section 512.5 of this Part that are most closely associated with evidence-based practices, as of the effective date of this Part, include the following: family psychoeducation/intensive family support; integrated treatment for dual disorders (IDDT); medication management; ongoing rehabilitation and support (related to the evidence-based practice of supported employment); and wellness self-management.

([o]j) Face-to-face means contact between a PROS participant, or [~~his or her~~] their collateral, and a member of the PROS [~~clinical~~] staff, [~~at a specific location,~~] for the purpose of providing a medically necessary service for the PROS participant's benefit.

([p]k) Functional disability means a deficit that rises to the level of impairment in one or more of the following areas: self-care; activities of daily living; interpersonal relations; or adaptation to change or task performance in work or work-like settings.

([q]l) Licensed practitioner of the healing arts (LPHA) means the following licensed [~~professional~~] staff, as defined in this Part:

(1) nurse practitioner;

(2) physician;

(3) physician assistant;

(4) psychiatric nurse practitioner;

(5) psychiatrist;

(6) psychologist;

(7) registered professional nurse;

(8) licensed clinical social worker (LCSW); [~~and~~]

(9) licensed master social worker (LMSW) if supervised by an LCSW, licensed psychologist, or psychiatrist employed by the agency[~~.~~];

(10) licensed mental health counselor;

(11) licensed creative arts therapist;

(12) licensed marriage and family therapist; and

(13) licensed psychoanalyst.

([r]m) 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.

([s]n) Month means any time between and including the first and last days of any calendar month in a given year.

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

([u]p) 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.

([v]q) Office means the New York State Office of Mental Health (OMH).

([w]r) Off-site, for purposes of providing PROS services, means any clinically appropriate location in the community, other than a licensed PROS site, where an individual may receive services.

([x]s) Off-site Program Participation means the duration of time spent in the delivery of face-to-face services to a PROS participant or collateral at an off-site location.

([y]t) On-site Program Participation means the duration of time that a PROS participant or collateral is in attendance at the PROS program on a given day.

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

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

(u) Paraprofessional Staff are PROS staff members who are not professional staff, as specified below. Paraprofessional Staff must possess a combination of education and professional and/or personal experience in a mental health or human services setting. Paraprofessional Staff shall

have attained at least 18 years of age, possess at least a High School Diploma or GED, and demonstrate six (6) months of professional and/or personal experience in a mental health or human services field.

([z]v) 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.

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

(1) creative arts therapist, [~~which means~~] is 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;

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

(3) marriage and family therapist, [~~which means~~] is 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;

(4) mental health counselor, [~~which means~~]is 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;

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

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

(7) occupational therapist, [~~which means~~] is an individual who is currently licensed or has a limited permit to practice as an occupational therapist by the New York State

Education Department and who meets the qualifications set forth in 42 CFR § 440.110(b)(2);

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

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

(10) physician assistant, [~~which means~~] is 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;

(11) psychiatrist, [~~which means~~] is 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;

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

(13) psychologist, [~~which means~~] is an individual who is currently licensed or has a 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;

(14) registered professional nurse, [~~which means~~] is 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;

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

(16) social worker, [~~which means~~] is 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. However, social workers who have obtained at least a master's degree in social work from a program approved by the New York State Education Department may be considered professional staff for the purposes of calculating professional staff and full-time equivalent professional staff; and

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

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

([ab]x) Program participation means a combination of on-site program participation and off-site program participation for a specific individual on a given day.

[(~~ac) PROS program or PROS provider, unless otherwise specified, means a Comprehensive PROS program or a limited license PROS program~~].

([ad]y) PROS unit is determined by a combination of on-site and off-site program participation and service frequency.

([ae]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.

([af]aa) Recipient attestation form is a form provided to a recipient by a PROS program for [~~him or her~~] them to sign when [~~he or she has~~]they have chosen to participate in one or more components of the PROS program.

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

(a[h]c) 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 [o]Office as authorized providers of PROS services for those individuals.

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

(a[j]d) Relapse prevention plan means a collaboratively developed document, required as part of individualized recovery planning and included in the individualized recovery plan, that identifies a series of actions to be taken by the individual, the program, and/or a collateral identified by the individual to avoid worsening of an individual's mental health symptoms and prevent hospitalization.

(a[k]e) Service frequency means the number of medically necessary PROS services delivered to an individual or collateral during the course of a program day.

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

(a[m]g) 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.

(ah) Supervision or Direct Supervision for the purposes of service delivery under this Part means that the appropriate professional staff must be available at all times to furnish assistance and direction to paraprofessional staff and 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.

512.5. Service categories and requirements.

Each of the following services, offered by PROS providers in accordance with their certification category, are provided face-to-face 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) Assessment is a service designed to review and determine an individual's level of functioning, the past benefits of participating in mental health services, and his or her ability to function in specific life roles. In addition, the assessment service should identify the individual's strengths as well as challenges and barriers encountered as a result of his or her psychiatric~~

~~condition. The assessment service involves a comprehensive and continuous process, conducted within the context of the individual's self-identified needs, goals, and ethnic, religious and cultural identities. Each assessment must result in a summary of findings, within the context of the specific assessment focus, that addresses the individual's strengths, talents, and abilities, as well as the challenges and barriers presented by the individual's mental illness~~.]
(a) Alcohol, Tobacco and Other Drug Assessment is an assessment service conducted by professional staff, 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.

(b) Basic living skills [~~training~~] is a service conducted by professional staff or paraprofessional staff under supervision of professional staff, designed to improve an individual's ability to perform the basic skills necessary to achieve maximum independence and acceptable community behaviors that are critical to [~~his or her~~] their recovery. This service focuses on the acquisition of skills, as well as strategies for appropriate use of the skill, utilizing teaching interventions including but not limited to [~~such as~~] motivational, educational and cognitive-behavioral techniques. The service may include opportunities to practice, observe, reinforce and improve the individual's skill performance. The topics which may be covered include, but are not limited to: grooming and personal hygiene, nutrition, homemaking, building relationships, childcare, transportation, use of community resources, and engaging in social interactions.

(c) Benefits and financial management is a service conducted by professional staff or paraprofessional staff under the supervision of professional staff, designed to support an individual's functioning in the community through understanding and skill in handling [~~his or her~~] their financial resources. The instruction may include counseling on budgeting, income and benefits, including incentives for returning to work as well as basic counseling on income maintenance, eligibility for benefits from relevant sources, and determination of the need for plans for additional support and assistance in managing personal finances. This service may also include psychosocial rehabilitation services which assists individuals in reacquiring skills and capabilities that were lost as a result of the onset of mental illness and that are necessary to manage their own finances. This service is designed to support an individual's functioning in the community through understanding, and skill in handling their own financial resources.

(d) Clinical counseling and therapy is a service conducted by Licensed Practitioners of the Healing Arts or Professional Staff under the supervision of a Licensed Practitioner of the Healing Arts, designed to provide goal-oriented verbal counseling or therapy, including but not limited to 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 abuse (including alcohol) disorder, and the related effects on role functioning.

(e) Cognitive remediation is a service conducted by Professional Staff with appropriate training as approved by the Office of Mental Health, and is a set of techniques and interventions, such

as drills, activities and exercises, designed to improve an individual's functioning by improving the cognitive skill that is the target of the remediation task. These skills include, but are not limited to: the ability to pay attention, remember, process information, solve problems, organize and reorganize information, communicate and act upon information. Cognitive remediation techniques work to improve mental capabilities necessary to learn academic subject matter, and more generally to function in daily life. Cognitive remediation is an optional PROS service, subject to prior review and written approval of the office.

(f) Community living exploration is a service conducted by Professional Staff or Paraprofessional Staff under the supervision of Professional Staff, designed to help an individual understand the demands of specific community life roles, in order to make decisions regarding participation in those roles. Community living exploration services can also be used to help motivate individuals who are not yet exhibiting active interest in more integrated community life roles, by increasing their knowledge of opportunities available in the community. Topics may include, but are not limited to: options for satisfactory experiences with living environments, work or career opportunities, educational opportunities, opportunities to connect to culturally-based community services, and resources for use of leisure time. It is expected that, to the extent possible, these services will be developed in natural community environments.

(g) Crisis intervention is a service conducted by Professional Staff, designed to safely and respectfully de-escalate situations of acute distress or agitation which require immediate attention. Such service may include, but is not limited to, calming techniques to interrupt escalating behavior.

(h) ~~[Engagement is a service designed to reach out to individuals over time for the purpose of fostering a commitment on the part of an individual to enter into therapeutic relationships supportive of the individual's recovery. This service may include, but is not limited to, activities such as initial contacts with potential program participants, as well as ongoing efforts to engage individuals to participate in program services.]~~ Engagement in Recovery is a psychosocial rehabilitation service conducted by Professional Staff or Paraprofessional Staff under the supervision of Professional Staff, designed to motivate and support individuals receiving PROS to continue to participate in the rehabilitation and recovery process. This includes: fostering therapeutic relationships supportive of the individual's recovery, evaluating recovery goals, readiness, and overall satisfaction of life roles and the individual recovery plan.

(i) Family psychoeducation/intensive family support is an intensive rehabilitation (IR) service conducted by Professional Staff or Paraprofessional Staff under the supervision of Professional Staff who have completed Office approved training, designed to provide information, clinical guidance and support to collaterals and PROS participants when desired and appropriate, for the purpose of assisting and enhancing the capacity of a collateral to facilitate an individual's recovery. [~~Specific examples of family psychoeducation/intensive family support include consumer-centered family consultation (CCFC), psychoeducational multiple family groups (MFGs), and behavioral family therapy~~.]

(j) Health assessment is a service conducted by a Nurse Practitioner, Nurse Practitioner in Psychiatry, Physician, Physician's Assistant, Psychiatrist or Registered Professional Nurse, designed to gather data concerning an individual's medical history and any current signs and symptoms and assess such data to determine [~~his or her~~] their physical health status and need for referral. [~~The assessment of the data shall be done by a nurse practitioner, psychiatric nurse practitioner, physician, physician's assistant, psychiatrist or registered professional nurse~~.] Where indicated, this service shall include screening for metabolic syndrome, diabetes, and hypertension on a periodic basis.

(k**)** Individualized recovery planning a service conducted by Professional Staff or Paraprofessional Staff under the supervision of Professional Staff, is a continuous, dynamic process that engages each person as an active partner in developing, reviewing and modifying a course of care that supports [~~his or her~~] their progress towards recovery. The course of care is based on an assessment process and the individual's personal preferences and desired life roles. The course of care is reflected in an individualized recovery plan (IRP), which includes the identification of medically necessary services and which supports the individual's goals and desires. The individualized recovery planning process also includes the development of a relapse prevention plan by the individual in partnership with the PROS practitioner and, when appropriate, an advance directive. The service may also involve activities designed to help identify and develop compensatory supports necessary to assist an individual during [~~his or her~~] their recovery process.

(l)[~~ Information and education regarding self-help is a service designed to encourage individuals to participate in self-help and mutual aid groups. The service is designed to help an individual understand what self-help resources are available in the community and how to benefit from participating in them. The service may be conducted by people who have common experiences, and is intended to help the individual to learn how to share personal experiences with others who have had a common experience, to learn about the variety of available self-help groups, and to aid the individual in accessing the self-help options of his or her choice.]~~

[(~~m~~)]Integrated treatment for dual disorders (IDDT) is [~~an evidence-based practice designed to address the mental health and substance abuse needs of persons with co-occurring disorders simultaneously. Such service includes, but is not limited to, motivational, cognitive-behavioral and harm reduction approaches, wherein practitioners coordinate care with appropriate substance abuse providers when it is determined that the co-occurring disorder is acute or serious, and the recipient is ready to accept related treatment~~]a rehabilitation counseling service conducted by Professional Staff or Paraprofessional Staff under the supervision of Professional Staff who have completed a core set of training modules as provided for in guidance issued by the office. Such service is 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.

([n]m) Intensive rehabilitation goal acquisition (IRGA) is a service conducted by Professional Staff or Paraprofessional Staff under the supervision of Professional Staff, designed to assist an individual in identifying, attaining and retaining personally meaningful goals that will help the person to resume normal functioning in adult life roles. This service should be used to provide active support once an individual has made a commitment to achieving a new role, such as returning to work or school, returning to adult care giving or parenting roles, resuming roles as a spouse or significant other, obtaining a desired housing arrangement, and resuming a role as a community volunteer. Due to the urgency associated with the individual's readiness to attain and maintain a preferred life role, this service is not normally a long-term intervention.

([o]n) Intensive relapse prevention is a service conducted by Professional Staff or Paraprofessional Staff under the supervision of Professional Staff, designed to address an exacerbation of acute symptoms, or manage existing symptoms that are not responsive to the current service formulation. This may include the provision of targeted, intensive interventions necessary to address immediate risks such as relapse, hospitalization, loss of housing, or involvement with the criminal justice system 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 may also include the execution of a series of predetermined steps identified in the relapse prevention plan.

([p]o) Medication management is a service conducted by a Psychiatrist or Psychiatric Nurse Practitioner designed to prescribe or administer medication with the highest efficacy and lowest toxicity in treating 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. The purpose of such consultation is to determine personal preferences, as well as past and present experiences with medication, including related efficacy, side effects and compliance. 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. This service does not include reimbursement for the cost of Medications.

([q]p) Ongoing rehabilitation and support [~~is a service designed to provide ongoing counseling, mentoring, advocacy and support for the purpose of sustaining an individual's role in~~ ~~*competitive, integrated employment*. Such service does not include task-specific job training~~] (ORS) services are conducted by Professional Staff or Paraprofessional Staff under the supervision of Professional Staff, which include psychosocial rehabilitation services including rehabilitation counseling, social, coping, and basic living skills training services designed to assist an individual manage the disabling symptoms of mental illness in the workplace, develop

strategies for resolving workplace issues, and maintain other functional skills necessary to sustain competitive employment. 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. ORS does not include educational, vocational or job training services.

([r]q) Pre-admission screening is a service [~~designed to include the initial process of contacting, engaging, interviewing and evaluating an individual to determine his or her need and desire for PROS services. The result of pre-admission screening is a determination of the individual's desire to participate in services and the program's appropriateness to meet the needs of the individual~~] conducted by Professional Staff or Paraprofessional Staff under the supervision of Professional Staff, including 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.

([s]r) Psychiatric assessment is a service conducted by a psychiatrist or a psychiatric nurse practitioner, 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. [~~Assessment of the data shall be done by a psychiatrist or psychiatric nurse practitioner~~.]

(s) Psychiatric Rehabilitation Assessment is a service conducted by Professional Staff or Paraprofessional Staff under the supervision of Professional Staff, with the active involvement of the individual, the 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. 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.

(t) Skill Building for Self-help is a psychosocial rehabilitation service conducted by Professional Staff or Paraprofessional Staff under the supervision of Professional Staff, designed to help individuals restore the skills necessary to identify and participate in or take advantage of appropriate self-help resources or mutual aid groups. The service is intended to help the individual to learn how to share personal experiences with others who have had a common experience, to learn about the variety of available self-help groups, and to aid the individual in accessing the self-help options of their choice.

([t]u) Structured skill development and support [~~is a service designed to assist individuals in developing instrumental skills for performing normative life roles associated with group membership, work, education, parenting or living environments. The focus of structured skill development is to develop skills through a process of teaching, practice, and feedback in community environments replicated at the program site. The modality for teaching these skills~~

~~is a combination of individual, group and structured activities. It is often provided in structured club-like settings such as a work-ordered day or an activity-center format, where staff employ supportive counseling, mentoring and skill development techniques to assist the individual in completion of essential tasks]~~ is a psychosocial rehabilitation service conducted by Professional Staff or Paraprofessional Staff under the supervision of Professional Staff, designed to assist individuals to regain the skills necessary for performing normative life roles associated with group membership, work, education, parenting, or living environments by modeling and practicing skills in actual community settings off-site or community environments replicated at the program site and through the use of structured activities.

([u]v**)** Symptom monitoring is a service conducted by Licensed Practitioners of the Healing Arts and Professional or Paraprofessional Staff under the supervision of a Licensed Practitioners of the Healing Arts, 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 [~~his or her~~] their individualized recovery plan, and [~~his or her~~] their response to treatment, within the context of other support and rehabilitation services. Such service may include consultation with identified collaterals. If this service is provided by a staff person other than a psychiatrist, nurse or nurse practitioner, it must include communication of observed symptoms and treatment responses to the physician or nurse which may be accomplished through documenting such observed symptom in the case record.

([v]w) Wellness self-management (also known as illness management and recovery) is a service conducted by Professional Staff or Paraprofessional Staff under the supervision of Professional Staff, designed to develop or improve personal coping strategies, prevent relapse, and promote recovery. Such services may be provided to recipients and/or collaterals, and may include, but are not limited to:

(1) coping skills training which means teaching individuals strategies to address symptoms, manage stress and reduce exposure and vulnerability to stress;

(2) disability education which means instruction on the facts concerning mental illness and the potential for recovery. The intent of this service is to give individuals admitted to PROS programs and collaterals hope as well as practical information on prevention and recovery practices, including evidence-based practices;

(3) dual disorder education which means providing individuals admitted to PROS programs and/or collaterals with basic information on the nature of substance abuse disorders and how they relate to the symptoms and experiences of mental illness;

(4) medication education and self-management which means providing individuals admitted to PROS programs or collaterals with information on the individual's medications, including related efficacy, side effects and compliance issues. Individuals are supported in managing their medications and in learning about the effects of the medication on their mental health condition and in managing the side effects of

medication through healthy life style changes such as smoking cessation, nutrition, and weight loss;

(5) problem-solving skills training which means a series of learning activities designed to assist individuals admitted to PROS programs and collaterals develop effective solutions for stressful responses to routine life situations. These activities may include, but are not limited to: role playing exercises, homework assignments or the mastery of specific principles and techniques; and

(6) relapse prevention planning which means a process to engage individuals admitted to PROS programs and collaterals in understanding factors which may trigger a recurrence of severe symptoms of mental illness and ways to cope with the potential for recurrence. Planning activities may include the development of an advance directives document and specific instructions on what steps need to be taken in the event of a relapse.

512.6. 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) [~~Comprehensive PROS:~~

~~(i)~~] with clinical treatment; or

([ii]2) without clinical treatment.[; or]

~~[(2) limited license PROS.]~~

~~[(c) It is the preference of the office to establish fully-integrated [Comprehensive] PROS programs. However, applications for limited license PROS programs may be considered in cases where there is a need for the program identified by the local governmental unit and the capacity of the provider is not sufficient to deliver a comprehensive PROS.]~~

([d]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 capacity;

(5) the population to be served; and

(6) the term of the operating certificate.

([e]d) The initial operating certificate issued pursuant to subdivision (a) of this section shall be for a term of up to one year. The provider's capacity and monthly caseload identified in the initial operating certificate shall be expressed by a numeric range. At a time determined by the office, but not less than one year from the date of initial licensure, the capacity and monthly caseload identified in the renewal of the initial operating certificate shall be in accordance with the provider's actual capacity and monthly caseload, as determined by the office, at that time.

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

(2) A provider shall not exceed the capacity range identified in its operating certificate by more than 15 percent, on a regular or routine basis, unless the provider receives approval pursuant to Part 551 of this Title.

([f]e) A PROS provider may offer services identified in section 512.7(b) 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.

([g]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 ([~~h~~]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 capacity;

(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.

([h]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.

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

([j]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.

([k]j) The commissioner, in consultation with the local governmental unit, may reduce a program's capacity and 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 512.7(c)(6) of this Part. Such reduced capacity and 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.

([l]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.

([m]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.

([n]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.

([o]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.

512.7. 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.

(2) Depending upon program configuration and licensure category, PROS programs will include the following components: community rehabilitation and support (CRS); intensive rehabilitation (IR); ongoing rehabilitation and support (ORS); and clinical treatment.

(i) [~~The CRS component shall be designed to engage and assist individuals in managing their illness and in restoring those skills and supports necessary to live in the community.~~]The CRS component shall be designed to offer an array of recovery-oriented assessment, psychosocial rehabilitation, counseling, family psychoeducation, and crisis intervention services designed to restore, rehabilitate and support individuals to regain skills and functionality lost due to mental illness, and manage the symptoms of their mental illness so that they may live successfully in the community.

(ii) The IR component shall be designed to intensively assist individuals in attaining specific life roles such as those related to competitive employment, independent housing and school. The IR component may also be used to provide targeted interventions to reduce the risk of hospitalization or relapse, loss of housing or involvement with the criminal justice system, and to help individuals manage their symptoms.

(iii) The ORS component shall be designed to assist individuals in managing symptoms and overcoming functional impairments as they integrate into a competitive workplace. ORS interventions shall focus on supporting individuals in maintaining competitive integrated employment. Such services shall be provided off-site.

(iv) The clinical treatment component shall be designed to help stabilize, ameliorate and control an individual's symptoms of mental illness. 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.

(3) A [~~Comprehensive~~] PROS program shall offer, at a minimum, CRS, IR and ORS components. A [~~Comprehensive~~] PROS program must be able to provide the following assessments:

(i)[~~ psychosocial assessment;~~]

[(ii)] psychiatric rehabilitation assessment that addresses living, learning, working and social domains; and

(ii[i]) [~~screening for~~] alcohol, [~~substance abuse, and nicotine addiction~~] tobacco and other drug assessment.

(4) A [~~comprehensive~~] PROS program with clinical treatment shall offer, at minimum, CRS, IR, ORS, and clinical treatment components. In addition to the assessments required to be provided by all [~~Comprehensive~~] PROS programs, a [~~Comprehensive~~] PROS program with clinical treatment must be able to provide:

(i) psychiatric assessment; and

(ii) health assessment.

~~[(5) A limited license PROS program shall offer IR and ORS components.]~~

([6]5) 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 paragraph (2) of this subdivision that are delivered by the same PROS provider;

(ii) coordination among any of the PROS components as specified in paragraph (2) of this subdivision which are delivered by multiple PROS providers; and

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

(b) Components and services

(1) [~~All PROS programs, regardless of certification category, shall offer the following services:~~

~~(i) individualized recovery planning services; and~~

~~(ii) pre-admission screening services.~~]

[(2)] A CRS component shall include, at a minimum, the following services:

(i)[~~ assessment]~~ alcohol, tobacco and other drug assessment

(ii) basic living skills [~~training~~];

(iii) benefits and financial management;

(iv) community living exploration;

(v) crisis intervention;

(vi)[engagement]engagement in recovery;

(vii) individualized recovery planning;

(viii) [information and education regarding self help;] pre-admission screening services;

(ix) [structured skill development and support] psychiatric rehabilitation assessment;

(x) [wellness self-management.] skill building for self-help;

(xi) structured skill development and support; and

(xii) wellness self-management.

([3]2) 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 clinically appropriate for the service being provided. Pursuant to section 512.11(b)(13) of this Part, a PROS program may, within the specified limits, still use the service to satisfy the service frequency requirement of section 512.11(b)(11) of this Part for some group participants.

([4]3) An IR component, as part of a [Comprehensive] PROS program, shall include, at a minimum, the following services:

(i) family psychoeducation/intensive family support;

(ii) integrated treatment for dual disorders;

(iii) intensive rehabilitation goal acquisition; and

(iv) intensive relapse prevention.

([5]4) In order to receive Medicaid-reimbursed integrated treatment for dual disorders as part of the IR component, the individual must also be receiving clinical treatment services within the PROS program or from another licensed, certified or otherwise authorized clinical treatment provider [OMH- licensed clinic]. If the individual is not receiving clinical treatment services directly within the PROS program, the PROS program shall document that the services provided by the [clinical] mental health outpatient treatment and rehabilitative services provider are integrated with those provided by the PROS program. Such integration shall include, at a minimum, the ongoing exchange of information, documentation of progress and outcomes related to the services provided by the [clinical] mental health outpatient treatment and rehabilitative services provider, and shall indicate the name of the treating psychiatrist

or nurse practitioner at such clinical treatment provider who will be collaborating with a designated member of the PROS [~~clinical~~] staff.

~~[(6) An IR component, as part of a limited license PROS program, shall include, at a minimum, intensive rehabilitation goal acquisition services. Such services shall be limited to employment and education-oriented goals.]~~

([7]5) 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(b)(11) of this Part or the IR service requirement of section 512.11(c)(2)(i) of this Part for some group participants.

([8]6) An ORS component shall include, at a minimum, ongoing rehabilitation and support services.

([9]7) Clinical treatment is intended to enhance the array of available services offered within other PROS program components. The following services shall be available:

(i) clinical counseling and therapy;

(ii) health assessment;

(iii) medication management;

(iv) symptom monitoring; and

(v) psychiatric assessment.

([10]8) Providers offering medication management services 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.

([11]9) Any additional services delivered by a PROS program that are clinically appropriate shall be considered as optional and shall be subject to prior review and written approval of the office. Such services may include, but are not limited to, cognitive remediation services.

(c) 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 abuse. A provider of service shall not deny access to services by an otherwise appropriate individual solely on the basis of multiple diagnoses or a diagnosis of HIV infection, AIDS, or AIDS-related complex.

(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 a licensed practitioner of the healing arts (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.

(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 a member of the professional staff in partnership with the individual. The initial service recommendation plan identifies the individual's primary service needs and a list of services in which [~~he or she~~] 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 a decision to admit an individual to a PROS program, a recipient attestation form shall be completed. Such form shall be dated and signed by the individual, which indicates [~~his or her~~] their choice to participate in the PROS program and specified program components.

(11) Upon admission of an individual and the completion of the recipient attestation form, the PROS program shall complete and submit a PROS registration form, using the registration system approved by the office.

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

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

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

(13) 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.

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

(d) Staffing.

(1) A PROS provider shall continuously employ an adequate number and appropriate mix of [~~clinical~~] professional and paraprofessional staff consistent with the objectives of the program and the intended outcomes. Such staff may include persons who are also recipients of service from a PROS program, subject to the requirements of paragraph (9) of this subdivision and section 512.9 of this Part.

(2) PROS providers shall maintain an adequate and appropriate number of professional staff relative to the size of the [~~clinical~~] total staff.

(i) A [~~Comprehensive~~] PROS provider shall be deemed to have met such standard if at least 40 percent of the total [~~clinical~~] staff full-time equivalents (FTEs) are represented by professional staff.

~~[(ii) A limited license PROS program shall be deemed to have met such standard if at least 20 percent of the total clinical staff FTEs are represented by professional staff.]~~

[~~(3) For the purpose of calculating professional staff ratios, a provider may include staff credentialed by the United States Psychiatric Rehabilitation Association (USPRA) for up to 20 percent of the total number of required professional staff.~~]

([4]3) [~~For Comprehensive] PROS programs, a~~]At least one of the members of the provider's professional staff shall be a licensed practitioner of the healing arts and shall be employed on a full-time basis.

~~[(5) For limited license PROS programs, at least one of the members of the provider's professional staff shall be employed on a full-time basis.]~~

([6]4) IR services shall be provided by[, ~~or under the direct supervision of, professional staff]~~ ~~P~~rofessional Staff or Paraprofessional Staff under the supervision of Professional Staff.

([7]5) PROS providers shall maintain an adequate and appropriate number of staff in proportion to the number of individuals served. Providers shall be deemed to have met such standard if their staffing ratios, based on average attendance, are at least in accordance with the following:

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

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

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

(iv) for [~~Comprehensive~~] PROS programs with clinical treatment, the following additional standards shall apply:

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

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

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

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

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

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

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

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

([8]6) All staff shall be afforded regular supervision. Such supervision shall address quality of care provided and ongoing staff development.

(a) Paraprofessional Staff Training and Supervision.

(i) Paraprofessional Staff Training - 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.

(ii) Required Supervisory Arrangements – Initial Service Recommendations and Individualized Recovery Plans must be developed and documented under the supervision of Professional Staff. Professional Staff must provide direct supervision as defined in this Part, to Paraprofessional Staff in the delivery of service components contained herein. Professional Staff supervision 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 professional supervision of group-delivered services as a condition of program licensure.

([9]7) A PROS provider may use recipient employees. In such circumstances, the following requirements shall apply:

(i) Recipient employees shall be included in the PROS provider's staffing plan.

(ii) PROS participants may perform a variety of non-paid functions related to the operation of the program as part of the program's therapeutic environment when such functions are identified in the person's individualized recovery plan. Non-paid functions of PROS participants shall not be reflected in the PROS provider's staffing plan.

(iii) Recipient employees shall adhere to the same requirements, pursuant to this Part, which are applicable to other PROS employees.

(iv) Recipient employees shall receive training regarding the principles and requirements of confidentiality, ethics and boundaries, and workplace harassment.

(v) Ongoing supervision of recipient employees shall address, as warranted, boundary issues, transition between roles, and potential conflicts of interest.

(e) Individualized recovery planning process.

(1) The individualized recovery planning process shall be carried out by, or under the direct supervision of, a member of the professional staff. Such process is intended to be reflective of person-centered planning principles 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 address the differences in individuals' cognitive abilities and/or learning style, culture, gender, age and other issues that may impact service delivery.

(3) 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) identification and completion, within 45 days of the individual's admission date, of all required screenings or assessments, as determined based on the PROS Components in which the individual has enrolled;

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

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

(4) An initial IRP shall be developed within 60 days of the individual's admission date.

(5) 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 at least every six months or sooner if conditions warrant it. This review and update should result in a new IRP reflective of the individual's progress or lack of progress toward [~~his or her~~] their goal and must be signed by all required parties, including:

(a) PROS participant;

(b) [~~clinical~~] staff member who prepared the IRP;

(c) professional staff member if the ~~[clinical]~~ staff member who prepared the IRP is not a professional; and

(d) physician or nurse practitioner in psychiatry, if the individual is enrolled in the clinical component.

(ii) Three month review of IR/ORS services: reviews must be conducted every three months to determine the need for continuation of IR or ORS services. This review concerns the continuation of the IR or ORS services and does not require that the complete IRP be reviewed.

(6) 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.

(7) For individuals receiving IR or ORS services, the IR or ORS services identified in the IRP shall be assessed for continued need, at a minimum, every three months. The decision to continue or discontinue the service shall be documented and include the following:

(i) reason for the decision;

(ii) signature of the individual; and

(iii) signature of the ~~[clinical]~~ staff member assessing the need for continued service. If the [~~clinical~~] staff member who conducted the assessment is a paraprofessional [~~not a~~

~~member of the professional staff~~], the signature of the professional staff member who supervised the paraprofessional, [~~staff member~~] must also be recorded.

(8) 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.

(9) If a PROS participant receives PROS services only from one PROS provider, and receives only IR or ORS services, the provider of IR or ORS services shall be responsible for the completion, review and update of an IRP pursuant to the requirements of this subdivision.

512.8. Documentation.

(a) Case records.

(1) There shall be a complete case record maintained for each person admitted to a PROS program. Such case record shall be maintained in accordance with recognized and acceptable principles of 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) any pre-admission screening notes;

(ii) identifying information and history;

(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, an assessment of the individual's psychiatric and physical needs, and dated and signed records of all medications prescribed;

(vi) for individuals who are receiving integrated dual disorder treatment from the PROS program and clinical treatment services from a source other than the PROS program, documentation that the services provided by the licensed, certified or otherwise authorized clinical treatment provider [clinic] are integrated with those provided by the PROS program, including, at a minimum, the ongoing exchange of information, documentation of progress and outcomes related to the services provided by the clinic, and the name of the treating psychiatrist or nurse practitioner at such clinic who will be collaborating with a designated member of the PROS [clinical] staff;

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

(viii) screening and admission note;

(ix) attestation form;

(x) initial services recommendation plan;

(xi) the individualized recovery plan (IRP), IRP service addition form, and all reviews of the IRP;

(xii) documentation satisfying the requirements in subdivision (d) of this section;

(xiii) dated progress notes;

(xiv) any referrals to other programs and services;

(xv) any consent forms; and

(xvi) discharge plan and/or summary, as appropriate.

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

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

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

(b) Individualized recovery plan (IRP).

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

(i) a description of the individual's strengths as identified in the summary of findings provided in each required assessment;

(ii) a description of the barriers created by the individual's mental illness that prevent the individual's achievement of [~~his or her~~] their stated goals, as identified in the summary of findings provided in each required assessment;

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

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

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

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

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

(viii) a relapse prevention plan, which includes a description of the individual's preferences regarding treatment and any PROS services that may be used in the event of a crisis;

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

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

(xi) for PROS participants receiving treatment services from a clinic licensed pursuant to Part 599 of this Title, a description of how such services are integrated with the individual's IRP; and

(xii) 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 the individual's return to the program;

(b) the signature of the [~~clinical]~~ staff member who prepared the IRP;

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

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

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

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

(4) Services may be provided on an interim basis and be considered part of the IRP by completing a service addition form or 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 service addition form or 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 individual and a member of the ~~[clinical]~~ staff; and

(iii) for clinical treatment services, the signature of the psychiatrist or nurse practitioner in psychiatry.

(c) Progress notes.

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

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

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

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

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

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

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

(d) Supporting documentation.

(1) The PROS program shall maintain documentation for each participant indicating:

(i) duration of on-site and off-site program participation per day;

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

(iii) upon request, capacity to provide the number of PROS units per person, per day, per month.

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

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;

(viii) written policies and procedures regarding the use of recipient employees that address, at a minimum, the requirements pursuant to section 512.7(d)([9]7) of this Part; and

(ix) 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.

(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) [~~Comprehensive~~] PROS programs with clinical treatment shall have a mechanism to provide, or arrange for, face-to-face contact with individuals enrolled in the program who need assistance when the program is not in operation.

(p) [~~Comprehensive~~] 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.

(q) 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.

(r) 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.

(s) 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 [~~his or her~~] 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 posted in a conspicuous location easily accessible to the public. The notice shall include the address and telephone number of the Commission on Quality of Care and Advocacy for Persons with Disabilities, 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 512.7(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]3) 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]4) In order to be eligible for reimbursement, any PROS service provided to a PROS participant in the participant's employment setting and any ORS service shall be on a one-to-one basis.

(b) Reimbursement for [~~Comprehensive~~] PROS programs.

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

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

(i) monthly base rate;

(ii) IR component add-on;

(iii) ORS component add-on; and

(iv) clinical treatment component add-on.

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

(4) The PROS unit is determined by the duration of program participation, which includes a combination of on-site and off-site program participation 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 including Psychiatric Rehabilitation Assessment; Alcohol, Tobacco and Other Drug Assessment conducted by Professional Staff; Health Assessment; and Psychiatric Assessment.

(ii) crisis intervention services;

(iii) engagement in recovery 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,~~] [~~t~~]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~~]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 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]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 512.7(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]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 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 licensed pursuant to Part 599 or Part 679 of this Title, as long as [~~only if the clinic provider and the PROS provider are not operated by the same sponsor, and~~] the individual is not registered in the PROS clinical treatment component.

~~[(iii) Medicaid may reimburse for services provided to an individual in a given month in both a limited license PROS program and a clinic licensed pursuant to Part 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]6) 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]7) [~~Intensive, supportive or blended case management (ICM/SCM/BCM) program~~] Health Home Care Management (HHCM) and PROS program. Medicaid may reimburse for services in a given month provided in both a PROS program and an [ICM/SCM/BCM] HHCM 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]8) 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]9) 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]10) 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]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 ([~~f~~]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 clinic program licensed pursuant to Part 599 or 679 of this Title, that was not authorized pursuant to paragraph ([f]e)(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]e)(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]5) If Medicaid provided reimbursement to a PROS program and an ACT program that are not authorized pursuant to paragraph ([f]e)([7]6) 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]6) 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]e)([10]8) of this section, the PROS provider is not entitled to retain the IR or ORS component add-on.

([9]7) If Medicaid provided reimbursement to a PROS program and an OPWDD-sponsored day program that was not authorized pursuant to paragraph ([f]e)([11]9) of this section, the PROS provider is not entitled to retain any amounts in excess of level 2 of the monthly base rate.

([10]8) If Medicaid provided reimbursement to a PROS program and a DOH-licensed program that was not authorized pursuant to paragraph ([f]e)([12]10) 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]9) 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.

Section 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.

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

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

(e) The monthly base rate and component add-on schedules for PROS Programs shall be in accordance with the most recent Fee Schedule.

[Effective July 1, 2012, the monthly base rate and component add-on schedules for PROS programs are as follows:

(1) Comprehensive PROS programs:

(i) for programs operated in the Downstate Region:

Monthly Base Rate*						Component Add-On		
Pre-Adm	Level 1	Level 2	Level 3	Level 4	Level 5	IR	ORS	CT
	2-12 Units	13-27 Units	28-43 Units	44-60 Units	61+ Units			
$153	$235	$553	$789	$886	$998	$414	$355	$279

(ii) for programs operated in the Upstate Region:

Monthly Base Rate*						Component Add-On		
Pre-Adm	Level 1	Level 2	Level 3	Level 4	Level 5	IR	ORS	CT
	2-12 Units	13-27 Units	28-43 Units	44-60 Units	61+ Units			
$140	$214	$503	$718	$786	$908	$377	$324	$254

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

(2) Limited license PROS programs:

(i) for programs operated in the Downstate Region:

Reimbursement Category	Monthly Fee
Intensive Rehabilitation	$474
Ongoing Rehabilitation and Support	$391

(ii) for programs operated in the Upstate Region:

-

~~Reimbursement Category~~	~~Monthly Fee~~
~~Intensive Rehabilitation~~	~~$431~~
~~Ongoing Rehabilitation and Support~~	~~$355~~]

-

(f) 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 capacity and purpose.

(3) All [~~Comprehensive~~] 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) Requirements for psychiatric coverage associated with [Comprehensive] PROS programs with clinical treatment may be waived under the following circumstances:

(1) the office, in consultation with the local governmental unit, may approve the use of a physician in lieu of a psychiatrist in circumstances where the PROS program can demonstrate that a psychiatrist is unavailable to meet the requirement. Such physician shall have specialized training or experience in the treatment of mental illness; or

(2) if the requirements of paragraph (1) of this subdivision cannot be met, the office, in consultation with the local governmental unit, may approve a plan for the provision of an equivalent level of care which shall include, but not be limited to, a physician who does not have specialized training or experience in the treatment of persons with mental illness and at least a licensed psychologist, nurse practitioner, registered professional nurse or licensed social worker who is experienced in the treatment of adults with a diagnosis of mental illness.

(b) In the event that the requirements for psychiatric coverage have been waived pursuant to subdivision (a) of this section, the requirement for collaboration with a psychiatrist who is employed by the sponsor in accordance with section 512.7(d)(7)(v)(c) of this Part may be waived in circumstances where the PROS program can demonstrate that a psychiatrist who is not employed by the sponsor is otherwise available to provide such collaboration.

~~(c) The office, in consultation with the local governmental unit, may approve the use of a professional staff member on less than a full-time basis in a limited license PROS program in circumstances where the PROS program can demonstrate that a professional staff member is unavailable to meet this requirement.~~

([d]c) 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 [~~or intensive psychiatric rehabilitation treatment~~] program 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([f]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.

~~[(c) Until such time as the PROS registration system can be used to enforce the co-enrollment limitations established pursuant to this Part, the provisions of section 512.11(g) of this Part, as they relate to the recovery of Medicaid, shall not become effective until three months after the effective date of the PROS provider's initial operating certificate issued pursuant to Part 551 of this Title. Notwithstanding this exception, co-enrollment limitations as they pertain to multiple providers operated by the same sponsor shall become effective upon the effective date of the PROS provider's initial operating certificate issued pursuant to Part 551 of this Title~~.]

([d]c) 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)(2) 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, [he or she] they shall be replaced with an individual who will bring the program closer to compliance with section 512.7(d) of this Part.

[(e) The commissioner may permit providers operating pursuant to a PROS operating certificate on or before November 1, 2006, to continue to operate pursuant to the requirements of Part 512 in effect prior to November 1, 2006. Such permission shall be granted only if such providers shall have submitted and the commissioner shall have approved a transition plan setting forth a timetable for complying with the requirements 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 [his or her] 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.

[~~512.19. Behavioral health organizations.~~

~~Providers shall cooperate with the designated regional behavioral health organizations and shall be authorized pursuant to section 33.13(d) of the Mental Hygiene Law to exchange clinical information concerning clients with such organizations. Information so exchanged shall be limited to the minimum necessary in light of the reason for the disclosure. Such information shall be kept confidential and any limitations on the release of such information imposed on the party giving such information shall apply to the party receiving such information~~.]

[~~Section 512.20. Target population services~~

~~(a) Individuals who are target population members as defined in Section 512.4 of this Part must meet the standard eligibility criteria for enrollment in PROS in accordance with Section 512.7 of this Part.~~
~~(b) Effective April 1, 2014, the following additional provisions shall apply to PROS providers that are providing services to target population members.~~
~~(1) Reimbursement for services to target population members who are in continuous pre-admission status is limited to four consecutive months, whether or not the individual is ultimately admitted to the program. Programs will be reimbursed for pre-admission services for target population members at the existing pre-admission rate plus 25 percent.~~
~~(2) Medicaid may reimburse the Intensive Rehabilitation (IR) component add-on for up to 50 percent of a provider's total number of monthly base rate bills submitted annually. IR services provided to target population members shall not count toward the 50 percent limitation for Medicaid reimbursement.~~
~~(3) The following Community Rehabilitation and Support (CRS) services will offer an enhanced reimbursement when delivered off site, on separate days, to target population members:~~
~~(i) Basic skills living training;~~
~~(ii) Benefits and financial management;~~

(iii) Community living exploration;
(iv) Information and education regarding self help; and
(v) Wellness self management.
(4) If two or three of the identified CRS services are delivered off site to target population members in a calendar month, programs will be reimbursed at the base rate plus $135.33 (upstate) or $150.37 (downstate), effective April 1, 2015. If four or more of the identified CRS services are delivered off site to target population members in a calendar month, programs will be reimbursed at the base rate plus $270.67 (upstate) or $300.73 (downstate), effective April 1, 2015.]

PART 583
RESIDENTIAL TREATMENT FACILITIES
FOR CHILDREN AND YOUTH; ELIGIBILITY

A new Part 583 is added as follows:

583.1 Background and intent
583.2 Legal base
583.3 Applicability
583.4 Definitions
583.5 RTF Eligibility and Authorization Requirements
583.6 Responsibilities of the Office or Commissioner's designee

Section 583.1 Background and intent.

(a) Chapter 947 of the Laws of 1981 authorized the establishment of residential treatment facilities for children and youth.

(b) The purpose of residential treatment facilities for children and youth is to provide comprehensive and intensive mental health services under the supervision of a physician for children and youth who have attained their 5th birthday and have not, in most cases, attained their 21st birthday and who are in need of inpatient treatment in a residential setting.

(c) The purpose of these regulations is to provide for the establishment of procedures for accessing residential treatment facility services, a Medicaid eligible service; to articulate the criteria for determining eligibility of an individual to apply for admission or transfer to a specific residential treatment facility for children and youth; and to specify the procedures to be used in determining eligibility and priority for admission or transfer to residential treatment facility for children and youth.

(d) The purpose of the procedures for accessing residential treatment facility services is to assure uniform access to residential treatment facilities for children and youth regardless of the current setting or source of referral of a child.

583.2 Legal Base

(a) Section 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 retention of services for the mentally ill pursuant to an operating certificate.

(b) Section 9.51 of the Mental Hygiene Law provides that the Office of Mental Health will establish standards and priorities for residential treatment facilities for children and youth admissions and will evaluate medical necessity for applicants or recipients of medical assistance pursuant to title eleven of article five of the social services law applying to access residential treatment facility services

(c) Section 31.26(c) of the Mental Hygiene Law provides for the Commissioner to authorize the operation of residential treatment facilities for children and youth. The statute also provides that the Commissioner shall have the power to adopt rules and regulations governing the establishment and operation of residential treatment facilities for children and youth.

583.3 Applicability.

(a) These regulations apply to the establishment and operation of eligibility criteria of children and youth proposing access to available residential treatment facility services for children and youth.

583.4 Definitions

(a) Admission criteria are those factors of psychopathology, activities of daily living skills, age and intelligence quotient in addition, to the Office's eligibility criteria for access to residential treatment facility services, which are identified for use by a specific residential treatment facility to determine acceptance of applications for admission or transfer.

(b) Child is an individual who has passed at least their 5th birthday, and who has not yet reached their 22nd birthday.

(c) Committee on Special Education is a multidisciplinary team established in accordance with the provisions of the New York State Education law to evaluate each child with educational disabilities who resides within a school district.

(d) Designated mental illness means a disruption of cognitive, emotional, or behavioral functioning, which can be classified and diagnosed using the current edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM)*, or the *International Classification of Diseases (ICD)*, other than:

(1) Substance use disorders in the absences of other mental health conditions defined in the DSM or ICD;

(2) Neurodevelopmental disorders in the absence of other mental health conditions;

(3) Major neurocognitive disorders in the absence of other mental health conditions defined in the DSM or ICD except Attention-Deficit/Hyperactivity Disorder or Tic Disorders ; or

(4) Other conditions that may be a focus of clinical attention (commonly described with Z codes), except Parent-Child Relational Problem (V61.20/Z62.820) for children.

(e) Likelihood of serious harm is a substantial risk of physical harm to other persons as manifested by recent homicidal or other violent behavior by which others are placed in reasonable fear of serious physical harm.
(f) Eligibility Criteria means personal attributes and characteristics that an individual needs to have in order to access residential treatment facility services.
(g) Medical Necessity Criteria shall refer to criteria for access to residential treatment facility services set forth by the Office or Commissioner's designee, where minimally, outpatient, community-based, and other out of home interventions available, do not meet the treatment needs of the child, the child is experiencing a severity of psychiatric need which requires proper care and treatment of the child's psychiatric condition on an inpatient basis in a residential treatment facility under the direction of a physician, and care and treatment provided by residential treatment facility services can reasonably be expected to improve the child's condition or prevent further regression so that residential treatment facility services will no longer be needed.
(h) Office shall refer to the Office of Mental Health.
(i) Serious emotional disturbance means a child has a designated mental illness diagnosis according to the most current Diagnostic and Statistical Manual of Mental Disorders (DSM) and has experienced functional limitations due to emotional disturbance over the past 12 months on a continuous or intermittent basis. The functional limitations must be moderate in at least two of the following areas or severe in at least one of the following areas:

(1) ability to care for self (e.g., personal hygiene; obtaining and eating food; dressing; avoiding injuries); or

(2) family life (e.g., capacity to live in a family or family like environment; relationships with parents or substitute parents, siblings and other relatives; behavior in family setting); or

(3) social relationships (e.g., establishing and maintaining friendships; interpersonal interactions with peers, neighbors and other adults; social skills; compliance with social norms; play and appropriate use of leisure time); or

(4) self-direction/self-control (e.g., ability to sustain focused attention for a long enough period of time to permit completion of age-appropriate tasks; behavioral self-control; appropriate judgment and value systems; decision-making ability); or

(5) ability to learn (e.g., school achievement and attendance; receptive and expressive language; .relationships with teachers; behavior in school).

583.5 RTF Eligibility and Authorization Requirements

(a) Applications for an eligibility determination and authorization to access residential treatment facility services shall be in a form and format specified in standards and procedures established by the Office or Commissioner's designee.
(b) In order for a child to be found eligible and authorized to access residential treatment services they must meet the following criteria:

(1) be between the age of 5 years old and 20 years old;

(2) have an intelligence quotient equal to or greater than 51;

(3) meet criteria for voluntary admission as defined in section 9.13 of the Mental Hygiene Law;

(4) have a current primary diagnosis of a designated mental illness;

(5) meet criteria for serious emotional disturbance; and

(6) meet medical necessity criteria for residential treatment facility services.

(i) Medical necessity criteria determinations shall comply with the Code of Federal Regulations, title 42, section 441.153 and standards and procedures set by the Office or Commissioner's designee. Medical necessity criteria shall also meet the CFR 42 section 441.152 Certification of Need requirements where the child is an applicant or recipient of medical assistance pursuant to Social Services Law, title 11, article 5.

(ii) Medical Necessity criteria includes the following in accordance with standards and procedures established by the Office or Commissioner's designee:

(a) Outpatient, community-based, and other out of home interventions available, do not meet the treatment needs of the child as evaluated in accordance with standards and procedures developed by the Office or Commissioner's designee;

(b) The child is experiencing a severity of psychiatric need which requires proper care and treatment of the child's psychiatric condition on an inpatient basis in a residential treatment facility under the direction of a physician, as evaluated in accordance with standards and procedures developed by the Office or Commissioner's designee;

(c) Care and treatment provided by residential treatment facility services can reasonably be expected to improve the child's condition or prevent further regression so that residential treatment facility services will no longer be needed, provided that a poor prognosis shall not in itself constitute grounds for a denial of determination of eligibility if treatment in a residential treatment facility offers can be expected to effect a change in prognosis, as evaluated in accordance with standards and procedures developed by the Office or Commissioner's designee.

(c) Eligibility criteria to obtain authorization to access residential treatment facility services delivered by a residential treatment facility developed in collaboration with the Office and the Office of People with Developmental Disabilities, to serve children with a designated mental illness and an intellectual and/or development disability, shall be exempt from Parts 583.5(b)(2) and 583.5(b)(4).

(d) A child will not receive an authorization for access to residential treatment facility services unless a child meets the eligibility criteria pursuant to this section.

583.6 Responsibilities of the Office or Commissioner’s designee

(a) The Office or the Commissioner’s designee will receive all applications for authorization to access residential treatment facility services.

(i) The Office or the Commissioner’s designee will review applications for authorization to access residential treatment facility services for completeness in accordance with standards and procedures established by Office or Commissioner's designee.

(b) Prior to a residential treatment facility admission, and as frequently as the Office or its designee deems necessary, the Office or its designee shall evaluate each complete application for authorization by a child applicant or recipient of medical assistance, pursuant to Social Services Law Title 11, Article 5, to determine their eligibility for accessing residential treatment facilities. The eligibility review to determine whether or not such child meets eligibility criteria will be conducted in accordance with this Part and as specified in standards and procedures established by the Office or Commissioner's designee. If a child is found eligible, they will receive an authorization. Once a child receives an authorization, the Office will send the authorized application to the residential treatment facilities that would best be able to serve the child’s needs based upon the facility’s admission criteria. Each residential treatment facility has its own admission criteria, which may be based on the age of the child, their diagnosis and the residential treatment facilities’ area of expertise. The Office certifies residential treatment facilities to operate in accordance with Part 584 of this Title. The residential treatment facilities are not operated directly by the Office, therefore the decision to accept a child who has been authorized for services is an independent decision made by the facility.

(1) Reviews of eligibility shall include an assessment of educational needs. When an assessment of a child’s educational needs is required and is not available from a committee on special education, the Office or Commissioner’s designee shall request such assessment from the appropriate committee on special education, in accordance with Education Law Section 4003.5. For the purposes of this Part, the appropriate committee on special education shall be the committee on special education of the school district of residence at the time of the application for eligibility.

(c) After the eligibility review is completed, the Office or the Commissioner’s designee shall notify the child, child's legally authorized representative, the referral source, and Local Government Unit in writing that:

(1) eligibility criteria has been met and the child has authorization to access residential treatment facility services; or

(2) the request requires additional documentation in order to make a determination regarding eligibility for authorization to access residential treatment facility services. Such notice will include the timeframe in which the additional information must be submitted for consideration to the Office or Commissioner’s designee. If additional information is not submitted in the requested timeframe, the application will be considered incomplete and an administrative denial will be issued; or

(3) the child does not meet eligibility criteria and is not authorized to access residential treatment facility services.

(i)The Office or Commissioner’s designee will provide the child, child's legally authorized representative, the referral source, and Local Government Unit with a notice detailing the right to request a reconsideration of the child applicant’s meeting of eligibility criteria within 30 days of the notice date.

(ii) If a request for reconsideration is submitted within 30 days of the notice date, the Office or Commissioner’s designee will complete a reconsideration review in accordance with a timeframe specified in standards and procedures to be established by this Office.

(iii) After the reconsideration review is completed, the Office or the Commissioner’s designee shall notify the child, child's legally authorized representative, the referral source, and Local Government Unit in writing that:

(1) eligibility criteria has been met and the child is authorized to access residential treatment facility services; or

(2) the request requires additional documentation in order to make a determination regarding eligibility for authorization to access residential treatment facility services. Such notice will include the timeframe in which the additional information must be submitted for consideration to the Office or Commissioner’s designee. If additional information is not submitted in the requested timeframe the application will be considered incomplete and an administrative denial will be issued; or

(3) the child does not meet eligibility criteria and is not authorized to access residential treatment facility services.

(i) The Office or Commissioner’s designee shall inform the child and the child's legally authorized representative of the right to request a Medicaid fair hearing within 60 days of the notice.

(ii) Such fair hearings will be adjudicated in accordance with 18 NYCRR 358-2.30, 358-5, and any procedures used by the entity conducting the hearing.

(d) Where a child receives an authorization to access residential treatment facility services and the child has not been admitted to a residential treatment facility, or the authorization was suspended, the Office or its designee shall conduct additional reviews to reconfirm eligibility in accordance with standards and procedures established by this Office.

(i) To conduct a reconfirmation of eligibility review the Office or its designee shall request a written update of the child's status in a form, substance and timeframe to be established by the Office or Commissioner’s designee. If a written update is not provided as required by the Office or designee the application will be considered incomplete and an administrative denial will be issued.

(ii) The Office or its designee shall base its reconfirmation of eligibility on a review of the documentation provided.

(iii) Notification of eligibility will be completed in accordance with 583.6(c) of this section

(e) Where the Office or Commissioner's designee has authorized a child for access to residential treatment facility services and the child is expected to be temporarily unavailable for admission the child's eligibility shall be considered to be suspended in accordance with standards and procedures to be established by this Office.

(i) To end the suspension of an authorization a review to reconfirm eligibility will be conducted in accordance with this section 583.6 (d).

PART 584

OPERATION OF RESIDENTIAL TREATMENT FACILITIES

FOR CHILDREN AND YOUTH

Part 584 is amended as follows:

Sec.

584.1 Background and intent
584.2 Legal base
584.3 Applicability
584.4 Definitions pertaining to this Part
584.5 Certification
584.6 Organization and administration
584.7 Admission, continued stay and discharge criteria
584.8 Admission, transfer, continued stay and discharge policies and procedures
584.9 Written plan for services and staff composition
584.10 Staffing
584.11 Service requirements
584.12 Treatment program and environment
584.13 Special treatment procedures
584.14 Treatment team
584.15 Individual treatment plan
584.16 Case record
584.17 Quality assurance
584.18 Utilization review
584.19 Premises
584.20 Statistical records and reports
584.21 Waiver provisions

Section 584.1 Background and intent.

(a) Chapter 947 of the Laws of 1981 authorized the establishment of residential treatment facilities for children and youth.

(b) The purpose of residential treatment facilities for children and youth is to provide comprehensive mental health services under the supervision of a physician for children and youth who have attained

[~~his/her~~] their 5th birthday and have not, in most cases, attained [~~his/her~~] their 21st birthday and who are in need of [~~long-term~~] inpatient treatment in a residential setting.

(c) Residential treatment facilities for children and youth are not intended for children and youth who:

(1) present a likelihood of serious harm to others as defined in section 9.01 of the Mental Hygiene Law.; or

(2) have a primary diagnosis of intellectual disability [~~mental retardation~~] or developmental disability unless the residential treatment facility unit(s) was developed in collaboration by the Office of Mental Health and the Office of People with Developmental Disabilities to serve children with a designated mental illness and an intellectual and/or development disability.

(d) The purpose of these regulations is to describe requirements for the establishment and operation of residential treatment facilities for children and youth; outline the requirements for admissions, transfers and discharge; and specify the requirements for staffing, services, treatment planning, quality assurance and recordkeeping.

(e) These regulations provide for the active involvement, to the extent possible, of the family or guardian of a child in all aspects of the care and treatment of that child.

584.2 Legal base.

(a) 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 his/her jurisdiction and to set standards of quality and adequacy of facilities, equipment, personnel, services, records and programs for the rendition of services for persons with mental illness, pursuant to an operating certificate.

(b) Section 31.26 of the Mental Hygiene Law provides for the establishment of the subclass of hospitals known as residential treatment facilities for children and youth which provide active treatment under the direction of a physician for individuals who are under 21 years of age.

(c) Section 31.02 of the Mental Hygiene Law prohibits any individual, association, corporation or public or private agency from operating a residential facility, hospital or institution for the examination, diagnosis, care, treatment, rehabilitation or training of persons with mental illness unless an operating certificate has been obtained from the commissioner of the Office of Mental Health.

(d) Sections 31.05, 31.07, 31.09, 31.11 and 31.19 of the Mental Hygiene Law authorize the commissioner or [~~his or her~~] their representative to examine and inspect such facilities to determine their suitability and operation. Sections 31.16 and 31.17 authorize the commissioner to suspend, revoke or limit any operating certificate.

584.3 Applicability.

(a) These regulations apply to any provider of services which operates or proposes to operate a residential treatment facility for children and youth. Such facilities are a subclass of hospitals pursuant to section 1.03 of the Mental Hygiene Law.

(b) These regulations do not apply to hospitals operated by the Office of Mental Health, or to hospitals issued an operating certificate by the Office of Mental Health pursuant to Part 582 of this Title.

584.4 Definitions pertaining to this Part.

(1) Admission criteria are those factors of psychopathology, activities of daily living skills, age, gender, and intelligence quotient in addition to the Office's eligibility criteria for access to residential treatment facility services, which are identified for use [in determining a child's eligibility] by a specific residential treatment facility to determine acceptance of applications [eligibility] for admission or transfer [to a residential treatment facility].

(2) Alternate care determination is a decision made in accordance to standards and procedures established by the Office of Mental Health or the commissioner's designee, that a child who has been receiving residential treatment facility services no longer meets medical necessity for continued access to residential treatment facility services. [utilization review committee decision that another specifically identified method of care or no care is more appropriate than the method being provided. This decision is the result of a utilization review committee evaluation of a resident, in person or through review of the resident's case record, against criteria for continued stay in the residential treatment facility program.]

(3) Case records are those reports which contain information on all matters relating to the admission, legal status, assessment, treatment planning, treatment and discharge of the resident, and shall include all pertinent documents relating to the resident.

(4) Child is an individual who has passed at least [his/her] their 5th birthday, and who has not yet reached [his/her] their 22nd birthday.

(5) Clinical staff are all staff members who provide services directly to residents and their families or legal guardian. Clinical staff shall include professional staff, paraprofessional staff and other nonprofessional staff.

(6) Continued stay criteria are those factors of psychopathology, activities of daily living skills and age which are identified for use in determining the eligibility and medical necessity [and appropriateness] of a [the] resident's continued access [placement] to residential treatment facility services. These factors shall provide the basis for determining that the resident continues to meet the admission criteria of the residential treatment facility. Such evidence shall be directly observed and documented by staff of the residential treatment facility or be documented in reports of hospital or therapeutic leaves [trial visits to the home or to less restrictive settings.]

(7) Designated mental illness means a disruption of cognitive, emotional, or behavioral functioning, which can be classified and diagnosed using the current edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM)*, or the *International Classification of Diseases (ICD),* other than:

(1) Substance use disorders in the absences of other mental health conditions defined in the DSM or ICD;

(2) Neurodevelopmental disorders in the absence of other mental health conditions;

(3) Major neurocognitive disorders in the absence of other mental health conditions defined in the DSM or ICD except Attention-Deficit/Hyperactivity Disorder or Tic Disorders ; or

(4) Other conditions that may be a focus of clinical attention (commonly described with Z codes), except Parent-Child Relational Problem (V61.20/Z62.820) for children.

([7]8) Education records means those reports which contain information on all matters relating to the education of the resident, and shall include all pertinent documents. For children determined to have an educational [handicapping condition] disability classification by a committee on special education [the handicapped], the education record shall contain the individualized education program. Education records shall be separate and distinct from the case record.

(9) Eligibility Criteria means personal attributes and characteristics that an individual needs to have in order to access residential treatment facility services.

(10) Medical Necessity Criteria shall refer to criteria for access to residential treatment facility services set forth by the Office or commissioner's designee, where minimally, outpatient, community-based, and other out of home interventions available, do not meet the treatment needs of the child, the child is experiencing a severity of psychiatric need which requires proper care and treatment of the child's psychiatric condition on an inpatient basis in a residential treatment facility under the direction of a physician, and care and treatment provided by residential treatment facility services can reasonably be expected to improve the child's condition or prevent further regression so that residential treatment facility services will no longer be needed.

[(8) Mental illness means an affliction with a mental disease or mental condition which is manifested by a disorder or disturbance in behavior, feeling, thinking or judgment to such an extent that the person afflicted requires care, treatment and rehabilitation.]

[(9) Preadmission certification committee is a committee, established and operated pursuant to the provisions of Part 583 of this Title, whose purpose is to determine the eligibility of children for placement in a residential treatment facility and to certify children as priority for admission to a residential treatment facility.]

(1[0]1) Provider of services means the organization which is legally responsible for the operation of a program. The organization may be an individual, partnership, association, corporation, public agency, or a psychiatric center or institute operated by the Office of Mental Health.

(1[1]2) Residential treatment facility is an inpatient psychiatric facility which is family centered and provides active the direction of a physician for children who are under 21 years of age and is issued an operating certificate pursuant to this Part.

(1[2]3) Restraint means "restraint" as such term is defined in section 526.4(a) of this Title.

(1[3]4) Seclusion means "seclusion" as such term is defined in section 526.4(a) of this Title.

(1[6]5) Serious emotional disturbance means a child has a designated mental illness diagnosis according to the most current Diagnostic and Statistical Manual of Mental Disorders (DSM) and has experienced functional limitations due to emotional disturbance over the past 12 months on a continuous or intermittent basis. The functional limitations must be moderate in at least two of the following areas or severe in at least one of the following areas:

(1) ability to care for self (e.g., personal hygiene; obtaining and eating food; dressing; avoiding injuries); or

(2) family life (e.g., capacity to live in a family or family like environment; relationships with parents or substitute parents, siblings and other relatives; behavior in family setting); or

(3) social relationships (e.g., establishing and maintaining friendships; interpersonal interactions with peers, neighbors and other adults; social skills; compliance with social norms; play and appropriate use of leisure time); or

(4) self-direction/self-control (e.g., ability to sustain focused attention for a long enough period of time to permit completion of age-appropriate tasks; behavioral self-control; appropriate judgment and value systems; decision-making ability); or

(5) ability to learn (e.g., school achievement and attendance; receptive and expressive language; relationships with teachers; behavior in school).

(1[4]6) Time-out means "time out" as such term is defined in section 526.4(a) of this Title.

(b) Services.

(1) Case coordination services are activities to assure the full integration of all services provided to each resident. Case coordination activities include, but are not limited to, monitoring the resident's daily functioning to assure the continuity of service in accordance with the resident's treatment plan and e[i]nsuring that all clinical staff responsible for the care and delivery of services actively participate in the development and implementation of the resident's treatment plan.

(2) Dietetic services are services designed to meet the nutritional needs of all residents. Dietetic services include, but are not limited to: [assuring]ensuring that each resident on a special diet receives the prescribed diet; [insuring]ensuring food storage and preparation in a safe and sanitary manner; directing the nutritional aspects of resident care; and providing planned menus that reflect the food acceptance of the residents.

(3) Educational and vocational services are those activities the purpose of which is to assist the resident in the acquisition or development of academic and occupational skills.

(4) Medication therapy is the reviewing of the appropriateness of the resident's existing medication regimen through review of the resident's medication record and consultation with the resident and, as appropriate,

[~~his/her~~] their family or guardian; prescribing and/or administering medication; and monitoring the effects and side effects of the medication on the resident's mental and physical health.

(5) Physical health services is a comprehensive program of preventive, routine and emergency medical and dental care, and an age-appropriate program of health education.

(6) Task and skill training is a nonvocational activity whose purpose is to enhance a resident's age-appropriate skills necessary to facilitate the resident's ability to care for [himself/herself] themself and to function effectively in community settings. Task and skill training activities include, but are not limited to: homemaking; personal hygiene; budgeting; shopping; and the use of community resources.

(7) Therapeutic recreation services are planned therapeutic activities whose purposes are: the acquisition or development of social and interpersonal skills; the improvement of the psychomotor and cardiovascular abilities of the residents; the enhancement of the self concept of the residents; the development of healthy, lifelong activities toward participation in recreation and physical activity; and the improvement or maintenance of a resident's capacity for social and/or recreational involvement by providing opportunities for the application of social and/or recreational skills.

(8) Verbal therapies are planned activities whose purpose is to provide formal, individual, family, and group therapies. These therapies include, but are not limited to, psychotherapy and other face-to-face verbal contacts between staff and the resident which are planned to enhance the resident's psychological and social functioning as well as to facilitate the resident's integration into a family unit. Verbal contacts that are incidental to other activities are excluded from this service. Verbal therapy shall include play therapy and other forms of expressive therapy.

(c) Staff qualifications.

(1) Dentist is an individual who is currently licensed as a dentist by the New York State Education Department.

(2) Dietitian is an individual who is either currently registered or eligible for registration by the Commission on Dietetic Registration; or has the documented equivalent in education, training and experience, with evidence of relevant continuing education.

(3) Limited permit physician is an individual who has received from the New York State Education Department a current permit to practice medicine which is limited as to eligibility, practice and duration.

(4) Nurse is an individual who is currently licensed as a registered professional nurse by the New York State Education Department.

(5) Occupational therapist is an individual who is currently licensed as an occupational therapist by the New York State Education Department.

(6) Physician is an individual who is currently licensed to practice medicine by the New York State Education Department.

(7) Psychiatrist is an individual who is currently licensed as a physician by the New York State Education Department and who is certified by, or eligible to be certified by, the American Board of Psychiatry and Neurology as a psychiatrist or a child psychiatrist.

(8) Psychologist is an individual who is currently licensed as a psychologist by the New York State Education Department.

(9) Rehabilitation counselor is an individual who either has a master's degree in rehabilitation counseling from a program approved by the New York State Education Department, or is currently certified by the Commission on Rehabilitation Counselor Certification.

(10) Social worker is an individual who is either currently licensed as a licensed master social worker or as a licensed clinical social worker by the New York State Education Department, or has a master's degree in social work from a program approved by the New York State Education Department.

(11) Speech pathologist is an individual who either has a master's degree in speech pathology or speech and/or language therapy, <u>and</u> [or] who is currently licensed as a speech pathologist by the New York State Education Department.

(12) Therapeutic recreation specialist is an individual who either has a master's degree in therapeutic recreation or in recreation with emphasis in therapeutic recreation from a program approved by the New York State Education Department, or is currently registered as a therapeutic recreation specialist by the National Therapeutic Recreation Society.

(13) Teacher is an individual who is currently licensed as a teacher by the New York State Education Department.

584.5 Certification.

(a) Each provider of services that intends to operate a residential treatment facility must be issued an operating certificate by the Office of Mental Health prior to the operation of the facility.

(b) Residential treatment facilities may only be operated by not-for-profit corporations.

(c) An operating certificate may be issued to a residential treatment facility which complies with the requirements of these regulations.

(d) The term of the operating certificate shall be determined by the Office of Mental Health, but in no event shall the term exceed three years.

(e) An operating certificate shall be issued for a residential treatment facility for a resident capacity of no fewer than 14 and no more than 56 residents; provided, however, that for the period commencing April 1, 2000 through September 30, 2016, bed capacity for facilities primarily serving New York City residents may be temporarily increased up to an additional ten beds over the maximum certified capacity with the prior approval

of the Commissioner. In order to receive such approval, the residential treatment facility must demonstrate that the additional capacity will be used to serve those children and youth deemed most in need of RTF services by the New York City Preadmission Certification Committee as set forth in section 583.8 of this Title.

(f) A residential treatment facility must provide the full range of services required by section 584.11 of this Part at a single location.

(g) An operating certificate may be limited, suspended, invalidated or revoked by the Office of Mental Health in accordance with the provisions of Part 573 of this Title. Certificates shall remain the property of the Office of Mental Health and invalidated or revoked certificates shall be returned to the Office of Mental Health.

(h) Each operating certificate will specify:

(1) the location of the residential treatment facility;

(2) the term of the operating certificate;

(3) any changes to be made in the operation of the residential treatment facility in order to retain the operating certificate; and

(4) the resident capacity of the residential treatment facility.

(i) In order to receive and retain an operating certificate, a provider of services shall:

(1) submit an application on such forms and such supporting documents as shall be required by the Office of Mental Health;

(2) frame and display the operating certificate within the residential treatment facility in a conspicuous place which is readily accessible to the public;

(3) cooperate with the Office of Mental Health during any review or inspection of the facility or program;

(4) make available to the Office of Mental Health or its designee upon request all documentation, files, reports, case records, or other materials required by this Part or requested by the Office of Mental Health in the course of visitation and inspection;

(5) undertake changes in the operation of the facility or program as required by the operating certificate;

(6) obtain prior approval of the Office of Mental Health in accordance with the procedures specified in Part 551 of this Title, to:

(i) change the physical location of the residential treatment facility or utilize additional physical locations;

(ii) initiate major changes in the program;

(iii) terminate the program or services in the program; or

(iv) change the powers or purposes set forth in the certificate of incorporation;

(7) comply with site selection requirements of section 41.34 of the Mental Hygiene Law if the residential treatment facility will have a resident capacity of 14 or fewer; and:

(i) is not located on the grounds of a residential facility licensed by the Department of Social Services or another State agency; or

(ii) is not a residential facility licensed by the Department of Social Services or another State agency at the time an application is submitted to the Office of Mental Health.

584.6 Organization and administration.

(a) The provider of services shall identify the individuals who have overall responsibility for the operation of the residential treatment facility. These individuals shall be known as the governing body. No individual shall serve as both a member of the governing body and of the paid staff of the residential treatment facility without the prior approval of the Office of Mental Health.

(b) The provider of services shall assure that the residential treatment facility has space, programs, staff and policies and procedures that are separately identifiable from any other programs which may be operated by the provider of services.

(c) The governing body shall meet on a regular basis, in no event less often than quarterly, and shall maintain written minutes of all meetings as a permanent record of the decisions made in relation to the operation of the residential treatment facility. The minutes shall be reviewed and approved by the governing body.

(d) The governing body shall approve a written plan or plans that, at a minimum, address the following aspects of the operation of the residential treatment facility:

(1) the goals and objectives of the residential treatment facility, including the admission and discharge criteria and a statement of the involvement of the family;

(2) the plan of organization that clearly indicates lines of responsibility;

(3) a written plan for services and staff composition which:

(i) includes the qualifications and duties of each staff position by title, and addresses all essential aspects of the operation of the residential treatment facility including clinical, administration, fiscal, clerical, housekeeping, maintenance, dietetic, and recordkeeping and reporting functions; and

(ii) specifies all services available through the residential treatment facility including the treatment program and environment;

(4) the written quality assurance plan; and

(5) the written utilization review plan.

(e) The governing body shall approve written policies and procedures of the residential treatment facility, including but not limited to:

(1) Admission, transfer, <u>continued stay</u> and discharge policies and procedures.

(2) The governing body shall develop, and revise as necessary, written policies for the quantity, quality, scope, goals, objectives and evaluation of all programs, policies for the accomplishment of stated purposes, and personnel policies. Personnel policies shall prohibit discrimination on the basis of race, color, creed, disability, sex, marital status, age or national origin. Personnel policies and procedures shall provide for

verification of employment history, personal references, work record and qualifications, as well as requesting the Justice Center for the Protection of Persons with Special Needs to perform criminal history record checks in accordance with Part 550 of this Title.

(3) Staff training and development policies and procedures. Such policies and procedures shall address preemployment orientation, ongoing staff development and training which shall include child abuse prevention and identification, safety and security procedures, the principles of child development, use of physical intervention, techniques of group and child management, the laws and regulations governing the protection of children from child abuse and maltreatment.

(4) The governing body shall establish written volunteer policies and procedures. Such policies and procedures shall provide for screening of volunteers and verification of employment history, personal references and work history; supervision of volunteers; training in accordance with paragraph (3) of this subdivision. Such policies shall also provide for requesting the Justice Center for the Protection of Persons with Special Needs to perform criminal history record checks in accordance with Part 550 of this Title.

(5) Prescription and administration of medication policies and procedures. Such policies and procedures shall be consistent with applicable Federal and State laws and regulations.

(6) Case record policies and procedures. Such policies and procedures shall ensure confidentiality of patient records in accordance with the Mental Hygiene Law and shall ensure appropriate retention of case records.

(f) The governing body shall review the written plan or plans and policies and procedures required pursuant to subdivisions (d) and (e) of this section at least annually and shall make appropriate amendments or revisions.

(g) The governing body may delegate responsibility for the day-to-day management of the residential treatment facility in accordance with the written plan of organization provided for in paragraph (d)(2) of this section.

(1) Ongoing direction may be delegated to an individual who shall be known as the director and who shall meet the qualifications specified in section 584.10(d) of this Part.

(2) The director shall be employed by the residential treatment facility at least one half of the hours of a full-time employee.

(3) Administrative direction may be the responsibility of the director or may be delegated by the governing body to an individual who shall meet qualifications that are acceptable to the Office of Mental Health.

(h) The residential treatment facility shall participate with the local governmental unit in local planning processes. At a minimum, participation shall include:

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

(2) identification of the population being served by the residential treatment facility;

(3) identification of the geographic area being served;

(4) description of the relationship to other providers of services which serve the same geographic area, including but not limited to written agreements to ensure expeditious access to programs by persons who need them. At a minimum, these agreements shall provide for prompt referral, evaluation and, as necessary, admission to cooperating programs, and for sharing information about residents being served; and

(5) attendance at planning meetings as may reasonably be required by the local governmental unit.

(i) The residential treatment facility shall provide for the following:

(1) an annual written evaluation of the residential treatment facility's attainment of its stated goals and objectives which indicates any required changes in policies and procedures;

(2) an annual audit of the financial condition and accounts of the residential treatment facility performed by a certified public accountant who is not a member of the governing body or an employee of the residential treatment facility;

(3) emergency evacuation plans for the building in which the residential treatment facility is located. Evacuation plans shall address emergencies resulting from fire as well as potential hazards in the geographic area in which the residential treatment facility is located; and

(4) up-to-date copies of any regulations, guidelines, manuals, or other information required by the Office of Mental Health.

584.7 Admission, Continued Stay and discharge criteria.

(a) Each residential treatment facility shall maintain written admission, continued stay and discharge criteria [~~which are consistent with its goals and objectives and~~] which are subject to the approval of the Office of Mental Health.

(b) The admission criteria must, at a minimum, provide that Office of Mental Health or commissioner's designee has determined that an individual child is eligible and authorized to access residential treatment facility services pursuant to Part 583 of this Title.

[~~(1) identification of a serious and persistent psychopathology as evidenced by:~~

~~(i) severe thought disorder;~~

~~(ii) severe affective disorder;~~

~~(iii) moderate thought disorder in conjunction with an impulse control disorder or a deficit in activities of daily living skills;~~

~~(iv) moderate affective disorder in conjunction with an impulse control disorder or a deficit in activities of daily living skills;~~

~~(v) severe conduct disorder in conjunction with an impulse control disorder or a deficit in activities of daily living skills;~~

(vi) severe personality disorder in conjunction with an impulse control disorder or a deficit in activities of daily living skills; or

(vii) any combination of the above;

(2) intelligence quotient equal to or greater than 51;

(3) attainment of at least the 5th birthday but not the 21st birthday; and

(4) presentation of no likelihood of serious harm to others as defined in section 584.4(a)(8) of this Part.]

(c) Any additional admission criteria must relate to factors of psychopathology, activities of daily living skills, age, gender, and intelligence quotient. [observable characteristics of the child. Such criteria may include age and gender.] Admission criteria must comply with any standards and procedures established by the Office, and not discriminate based on race, color, creed, physical disability, or national origin.

(d) The continued stay criteria must, at a minimum, provide that the child meets eligibility criteria established in Part 583 of the Title, and does not meet the residential treatment facility's discharge criteria.

(e) The discharge criteria must at a minimum provide that the child has been evaluated and determined to no longer meet eligibility criteria pursuant to Part 583 of the Title. [relate to the necessity and appropriateness of the individual child's continued stay in a residential treatment facility.] Age in and of itself is not an appropriate basis for discharge from a residential treatment facility, except that no resident may remain in a residential treatment facility after attaining the age of 22.

584.8 Admission, transfer, continued stay, and discharge policies and procedures

(a) A residential treatment facility may only admit a child[ren] that has an authorization for access to residential treatment facility services, which was obtained

[have been certified to the residential treatment facility by a preadmission certification committee established]

pursuant to Part 583 of this Title [Chapter.] This requirement applies to admissions and transfers.

(b) A residential treatment facility may only make admission determinations [admit children who meet] based on the written admission criteria maintained pursuant to section 584.7 of this part. If the residential treatment facility requests to waive this standard for a particular child, it may apply to the Office of Mental Health or commissioner's designee for consideration of an extension or exemption of the standard with cause. If the residential treatment facility does not meet the standard, nor was it waived, the Office of Mental Health or commissioner's designee, may halt admissions at its discretion.

[and for whom the residential treatment facility finds:

(1) proper treatment of the child's psychiatric condition requires care and treatment under the direction of a physician within a residential treatment facility; and

(2) care and treatment in a residential treatment facility can reasonably be expected to improve the child's condition or prevent further regression so that services will no longer be needed, provided that a poor prognosis shall not in itself constitute grounds for a denial of determination of eligibility if treatment can be expected to effect a change in prognosis.]

(c) In accordance with Mental Hygiene Law § 9.51, a residential treatment facility shall admit any child with an authorization for access to residential treatment facility services who has also been designated as priority for admission by the Office of Mental Health or commissioner's designee, who applies for admission to the residential treatment facility.

(d) Any child who has also been designated as priority for admission by the Office of Mental Health or commissioner's designee, who applies for admission at a residential treatment facility shall admit to the next available bed. If the residential treatment facility requests to waive this standard for a particular child, it may apply to the Office of Mental Health or commissioner’s designee for consideration of an extension or exemption of the standard with cause. If the residential treatment facility does not meet the standard, nor was it waived, the Office of Mental Health or commissioner’s designee may halt admissions at its discretion.

[(c)] (e) Upon application for admission or transfer of a child, a residential treatment facility shall provide written notice [to the Office of Mental Health preadmission certification committee and families or legal guardian] as follows:

[(1) Upon referral of child as a priority for admission or transfer, notice shall be provided within 30 calendar days. The notice shall indicate the anticipated date of admission or transfer or, if the child is determined to be not appropriate for admission, the specific reason for such determination.]

(1) All notices shall be made to the referral source, parent/legal guardian, Office of Mental Health or commissioner's designee, and the local governmental unit of the child’s county of residence.

(2) The residential treatment facility shall give notice of receipt of an application for admission or transfer.

(3) The residential treatment facility shall evaluate and communicate the determination of the application for admission or transfer within a timeframe determined by the Office of Mental Health or commissioner's designee. If the residential treatment facility requests to waive this standard for a particular child, it may apply to the Office of Mental Health or commissioner’s designee for consideration of a seven day extension.

(i) The residential treatment facility shall give notice when a child is determined to meet criteria for admission or transfer. This notice shall include the anticipated date of admission or transfer and any other information specified by Office of Mental Health or commissioner's designee.

(ii) The residential treatment facility shall give notice when a child is determined to not meet admission criteria. This notice shall include the specific reason for such determination based on residential treatment facility’s admission criteria maintained pursuant to section 584.7 of this Part.

[(2)](6) When a resident is ready for discharge or transfer, notice shall be provided [if possible] 30 calendar days in advance of the anticipated date of discharge or transfer.

[(3)] (7) When a resident attains the age of 21, notice shall be provided within 30 calendar days with the discharge plan that will achieve the child's discharge from residential treatment facility services prior to the 22nd birthday.

[(d)] (f) Admissions, transfers and discharges shall be in accordance with the applicable requirements of articles 9 and 29 of the Mental Hygiene Law and Parts 15, 17 and 36 of this Title.

[(e)] (g) Written admission, transfer, continued stay and discharge policies and procedures shall be maintained as required in section 584.7 of this Part and shall be subject to approval by the Office of Mental Health. Such policies and procedures shall:

(1) specify that admission, transfer, continued stay and discharge shall be based on the written criteria established pursuant to section 584.7 of this Part;

(2) delineate special requirements for admission, transfer, continued stay and discharge of children in the custody of a social services official, the Office of Children and Families Services [Director of the Division for Youth], or another person granted custody by the Family Court;

(3) prohibit discrimination solely on the basis of race, color, creed, handicap, national origin, sex or age outside any additional admission criteria which relate to factors of psychopathology, activities of daily living skills, age, gender, and intelligence quotient;

(4) provide for notification of the mental health information service of each admission in accordance with the requirements of Part 15 of this Title;

(5) require that the eligibility[necessity and appropriateness] of each resident's continued stay in the residential treatment facility be regularly evaluated in accordance to standards and procedures established by the Office of Mental Health or commissioner's designee;

(6) be available to the staff, residents and their families, cooperating agencies and the general public; and

(7) require that discharge planning for each resident begin upon application for admission or transfer. Discharge planning shall be in accordance with section 29.15 of the Mental Hygiene Law and standards and procedures established by the Office of Mental Health or commissioner's designee; and shall include, at a minimum, identification of the discharge goals and the criteria for determining [the necessity and appropriateness of] the specific resident's discharge readiness [continued stay].

584.9 Written plan for services and staff composition.

(a) Each residential treatment facility shall develop and specify in a written plan for services and staff composition its goals and objectives and the manner in which it intends to achieve them. The written plan for services and staff composition shall be subject to approval by the Office of Mental Health.

(b) The written plan for services and staff composition shall address:

(1) the comprehensive treatment needs of the residents;

(2) the physical health needs of the residents;

(3) the vocational and educational needs of the residents; and

(4) the residential needs, including dietary, on a 24-hour basis.

(c) The written plan for services and staff composition shall encompass the following written plans and rationales required under this Part:

(1) services required to be available through the residential treatment facility;

(2) treatment program and environment addressing the day-to-day activities of the residents; and

(3) staffing required to provide services and day-to-day management and monitoring of the treatment program and environment.

(d) The written plan for services and staff composition shall address the manner in which the treatment team will integrate the services available through the residential treatment facility and the treatment program and environment into an individual treatment plan designed to meet the needs of each individual resident, and will involve the family or legal guardian.

584.10 Staffing.

(a) A residential treatment facility shall continuously employ an adequate number of staff and an appropriate mix of staff to carry out its goals and objectives as well as to ensure the continuous provision of sufficient regular and emergency supervision of all residents 24 hours a day. As a component of the written plan for services and staff composition, the residential treatment facility shall submit a staffing plan which includes the qualifications and duties of each staff position, by title. The residential treatment facility shall submit a written staffing rationale which justifies the staff to be utilized, the mix of staff and the plan for appropriate supervision of staff. The staffing plan shall include procedures for periodic supervisory conferences with staff and procedures for written performance evaluation consistent with any collective bargaining requirements. This staffing plan shall be based on the population to be served and the services to be provided. The staffing plan and its rationale shall be submitted for approval by the Office of Mental Health.

(b) All clinical staff shall have at least a high school diploma or its equivalent.

(c) At least 50 percent of the clinical staff hours shall be provided by full-time employees.

(d) For purposes of this Part, professional staff are individuals who are qualified by training and experience to provide direct treatment services under minimal supervision.

(1) Professional staff shall include the following as defined in section 584.4(c) of this Part:

(i) nurse;

(ii) occupational therapist;

(iii) physician;

(iv) psychiatrist;

(v) psychologist;

(vi) rehabilitation counselor;

(vii) social worker;

(viii) teacher;

(ix) therapeutic recreation specialist; and

(x) speech pathologist.

(2) Other professional disciplines may be included as professional staff, provided that the discipline is acceptable to the Office of Mental Health and is approved as part of the staffing plan by the Office of Mental Health. The discipline shall be from a field related to the treatment of mental illness. The individual shall be licensed in such discipline by the New York State Education Department, or have a master's degree in such discipline from a program approved by the New York State Education Department, and shall have specialized training or experience in treating persons with mental illness.

(e) In order to assure that the residential treatment facility employ an adequate number and mix of professional staff who meet the qualifications provided in section 584.4(c) of this Part, the staffing plan shall meet each of the following requirements. A single staff member may be counted against more than one requirement.

(1) At least two persons representing different professional staff categories as delineated in subdivision (f) of this section shall be employed on a full-time basis.

(2) Persons representing each of the following professional staff categories shall be employed at least one fifth of the hours of a full-time employee: nurse, psychiatrist, psychologist, social worker, and recreation therapist.

(3) One full-time equivalent professional staff member shall be employed for each seven residents.

(f) In order to assure that an adequate number of professional staff are qualified by training and experience to provide clinical supervision of other staff and to provide programmatic direction, at least 25 percent of the professional staff required to comply with paragraph (e)(3) of this section in each residential treatment facility shall meet the following qualifications:

(1) a nurse who has a bachelor's degree and at least three years post-licensure experience in treating mentally ill children;

(2) a physician who has at least one year of post-medical degree experience in treating mentally ill children;

(3) a psychiatrist who has at least one year of post-medical degree experience in treating mentally ill children;

(4) a psychologist who has specialized training in school psychology, clinical psychology or counseling psychology and at least two years of post-[~~licensure~~]-graduate experience in treating mentally ill children;

(5) a rehabilitation counselor who has a master's degree in rehabilitation counseling from a program approved by the New York State Education Department, current certification by the Commission on Rehabilitation Counselor Certification and two [~~three~~] years of post-[~~certification~~] graduate experience in treating mentally ill children;

(6) a social worker who has specialized training in clinical practice and two years post-graduate experience in treating mentally ill children; and/or

(7) a therapeutic recreation specialist who has a master's degree in therapeutic recreation from a program approved by the New York State Education Department, current registration as a therapeutic recreation specialist by the National Therapeutic Recreation Society and two [~~three~~] years of post-[~~registration~~] graduate experience in treating mentally ill children.

(g) In order to assure that the residents are adequately supervised and are cared for in a safe and therapeutic manner, the staffing plan shall meet each of the following requirements:

(1) At least two clinical staff members shall be assigned to direct care responsibilities for each living unit during all hours the residents are awake and not in school.

(2) At least one clinical staff member shall be assigned to direct care responsibilities for each living unit for each five residents during all hours the residents are awake and not in school.

(3) At least one clinical staff member shall be assigned direct care responsibility, be awake, and be continuously available to the children on each living unit during all hours the residents are asleep. A minimum of one additional clinical staff member for each 14 children shall be immediately available onsite to assist with emergencies or problems which might arise.

(4) Appropriate professional staff shall be available to assist in emergencies on at least an on-call basis at all times.

(5) A physician shall be available on at least an on-call basis at all times.

(h) In order to assure the appropriate supervision of the nutritional aspects of dietetic services, a qualified dietitian shall be available on at least a consultation basis.

(1) The amount of time a qualified dietitian is available shall be sufficient to permit the dietitian to direct nutritional aspects of patient care, assure that dietetic instructions are carried out and assist in the evaluation of the dietetic service.

(2) When a qualified dietitian is only available on a consultation basis, regular written reports shall be submitted to the director regarding the implementation and evaluation of dietetic services.

(i) All staff shall have qualifications appropriate to assigned responsibilities as set forth in the staffing plan and shall practice within the scope of their professional discipline.

(1) All staff shall submit documentation of their training and experience to the provider of services. Such documentation shall be retained on file by the residential treatment facility.

(2) [~~Clinical~~] psychological testing and evaluation procedures may only be provided by or under the supervision of a licensed psychologist.

(j) Students or trainees may qualify as clinical staff under the following conditions:

(1) The students and trainees are actively participating in a program leading to attainment of a recognized degree or certificate in a field related to mental health at an institution chartered or approved by the New York State Education Department. Limited permit physicians are considered students or trainees.

(2) The students or trainees are supervised and trained by professional staff meeting the qualifications specified in subdivision (f) of this section and limited permit physicians are trained by physicians.

(3) The students or trainees receive at least one hour of supervision for every five hours of treatment services provided. Limited permit physicians must work under the direct supervision of physicians.

(4) The students or trainees use titles that clearly indicate their status.

(5) Written policies and procedures pertaining to the integration of students and trainees within the overall operation of the residential treatment facility receive prior approval by the Office of Mental Health.

584.11 Service requirements.

(a) The services available through residential treatment facility must address the treatment needs of the resident and must include mental health services, educational and vocational services, physical health services and dietetic services.

(b) As a component of the written plan for services and staff composition, the residential treatment facility shall provide a written plan and rationale for the services available which shall be subject to approval by the Office of Mental Health. The written plan shall indicate what services will be available and whether the residential treatment facility will provide the services directly or through a written agreement with the provider of services. The written plan shall indicate what services will be available for involvement by the families or legal guardians of the residents.

(c) The mental health services available through the residential treatment facility shall include, but are not limited to, the services listed below. These mental health services must be provided directly by the residential treatment facility:

(1) case coordination services;

(2) verbal therapies;

(3) medication therapy;

(4) therapeutic recreation services;

(5) task and skill training.

(d) The physical health services available through the residential treatment facility shall include, but are not limited to, the services listed below. Physical health services may be provided directly by the residential treatment facility or may be provided by written agreement as provided for in subdivision (e) of this section.

(1) a physical examination upon admission, periodic assessment of physical condition, and treatment as needed;

(2) a dental examination within six months of admission, periodic assessment, and treatment as needed;

(3) an assessment of immunization upon admission, and an ongoing immunization program;

(4) health education and sex education; and

(5) emergency care on a 24-hour basis.

(e) When physical health services are not provided directly by the residential treatment facility, there shall be a written agreement between the provider of services and the residential treatment facility. When physical health services are provided by the same provider of services, written policies and procedures will be an acceptable alternative to a written agreement. The written agreement or written policies and procedures shall, at a minimum, address:

(1) referral of residents;

(2) qualifications of staff providing services;

(3) exchange of clinical information; and

(4) financial arrangements.

(f) Educational and vocational services available through the residential treatment facility shall include, but are not limited to, the minimum requirements of the State Education Law regarding regular education, vocational education and special education, as appropriate to meet the needs of the residents. Education services may be provided directly by the residential treatment facility or may be provided by written agreement as provided for in subdivision (g) of this section. In any case, education services approved by the Education Department must be available either on the same site or in close physical proximity to the residential treatment facility.

(g) When the education services are not provided directly by the residential treatment facility, there shall be a written agreement between the provider of services and the residential treatment facility. The provider of education services shall be a State Education Department-approved program. When education services are provided by the same provider of services, written policies and procedures will be an acceptable alternative to a written agreement. The written agreement or written policies and procedures shall, at a minimum, address:

(1) qualifications of staff providing services;

(2) participation of educational and vocational staff in the treatment planning process;

(3) access by staff of the residential treatment facility to educational and vocational programs and records; and

(4) financial arrangements.

(h) The dietetic services available through the residential treatment facility shall include, but are not limited to, the services listed below. Dietetic services may be provided directly by the residential treatment facility or may be provided by written agreement as provided for in subdivision (i) of this section.

(1) safe and sanitary storage and serving of foods;

(2) planned menus that provide for a nutritionally adequate diet for all residents; and

(3) provisions to meet special dietary needs.

(i) When dietetic services are not provided directly by the residential treatment facility, there shall be a written agreement between the provider of services and the residential treatment facility. When dietetic services are provided by the same provider of services, written policies and procedures will be an acceptable alternative to a written agreement. The written agreement or written policies and procedures shall, at a minimum, address:

(1) qualifications of staff providing services;

(2) planned menus that provide for a nutritionally adequate diet served in an appetizing manner to all residents;

(3) provisions to meet special dietary needs; and

(4) financial arrangements.

(j) The residential treatment facility must have a written agreement for the provision of emergency psychiatric services with a provider of inpatient psychiatric services operated or certified by the Office of Mental Health.

584.12 Treatment program and environment.

(a) The treatment program and environment shall be designed to provide appropriate care on a 24-hour basis and to enhance treatment for all residents. The treatment program and environment shall ensure:

(1) a planned and predictable day-to-day routine for all residents

(2) the provision of a balance of privileges, expectations and responsibilities as appropriate to the ages and levels of functioning of the residents; and

(3) the safety, comfort and well-being of all residents

(b) As a component of the written plan for services and staff composition, the residential treatment facility shall provide a written plan and rationale for the treatment program and environment which shall be subject to approval by the Office of Mental Health, and addresses, at a minimum, the following:

(1) the manner in which the treatment program and environment will be implemented. Implementation must be consistent for all residents, yet must be sufficiently flexible to accommodate the needs of individual residents;

(2) the manner in which the treatment program and environment will be explained to the residents and their families or legal guardians upon admission;

(3) the day-to-day routines that the residents and staff will follow;

(4) the behavioral expectations for all residents, including identification of behaviors that are acceptable and unacceptable. This must address time both in the residential treatment facility and away from it;

(5) the means for providing instruction to residents, consistent with their age, needs and clinical condition as well as the needs and circumstances within the facility or program, in techniques and procedures which will enable such residents to protect themselves from abuse and maltreatment;

(6) the house rules and the response the resident can expect if [~~he/she~~] they either comply[~~ies~~] or fail[s] to comply with them. This can include staff response, limitations on privileges or other actions specified by the residential treatment facility;

(7) the mechanism for enabling residents, where appropriate, to participate in the decision making process within the residential treatment facility relating to the treatment program and environment;

(8) the means of observing holidays and personal milestones in keeping with the cultural and religious background of the residents;

(9) the procedure for communications and/or visitations with family, legal guardians, friends, and significant others; and

(10) the means of providing restitution or reimbursement for damages to property of the resident, other residents, and the residential treatment facility.

584.13 Special treatment procedures.

(a) There shall be a written plan for the use of restraint and seclusion, as defined in section 584.4 of this Part, that is in accordance with section 526.4 of this Title.

(b) There shall be a written plan for the use of time-out, as defined in section 584.4 of this Part. This plan shall, at a minimum, specify the criteria and procedures for the use of time-out, the rooms to be used, the procedures for monitoring that shall provide for visual observation of the child at intervals of no more than 15 minutes, and the requirements for documentation in the case record. Time-out shall be limited to 30 minutes at one time, 45 minutes in any hour and two hours in any 24-hour period.

(c) No residential treatment facility shall use extraordinary risk procedures without prior approval by the Office of Mental Health of a written plan for the use of such procedures. The plan shall demonstrate compliance with all applicable Federal and State requirements. Extraordinary risk procedures include, but are not limited to, experimental treatment modalities, psychosurgery, aversive conditioning and electro-convulsive therapies.

584.14 Treatment team.

(a) Treatment shall be the responsibility of an interdisciplinary treatment team. A treatment team shall be responsible for developing and implementing a treatment plan for each resident as required by section 584.15 of this Part.

(b) In order to address all aspects of the resident's needs, a treatment team shall be established for each resident and shall be comprised of the resident, clinical staff who are involved in the treatment of the individual resident on a regular basis, and where appropriate, of the family or legal guardian.

(1) The treatment team shall include all staff having significant participation in the treatment of the resident. The team shall, at a minimum, include a psychiatrist, at least one member of the clinical staff who is assigned to the living unit on a daily basis, and at least one member of the professional staff responsible for providing each of the following services to the resident:

(i) verbal therapies;

(ii) therapeutic recreation services; and

(iii) education and vocational services.

(2) One member of the treatment team must be designated as case coordinator for the resident.

(c) The residential treatment facility must develop written policies and procedures for the operation of its treatment teams which shall be subject to approval by the Office of Mental Health. At a minimum, the policies and procedures must address the following:

(1) the composition of treatment teams;

(2) the criteria for changing treatment team members;

(3) the representation required for the development of initial and comprehensive treatment plans and for treatment plan reviews;

(4) the responsibilities of the case coordinator;

(5) the manner in which the treatment team will coordinate with the appropriate committee on special education [~~the handicapped~~]; and

(6) the manner in which the treatment team will involve the family or legal guardian in the treatment process.

584.15 Individual treatment plans.

(a) An individual treatment plan shall be developed and implemented for each resident by the resident's treatment team.

(b) The individual treatment plan shall be based on a complete assessment of each resident.

(1) The assessment shall include, but shall not necessarily be limited to, physical, emotional, behavioral, social, educational, recreational and, when appropriate, vocational and nutritional needs. Special consideration shall be given to the role of the resident's family in each area of assessment.

(2) Clinical consideration of each resident's needs shall include a determination of the type and extent of special clinical examinations, tests and evaluations necessary for a complete assessment.

(3) The complete assessment shall be updated and documented at least annually as required in section 584.16 of this Part.

(c) The individual treatment plan shall address the needs of the resident.

(1) The individual treatment plan shall identify all service needs of the resident, whether or not the services are provided directly by the residential treatment facility.

(2) The individual treatment plan shall address the manner in which the family or legal guardian will be involved in the treatment process.

(3) The individual treatment plan shall address the manner in which the resident and his/her family or legal guardian will participate in the overall treatment program and environment of the residential treatment facility as provided for in section 584.12 of this Part.

(4) For those children that have been determined to be <u>classified with an educational disability</u>[educationally handicapped] and in need of special educational services and programs, the individual treatment plan shall address the special educational needs identified in the individualized education program. However, the individualized education program shall be maintained as a separate and distinct record.

(d) The resident and, as appropriate, the resident's family shall participate in the development and implementation of the individual treatment plan.

(e) The individual treatment plan shall be developed and revised as follows:

(1) an initial treatment plan which complies with the requirements of section 584.16(e) of this Part shall be developed within 72 hours of the resident's admission or transfer;

(2) a comprehensive treatment plan which complies with the requirements of section 584.16(f) of this Part shall be developed within 14 days of the resident's admission or transfer; and

(3) the comprehensive treatment plan shall be reviewed and revised if necessary at least every 30 days.

584.16 Case record.

(a) There shall be a complete case record maintained at one location for each resident admitted to the residential treatment facility. For those children that have been determined to be <u>classified with an educational disability</u> [educationally handicapped] and in need of special educational services and programs, there may also be an individualized education program, but such individualized education program shall be separate and distinct from the case record.

(b) The case record shall be confidential and access shall be governed by the requirements of section 33.13 of the Mental Hygiene Law and 45 C.F.R. Parts 160 and 164.

(c) The case record shall be available to all clinical staff involved in the care and treatment of the resident, consistent with the provisions of 45 C.F.R. Parts 160 and 164.

(d) Each case record shall include:

(1) identifying information about the resident served and the resident's family;

(2) a note upon admission, indicating source of referral, date of admission, rationale for admission, the date service commenced, presenting problem and immediate treatment needs of the resident;

(3) the application for admission to a residential treatment facility and [~~or~~] any other information obtained from the Office of Mental Health or designee's evaluation of eligibility for access to residential treatment facility services ~~[the pre-admission certification committee]~~, including an assessment from the committee on special education ~~[the handicapped]~~, when available;

(4) assessments of psychiatric, medical, educational, emotional, social and recreational needs. Where appropriate, assessments of vocational and nutritional needs shall be included. Special consideration shall be given to the role of the resident's family in each area of assessment;

(5) reports of all mental and physical diagnostic examinations and assessments, including findings and conclusions;

(6) reports of all special studies performed, including, but not limited to, X-rays, clinical laboratory tests, psychological tests, or electroencephalograms;

(7) initial and comprehensive treatment plans;

(8) Progress notes which relate to the goals and objectives of the initial or comprehensive treatment plans, which shall be signed by the staff member who provided the service or by one participating staff member when several staff members have had significant interaction with the resident.

(i) Progress notes shall be written at least weekly and additionally whenever a significant event occurs that affects, or potentially affects, the resident's condition or course of treatment.

(ii) Progress notes shall be written regarding the educational program as determined in the resident's individualized education program.

(iii) Progress notes shall be written regarding involvement of the family or legal guardian in treatment as determined in the resident's treatment plan;

(9) summaries of treatment plan reviews and special consultations regarding all aspects of the resident's complete daily program;

(10) dated and signed orders which indicate commencement and termination dates for all medications;

(11) a discharge summary, prepared within 15 days of discharge or transfer, which includes a summary of the clinical treatment, or reasons for discharge or transfer and, if appropriate, the provision for alternative treatment services which the resident may require; and

(12) information as may be required for the effective implementation of the utilization review plan provided for in section 584.18 of this Part.

(e) initial treatment plan shall include:

(1) admission diagnosis or diagnostic impression;

(2) a brief description of the resident's and the resident's family problems, strengths, conditions, disabilities or needs;

(3) objectives relating to the resident's problems, conditions, disabilities and needs, and the treatments, therapies and staff actions which will be implemented to accomplish these objectives; and

(4) initial discharge goals and criteria for determining the [necessity and appropriateness of the] specific resident's discharge readiness [continued stay], the anticipated discharge date and any other requirements established in standards and procedures established by the Office of Mental Health or commissioner's designee.

(f) The comprehensive treatment plan shall include:

(1) diagnosis;

(2) a brief description of the resident's and the resident's family problems, strengths, conditions, disabilities, functional deficits or needs;

(3) a brief description of the treatment and treatment planning which demonstrates that the program is addressing the functional deficits of the resident which substantiated the resident's eligibility for admission to the residential treatment facility;

(4) goals to address the resident's problems, conditions, disabilities and needs which indicate the expected duration of the resident's need for services in the residential treatment facility;

(5) objectives relating to the resident's goals. Objectives must be written to reflect the expected progress of the resident. Projections for accomplishing these objectives should be specific;

(6) the specific treatments, therapies and staff actions which will be implemented to accomplish each of the objectives and goals. These must be stated clearly to enable all staff members participating in the treatment program to implement the goals and objectives;

(7) discharge goals and the criteria for determining [the medical necessity and appropriateness of] the specific resident's discharge readiness [continued stay], the anticipated discharge date and any other requirements established in standards and procedures established by the Office of Mental Health or commissioner's designee;

(8) the name of the clinical staff member, designated as case coordinator, exercising primary responsibility for the resident;

(9) identification of the staff members who will provide the specified services, experiences and therapies;

(10) documentation of participation by the patient in the development of the treatment plan whenever possible and by representatives of the resident's school district, parent or legal guardian and referring agent, where appropriate;

(11) date for the next scheduled review of the treatment plan; and

(12) a copy of the individualized education program as defined in accordance with requirements of the Commissioner of Education.

584.17 Quality assurance.

(a) Each residential treatment facility shall have an organized quality assurance program designed to enhance resident care through the ongoing objective assessment of important aspects of resident care and the correction of identified problems. The quality assurance program shall provide for the following:

(1) identification of problems or concerns related to the care of residents;

(2) objective assessment of the cause and scope of the problems or concerns, including the determination of priorities for both investigating and resolving problems. Priorities shall be related to the degree of adverse impact on the care provided to residents that can be expected if the problems remain unresolved;

(3) implementation of decisions or actions that are designed to eliminate, insofar as possible, identified problems; and

(4) monitoring to assess whether or not the desired result has been achieved and sustained.

(b) Each residential treatment facility shall prepare a written quality assurance plan designed to ensure that there is an ongoing quality assurance program that includes effective mechanisms for reviewing and evaluating resident care and provides for appropriate response to findings. This quality assurance plan shall be subject to approval by the Office of Mental Health. The written quality assurance plan shall address at a minimum:

(1) the individual or group with the overall responsibility to administer or coordinate the quality assurance program;

(2) the activities or mechanisms for reviewing and evaluating resident care;

(3) the individuals or organizational entities to whom responsibility will be delegated for specific activities or mechanisms;

(4) the activities or mechanisms for assuring the accountability of the clinical staff for the care they provide;

(5) the individuals or organizational entities to whom responsibility will be delegated for responding to findings or implementing corrective actions designed to eliminate insofar as possible identified problems; and

(6) the activities or mechanisms for monitoring whether or not the corrective actions have been implemented, and whether or not the desired result has been achieved and sustained.

(c) As a component of the quality assurance program, each residential treatment facility shall establish a written plan for reviewing untoward incidents in accordance with Part 524 of this Title.

584.18 Utilization review.

(a) Each residential treatment facility shall have an organized utilization review program designed to monitor the appropriateness of continued stay and to identify the overutilization or underutilization of services.
(b) Each residential treatment facility shall prepare a written utilization review plan designed to ensure that there will be an ongoing utilization review program. This utilization review plan shall be subject to approval by the Office of Mental Health. The written utilization review plan shall address at a minimum:
(1) the establishment of a utilization review committee that shall be composed of at least three members of the clinical staff who meet the qualifications provided in section 584.10(d) of this Part, at least two of whom shall be [physicans] physicians. The utilization review committee shall include at least one physician who is knowledgeable in the diagnosis and treatment of mental illness;
(2) the operating procedures of the utilization review committee, including convening meetings as often as necessary to execute its functions, but in no event less often than quarterly; maintaining written minutes of meetings; and submitting reports to the director. Utilization review committee members who are directly involved in the care of a resident whose care is being reviewed shall be excluded from the committee's deliberations;
(3) the review of continued stays in accordance with section 584.18(c) of this Part; and
(4) the integration of the utilization review program into the quality assurance program provided for in section 584.17 of this Part.
(c) The utilization review committee shall review each resident's continued stay in accordance with the following requirements:
(1) An initial continued stay review shall be completed by the utilization review committee or its designee no later than 30 days after admission.
(2) Subsequent continued stay reviews shall be completed by the utilization review committee or its designee 90 days after the initial continued stay review and every 90 days thereafter.
(3) Review of each alternate care determination by the utilization review committee or a subcommittee of the utilization review committee which includes at least one physician.
(4) Notification of the physician on the resident's interdisciplinary treatment team of an alternative determination. Additional information provided by such physician shall be considered by the utilization review committee that includes at least two physicians.
(5) Notification of the director of final adverse decisions.

584.19 Premises.

The following standards shall apply to the physical plant or physical facilities of a residential treatment facility:

(a) Construction standards.

(1) Facilities shall be and remain in compliance with applicable sections of the 2010 edition of the Guidelines for Design and Construction of Health Care Facilities published by the Facility Guidelines Institute with assistance from the United States Department of Health and Human Services, provided, however, that this provision shall apply only to facilities which undertake construction or major renovations on or after the effective date of this paragraph. Facilities which have been constructed or have completed major renovations prior to that date in accordance with Part 77 of this Title shall be deemed to be in compliance with this paragraph.

(2) The design of the facility shall meet the requirements of the applicable sections of the Americans with Disabilities Act and the ADA Standards for Accessible Design and implementing regulations found at 28 CFR Parts 35 and 36.

(3) Waivers of up to 10 percent of the square footage for bedroom space will be considered by the Office of Mental Health upon application from the agency.

(b) Fire safety.

(1) All buildings containing sleeping quarters for children shall be protected by a fire detection system or a sprinkler system installed throughout. All buildings used by children, but not containing sleeping quarters for them shall be protected throughout by a sprinkler system, fire detection system, or manually operated fire alarm system. All areas of high fire hazard in all buildings used by children, whether or not they contain sleeping quarters for them, shall be protected by a sprinkler system and be separated from other areas by substantial, fire-resistant construction.

(2) All fire protection systems and equipment shall be installed according to recommendations of the National Fire Protection Association, and shall be inspected at least quarterly by a person who is expert in the installation, operation and inspection of such systems and equipment. A record of these inspections shall be kept by the facility. Facilities shall immediately correct any deficiency noted during inspection and testing.

(3) Each residential treatment facility shall request an annual inspection of each building used by children and its fire protection equipment by local fire authorities and/or the residential treatment facility's fire and casualty insurance carrier, who shall be requested to give the facility a written report of their findings. This report shall be kept on file on the premises until replaced by the next annual report of inspection. The residential treatment facility shall be responsible for correcting any fire hazards called to its attention throughout such inspection, and for keeping a written record on file of the action taken and when.

(4) Fire safety training. Facilities shall provide fire safety training to all staff. Newly hired staff shall be trained upon hiring and existing staff trained at least annually. Fire safety training shall include, but not be limited to:

(i) fire prevention;

(ii) discovering a fire;

(iii) operating the fire alarm system;

(iv) use of firefighting equipment; and

(v) building evacuation including fire drill protocols which identify staff roles.

(5) Fire drills. On a quarterly basis, facilities shall conduct fire drills in each building that houses patients. At least 50 percent of such drills must be unannounced.

(i) For each quarter, each such building must have a minimum of one practice fire drill per shift.

(ii) Facilities must direct all staff members on all shifts to participate in fire drills.

(iii) Drills shall be scheduled at varying times during a shift.

(iv) Use of alternative exits shall be practiced during fire drills.

(v) Whenever practicable, drills shall involve the actual evacuation of patients to an assembly point as specified in the evacuation plan. Consistent with the Life Safety Code standards, in larger facilities that are subdivided into separate smoke compartments to limit the spread of fire and smoke and move patients without leaving the building or changing floors, evacuation may include the relocation of patients to such compartments.

(vi) Properly documented actual or false alarms may be used for up to 50 percent of required drills for each shift, if all elements of the facility's fire plan were implemented.

(vii) Facilities must document and maintain records regarding fire drill performance which include an evaluation of the results of each fire drill, any corrective action that may be required, and completion of steps taken to achieve such corrective action.

(c) Prohibited items.

(1) The following items are prohibited from use within the structure:

(i) devices for heating, cooking, or lighting which use kerosene, gasoline, wood, or alcohol;

(ii) portable electric hot plates; and

(iii) barbeque grills. The use of barbeque grills is permissible when used outside of buildings but not within 30 feet of any structure including overhangs, canopies or awnings.

(2) The use of portable space heating devices is prohibited in patient sleeping and treatment areas of the facility, as well as in the facility administration offices. Use of a portable space heating device in any other building on the grounds of a facility shall be in accordance with guidelines of the office, provided that:

(i) the unit has an Underwriters Laboratories (UL) certification mark;

(ii) the unit is thermostat-controlled and has a tip-over cutoff device;

(iii) the unit is plugged directly into a wall receptacle (no extension cords);

(iv) combustible materials are not stored around or near the unit;

(v) at least a three-foot clearance around the unit is maintained; and

(vi) the unit is not placed underneath a desk, furniture or other combustible items.

(d) *Smoking.* Facilities must not permit smoking within any buildings on the grounds of the facility. If smoking is permitted on the grounds of the facility, it shall be contained to a specific location(s) equipped with an approved

non-combustible ash receptacle. Smoking shall not be permitted within 30 feet of any building structure, including overhangs, canopies or awnings.
(e) *Medication storage.* If medications are stored on the premises of the residential treatment facility, the residential treatment facility shall provide for controlled access maintenance of supplies in accordance with all applicable Federal and State laws and regulations.
(1) There shall be a single medication storage area within a single unit of the residential treatment facility.
(2) Medication shall be stored in a sturdy metal or sturdy wooden cabinet without glazing which shall be locked except when medication is needed. Controlled substances shall be stored in double-locked cabinets as follows:
(i) Schedule I, II, III and IV controlled substances shall be kept in stationary, double-locked cabinets. Both inner and outer cabinets shall have key-locked doors with separate keys. Spring locks or combination dial locks are not acceptable.
(ii) Schedule V controlled substances shall be stored in a stationary, secure, locked cabinet of substantial construction.
(3) Refrigerators used for storage of medication shall not be used for the storage of food or beverages unless the medication is stored in separate locked compartment within the refrigerator.
(f) Each living unit shall provide for the comfort and privacy of the residents and shall be limited in size to 14 residents. The premises shall be reasonably maintained to ensure access to services by all residents.

584.20 Statistical records and reports.
(a) Such statistical information shall be prepared and maintained as may be necessary for the effective operation of the facility and as may be required by the Office of Mental Health.
(b) Statistical information shall be reported to Office of Mental Health in a manner and within time limits specified by the Office of Mental Health.
(c) Statistical reporting shall be the responsibility of an individual whose name and title shall be made known to the Office of Mental Health.
(d) Summaries of statistical information shall be reviewed at least annually as part of the annual evaluation process.
(e) A residential treatment facility shall report to the Office of Mental Health or commissioner's designee and the Advisory Board on Residential Treatment Facility Admissions, as often as required, the disposition of applications for admission or transfer received by each residential treatment facility. Such report shall include, but not be limited to: the number of children that applied for admission or transfer to the residential treatment facility, the number of children deemed not appropriate for admission and the reason(s) why, the number of children admitted to each residential treatment facility, the number of children transferred from a hospital operated by the office of mental health and subsequently transferred to another hospital, the average length of

stay for residents at the residential treatment facility, the number of children served at each residential treatment facility, the number of involuntary placements and/or transfers from Office of Mental Health operated inpatient facilities, and any other information requested. The Advisory Board authority is limited to evaluating information relating to admission criteria and admission decisions and services provided by each residential treatment facility.

584.21 Waiver provisions.

In order to be eligible for the waiver provisions of this section, a residential treatment facility must meet one of the three following requirements:

(a) The residential treatment facility is located in a rural area and can demonstrate to the satisfaction of the Office of Mental Health the need for a waiver. For purposes of this Part, a *rural area* shall be a county where the population density is less than one hundred persons per square mile based upon current available data. The following sections of this Part are eligible for waiver:

(1) Section 584.5(d). The Office of Mental Health may approve a resident capacity of less than 14 where the residential treatment facility can demonstrate that this limitation would adversely affect the services provided. Consideration will be given to factors such as, but not limited to, geographic distance and transportation problems of residents' families and availability of staff.

(2) Section 584.10(e). The Office of Mental Health may approve the use of a physician in lieu of a psychiatrist where the residential treatment facility can demonstrate that a psychiatrist is unavailable to meet the requirement. The physician must have specialized training or experience in treating mentally ill children and youth.

(3) Section 584.10(e). The Office of Mental Health may approve the use of a person who has received a bachelor's degree in one of the following areas, art education, drama, early childhood education, music education, physical education, psychology, rehabilitation, sociology or special education in lieu of a therapeutic recreation specialist in circumstances where the residential treatment facility can demonstrate that a therapeutic recreation specialist is unavailable to meet the requirement. The person holding such a degree must also have specialized training or experience in treating mentally ill children and youth. This provision is extended to residential treatment facilities in other than rural areas.

(4) Section 584.11(f). Educational and vocational services may be provided at a location different than the residential treatment facility when the residential treatment facility can demonstrate that such arrangements would benefit the residents and that such services will be fully integrated through the treatment planning process.

(b) The residential treatment facility serves a specialized target population and can demonstrate to the satisfaction of the Office of Mental Health the needs for a waiver based upon the specialized needs of the target population. Section 584.5(d) of this Part is eligible for a waiver if the residential treatment facility can demonstrate that the need for such a program would not justify a program serving 14 or more residents.
(c) The residential treatment facility has a physical plant with living units designed for more than 14 residents and the residential treatment facility can demonstrate to the satisfaction of the Office of Mental Health the need for a waiver. Section 584.19(c) of this Part is eligible for a waiver if the residential treatment facility can demonstrate that such arrangements would be consistent with its goals and objectives and it would not be detrimental to the residents.

NEW YORK STATE | Office of Mental Health

14 NYCRR Part 602
Telehealth

(Statutory authority: Mental Hygiene Law §§1.03(6), 19.07(e), 19.09(b), 19.21(d), Article 36; Public Health Law Article 29G.)

Section:

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§ 602.1 Applicability

The provisions of this Part are applicable to all programs certified by the Office of Addiction Services and Supports (hereinafter referred to as "OASAS") and the Office of Mental Health (hereinafter referred to as "OMH") (together, hereinafter referred to as "the Offices") pursuant to Article 36 of the Mental Hygiene Law. Such programs shall require application for an operating certificate "designation" indicating approval by the Offices to provide such services.

§ 602.2 Legal base

(a) Article 36 of the Mental Hygiene Law allows the Commissioner of OASAS and the Commissioner of OMH to issue regulations to effectuate jointly certified programs of the Offices.

(b) Articles 1, 19, 22, 25 and 32 of the Mental Hygiene Law allows the commissioner of OASAS to issue rules and regulations for the implementation and operation of programs to treat addiction.

(c) Section 7.09 of the Mental Hygiene Law grants the Commissioner of OMH the power and responsibility to adopt regulations that are necessary and proper to implement matters under his or her jurisdiction.

(d) Sections 31.02 and 31.04 of the Mental Hygiene Law authorize the Commissioner of OMH to set standards of quality and adequacy of facilities, equipment, personnel, services, records and programs for the rendition of services for persons diagnosed with mental illness, pursuant to an operating certificate.
(e) Section 2999-dd of the Public Health Law provides that health care services delivered by means of telehealth are entitled to Medicaid reimbursement under Social Services Law Section 367-u.
(d) Section 829 of Title 21 of the United States Code governs the law concerning internet prescribing of controlled substances.
(e) Article 29-G of the Public Health Law relates to reimbursement and requirements for health care services delivered via telehealth.
(f) 14 New York Code of Rules and Regulations (NYCRR) Parts 800-857 specify rules for the implementation and operation of programs to treat addiction.
(g) 14 NYCRR 596 provide rules relating to the provision of telehealth services for OMH licensed, designated or otherwise authorized entities.

§602.3 Definitions

As used in this Part, the following terms shall have the following meanings:

(a)"Telehealth" means a dedicated secure real-time audio and/or interactive telecommunication system for the purpose of providing mental health and/or addiction services at a distance. Such services do not include an electronic mail message, text message or facsimile transmission between a provider and a recipient or a consultation between two professionals or clinical staff, although these activities may support the delivery of services via telehealth. Additionally, such services will not be defined as telehealth when provided where the originating and distant sites are the same location.
(b)"Designated program" means a Crisis Stabilization Center operating pursuant to Article 36 of the Mental Hygiene Law and has received an operating certificate designation indicating Offices approval.
(c)"Distant or hub site" means the distant secure location at which the practitioner delivering the service is located at the time the service is provided via telehealth technologies, which may include the practitioner's place of residence, office, or other identified space within the United States.

(d) “Originating or spoke site” means the site at which the service recipient is located at the time the service is being provided via telehealth technologies, which may include the service recipient’s place of residence, other identified location, or other temporary location out-of-state.

(e) “Practitioner” means:

(1) a prescribing professional eligible to prescribe medications including buprenorphine pursuant to federal regulations;

(2) other staff authorized by the Offices to provide addiction and mental health services consistent with their scope of practice where applicable, in accordance with guidelines established by the Offices and as authorized pursuant to this Title and Article 29G of the public health law.

(f) “Service recipient” means a person who is receiving services delivered via telehealth.

(g) “Telehealth technologies” means a dedicated secure interactive audio and/or video linkage system approved by the Offices to transmit data between an originating and distant site for purposes of providing telehealth services.

(h) Collateral means a person who is a member of the recipient’s family or household or other individual who interacts with the recipient and is directly affected by or has the capability of affecting their condition and is identified in the treatment plan as having a role in treatment and/or is necessary for participation in the evaluation and assessment of the recipient.

§ 602.4 General Standards Applicable to Delivery of Services Via Telehealth

(a) Telehealth services, as defined in this Part, may be authorized by the Offices for the delivery of addiction and mental health services provided by practitioners employed by, or pursuant to a contract or Memorandum of Understanding (MOU), with a program licensed by the Offices. Telehealth services may be provided only where clinically appropriate and with informed consent of the recipient. Where the recipient is a minor, consent shall also be provided by the parent/guardian or other person who has legal authority to consent to health care on behalf of the minor. The recipient may withdraw consent at any time. A provider may not deny services to an individual who has a preference to receive services in-person. Services may be delivered via telehealth in accordance with guidance issued by the Offices.

(b) The Offices support the use of telehealth as an appropriate component of the delivery of services to the extent that:

(1) it is both the preference and in the best interests of the person receiving services;

(2) is performed in compliance with applicable federal and state laws and regulations and the provisions of this Part in order to address legitimate concerns about privacy, security, service recipient safety, and interoperability; and

(3) is delivered by appropriate staff working within their scope of practice.

(c) Services may be provided via telehealth by a practitioner from a site distant from the location of the service recipient, provided both practitioner and service recipient are located in sites approved by the Offices pursuant to the policies and procedures submitted by a licensed program in an application for a telehealth designation and in accordance with guidance.

(d) A practitioner must be licensed, certified or credentialed to practice in New York State and be in good standing with the appropriate licensing or credentialing authority and be physically located in the USA when providing services via telehealth.

(e) The provision of buprenorphine prescribing and monitoring and other controlled substances via telehealth must comply with applicable state and federal laws and regulations and in accordance with additional guidance.

§ 602.5 Approval to Utilize Telehealth Services

(a) A program must obtain prior written authorization from the Offices pursuant to this section before implementing service delivery via telehealth; services shall be limited to those authorized and approved by the Offices in guidance issued by the Offices.

(b) Requests for authorization to provide services via telehealth shall be in the form and format prescribed by the Offices. Authorization will be based on a review of the program policies and procedures, completion of an attestation, and other information as may be requested by the Offices, in accordance with guidance. Once approved, such provider shall be accountable for ensuring compliance with all ethical and scope of practice requirements for the provision of such services via telehealth.

§602.6 Policies and Procedures

Policies and procedures. A program designated to deliver services via telehealth must have written policies and procedures submitted by the program for designation approval, and the applicable requirements of this Part.

(a) Programs shall issue written policies and procedures to allow for the delivery of services via telehealth consistent with the following criteria, including but not limited to:

(1) Telehealth services must be conducted via telehealth technologies employing acceptable authentication and identification procedures by both the sender and the receiver; applicant must document a relationship with a credible technology service provider.

(2) Delivery of services meet federal and state confidentiality requirements including, but not limited to, 42 C.F. R. Part 2, and 45 C.F.R. Parts 160 and 164 (HIPAA Security Rules). Such policies and procedures must ensure that:

(i) confidentiality requirements applicable to written medical records shall apply to telehealth services including the actual transmission of the service, any recordings made during the transmission, and any other electronic records.

(ii) spaces occupied by the practitioner must meet privacy standards as provided in guidance.

(3) Policies for ensuring that culturally competent translation services are provided when the service recipient and practitioner do not speak the same language;

(4) Procedures for handling emergencies with persons who receive telehealth services including procedures detailing the availability of in-person assessments;

(5) Procedures for a contingency plan in the event of a transmission failure or other technical difficulties which may render the service undeliverable;

(6) Where applicable, a written and executed contract or MOU between an applicant provider and an individual practitioner or a corporate entity encompassing multiple practitioners regarding the above criteria and including billing, payment, record sharing, background checks, and any other relevant details necessary for implementation;

(7) Procedures for assessing recipients to determine whether a recipient may be properly treated via telehealth services;

(8) Informed consent of persons who receive telehealth services and procedures for the withdrawal of such consent;

(b) Implementation policies and procedures must ensure that:

(1) The service recipient be provided basic information about telehealth including alternatives.

(2) The service recipient may refuse to receive services via telehealth.

(3) The service recipient and prospective service recipients must be evaluated to determine if telehealth is appropriate; additional evaluations may be required for medication for addiction treatment using controlled substances.

(c) Service delivery via Telehealth must be included in a provider's quality review process.

(1) The distant site practitioner must directly render the service delivered via telehealth.

(2) If the distant site is a hospital, the practitioner must be credentialed and privileged by such hospital, consistent with applicable accreditation standards.

(d) Policies and procedures relating to privacy must provide:

(1) Telehealth sessions shall not be recorded without the service recipient's consent, which shall be documented in the clinical record.

(2) Unless otherwise required, service recipients receiving services via telehealth may be accompanied by a staff member during the session or may be alone. If the initial evaluation or a subsequent treatment plan recommends that the service recipient be accompanied during telehealth sessions, the person must be accompanied for the session to be reimbursed.

(e) Contracts or Memorandum of Understanding (MOU) for the Provision of Services via Telehealth services.

(1) Prior approval of the Offices is not required before entering into such contracts or MOU; however, notice of such contracts or agreements must be provided to the Offices.

(2) The designated program is the default billing entity. Reimbursement of practitioners for services delivered via telehealth shall be pursuant to such contract or MOU; services are not separately billable by the practitioner unless agreed to in writing in advance of any service delivery.

(3) Designated programs or approved practitioners shall not engage in any services via telehealth not authorized by the Offices.

(4) Practitioners under contract or MOU with a certified and designated program must comply with the provisions of this Title related to criminal history information reviews or provide documentation that such security checks have been conducted and satisfied.

(5) Designated programs shall notify the Offices of any change in practitioners pursuant to a contract or MOU and compliance with provisions of Part and any guidance issued by the Offices.

(f) *Telehealth Standards.* The Offices shall post standards on its public website to assist in compliance with the provisions of this Part and in achieving treatment goals through the provision of services via telehealth. Such standards shall include, but not be limited to:

(1) Technology guidelines, including:

(i) The minimum technology thresholds (i.e., equipment, bandwidth, videoconferencing software, network specifications, carrier selection, hub/bridge, and security specifications), which shall be updated as new technology is approved; and

(ii) The form or format regarding the technology and communications to be used.

(2) Clinical standards, including but not limited to, the prescribing of medication for addiction treatment (MAT), including controlled substances, via telehealth.

§602.7 Revocation of Authority

(a)Failure to maintain minimum standards for authorization, implementation and/or reimbursement may result in disciplinary action against a program. In the event the Offices determine that an authorization must be revoked, the Office will notify the program in writing in accordance with guidance. The program may request an administrative review of such decision pursuant to this paragraph.

(i) The program must request such review in writing within fifteen (15) days of receipt of the notice of revocation of authorization. The request shall state the reasons the program considers the revocation of authorization incorrect and shall include any supporting documentation;

(ii) the commissioners of OASAS and OMH shall jointly notify the program, in writing, of the results of the administrative review within twenty (20) days of receipt of the request for review. Failure to notify the program within twenty (20) days shall be deemed confirmation of revocation of an authorization.

(iii) The determination jointly issued by the commissioners of OASAS and OMH after administrative review shall be final and not subject to further review.

§602.8 Reimbursement of Telehealth Services

(a) *Medicaid Reimbursement.*

(1) For purposes of billing for Medicaid reimbursement, both the practitioner and/or facility employing the practitioner, and the designated program must be Medicaid enrolled.

(2) For purposes of this subdivision, services delivered via telehealth shall be considered face-to-face contacts.

(3) To be eligible for Medicaid reimbursement, services delivered via telehealth must meet all requirements applicable to service delivery in accordance with this Title and the Part pursuant to which the designated program operating certificate is issued and must exercise the same standard of care as services delivered on-site or in-community.

(4) Services delivered via Telehealth shall be reimbursed at the same rates for identical procedures provided by practitioners in person unless otherwise specified by the Offices.

(5) The designated program is the primary billing entity; reimbursement for practitioners at a distant site must be pursuant to a contract or MOU. Delivery of services via telehealth are covered when medically necessary and under the following circumstances:

(i) the service recipient is located at an originating site and is seeking services from a certified program;

(ii) the practitioner is employed by or contracted with a program certified by the Offices;

(iii) the service recipient is present during the telehealth session;

(iv) the request for a telehealth session and the rationale for the request are documented in the case record;

(v) the service recipient case record includes documentation that the telehealth session occurred and the results and findings were communicated to the designated provider.

(6) If the service recipient is not present during the telehealth session, the service is not eligible for third party reimbursement and any incurred costs remain the responsibility of the designated provider.

(7) Services delivered via Telehealth may only be delivered via technological means approved by the federal Center for Medicaid and Medicare Services (CMS), provided such means are compliant with federal confidentiality requirements.

(8) If all or part of a Telehealth session is interrupted due to a failure of transmission or other technical difficulty, reimbursement shall not be provided.

§602.9 Severability

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