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Dear County MH Director:

As you know, over the past year the Office of Mental Health (OMH) has been working collaboratively with counties, mental health service providers, and consumer groups to conceptualize the design of a new licensed mental health program, Personalized Recovery Oriented Services (PROS). The new PROS license will give counties and providers the ability to integrate multiple programs into a comprehensive rehabilitation service. Providers may combine clubhouses, employment services, intensive psychiatric rehabilitation treatment (IPRT) and other rehabilitation program categories, reducing fragmentation and increasing continuity of care and accountability for achieving recovery goals. There are also options to incorporate Continuing Day Treatment (CDT) into a PROS license, and to transfer some existing clinic capacity to create a clinical treatment component within a PROS.

To ensure that the conversion of multiple programs to the new PROS license is accomplished with a minimum of disruption, and that the new PROS programs are well-integrated into the existing community service system, each County Mental Health Director is being asked to develop a PROS implementation plan for his or her county, in collaboration with OMH and local stakeholders. These PROS implementation plans will form the basis for reviewing individual Prior Approval Review (PAR) applications from providers requesting licenses to operate PROS programs.

OMH is planning a phased implementation process for the issuance of PROS licenses. Phase 1 will begin as soon as the county PROS implementation plans are received in OMH and the PROS PAR application package is ready for distribution, which is expected to be in October-November, 2003. During Phase 1, willing providers will be offered incentives to become early adopters of the new PROS license. A list of these incentives is provided in Attachment T-8. There will be a window of time during which PAR applicants will be eligible for the incentives, as described in the detailed PROS implementation time line in Attachment T-9. Finally, the implementation experiences of providers during Phase 1 will be reviewed, as described in Attachment T-10, to determine if program changes are needed before mandatory conversions begin (the anticipated start date for the mandatory conversion phase is no later than January 1, 2005).

## **PLANNING PACKAGE MATERIALS**

The enclosed materials are provided to assist in the development of the County PROS implementation plan. The materials are divided into two sets of attachments, as follows:

### **1) Planning Documents (Attachments P-1 – P-4)**

These documents, when completed, will comprise the county PROS implementation plan to be submitted to OMH. The documents are being provided in both hard copy and electronic form, and we ask that they be submitted in electronic form.

## **2. Tools and Supporting Information (Attachments T-1 – T-10)**

These materials are intended to help guide counties and providers through the necessary steps to explore programmatic and fiscal implications of various configurations of PROS services and programs, before finalizing the county-wide PROS implementation plan. Included in these attachments are a comprehensive description of the PROS program; a spreadsheet modeling tool to project PROS costs and revenues; fiscal profile information; a program site map; an explanation of the local share and overburden issues related to PROS; a list of the incentives for providers converting to PROS during Phase 1; and a projected timetable.

The contents of each Attachment are described in more detail in the Appendix to this letter.

## **PLAN DEVELOPMENT CONSIDERATIONS**

The following points should be considered in developing the County PROS implementation plan:

### **Planning Process**

Appropriate stakeholder involvement will be critical to the planning and implementation of PROS. In addition to working with affected provider agencies, OMH expects that counties will involve the Mental Health Subcommittee of the Community Services Board.

### **Program Capacity**

Sufficient funding has been earmarked to allow an increase in the Statewide gross program cost of the existing State aid funded rehabilitation programs that are mandated to convert to PROS. However, the potential for Statewide growth will not necessarily apply to each individual program or county. The amount of growth in the funding received by a particular provider or county will depend on many factors, primarily the current funding level, service volume, staffing and efficiency of existing programs.

Because the Statewide PROS capacity will not be unlimited, a reasonable estimate of capacity must be developed for each licensed PROS program, which will become part of the provider agency's approved PAR. In general, it is expected that a county's total PROS capacity will be consistent with the current service utilization within the PROS conversion programs, and counties should negotiate individual provider capacity with this in mind. The calculation of an appropriate capacity for each licensed PROS in the county's plan is a complex undertaking. There are risks to the provider in overestimating capacity, because the revenue generated by the PROS will not be sufficient to cover the incurred costs if the projected volume is not achieved. In addition, individual county and provider capacity will need to be renegotiated if the projected Statewide total PROS expenditures significantly exceed the budgeted funding amount.

It should be noted that PROS capacity is being defined in slightly different ways for different purposes within this package. For the purposes of using the County Planning Model Tool and completing the County PROS Implementation Plan Summary, capacity is defined as the average number of individuals served per month. This number is used by the tool to drive potential revenues and costs for each PROS program. For the purposes of the regulations and PAR application, capacity is defined as the approved “average attendance” of the program, which is the number of individuals, on average, receiving services from an individual PROS provider at any given time. This number will be used to determine whether the proposed staffing plan and daily staffing patterns for the PROS are in compliance with the regulations.

### **Elimination of Funding for the Innovative County Vocational Initiative**

All affected parties were previously notified that funding for the Innovative County Vocational Initiative will end as of December 31, 2004. OMH still hopes to be able to maintain this funding through 2004, although fiscal realities may require an earlier termination date. Counties and providers are encouraged to consider the implications of the elimination of this funding stream when developing PROS implementation plans, in particular the potential use of PROS Medicaid revenue to support program activities presently funded by the Innovative Initiative grants.

## **PROCESS AND TIMELINE FOR SUBMISSION OF PLANS**

### **County PROS implementation plans are due to OMH no later than 8 weeks from the mailing date of this package.**

Please submit an electronic copy of the county plan documents (Attachments P-1 – P-4) simultaneously to:

- The Director of the local OMH Field Office
  - Western NY: email address – coodtaw@omh.state.ny.us
  - Central NY: email address – huasjss@omh.state.ny.us
  - Hudson River: email address – coodjrr@omh.state.ny.us and ohnccxm@omh.state.ny.us
  - Long Island: email address – pgopwrs@omh.state.ny.us
  - NYC: email address – onlujpl@omh.state.ny.us
  
- Louis Delisio, Rehabilitation Services, 7<sup>th</sup> Floor, NYS Office of Mental Health, 44 Holland Avenue, Albany, NY 12229; email address – coctlmd@omh.state.ny.us

PAR applications from providers within a particular county will start being processed as soon as the county’s PROS implementation plan is approved. Beginning 12 weeks after the mailing date of this package, OMH will begin processing any PAR applications that have been filed.

## **NEXT STEPS**

The next major steps of the PROS implementation process include:

- Approval of the county PROS implementation plans and initiation of the PAR application process – See Attachment T-9 for a projected time line.
- Development of county/provider PROS agreements – It is anticipated that guidelines for these agreements will be distributed at the same time as the release of the PAR applications in October.
- Plans for training/technical assistance – Information about the technical assistance that will be available to providers, particularly in the areas of PROS program design and Medicaid billing, will be provided shortly.

Please direct any questions about the materials in this package, your PROS county implementation plan, or the PROS program in general to the Director of your local OMH Field Office. Thank you all for your ongoing participation in this important initiative.

Sincerely,

Linda Rosenberg  
Senior Deputy Commissioner

Peter Brown  
Deputy Commissioner

cc: Field Office Directors  
OMH PROS Implementation Team

## APPENDIX

### DESCRIPTION OF ATTACHMENTS

#### **Planning Documents (Attachments P-1 – P-4)**

##### Attachment P-1 County PROS Implementation Plan Summary

(Electronic format – Microsoft Word document, provided on the enclosed computer disk and CD.)

This form provides an overview of the county's plan, focusing on overall capacity and cost, and highlighting issues that may need to be addressed during the PAR application review process.

##### Attachment P-2 County Fiscal Profile Spreadsheet

(Electronic format – Excel spreadsheet, provided on the enclosed computer disk and CD.)

This chart displays the county specific array of existing programs that are eligible for conversion to PROS. It includes a provider-specific accounting of gross funding by program. A narrative explanation of each column of the chart is also provided.

When completed, this document will provide a graphic representation of the PROS conversion status of each of the mandatory and optional PROS conversion programs in the county.

It should be noted that certain previously requested changes (e.g., recoding of programs) have not been reflected in the County Fiscal Profile Spreadsheet. These situations will need to be addressed during the planning process and OMH review of county plans.

##### Attachment P-3 Individual PROS Data Sheet

(Electronic format – Excel spreadsheet, provided on the enclosed computer disk and CD.)

This form provides supplementary information about each individual PROS program, and should crosswalk to each of the PROS programs identified on the County Fiscal Profile Spreadsheet (Attachment P-2) and County Planning Model Tool Spreadsheet (Attachment P-4).

##### Attachment P-4 County Planning Model Tool Spreadsheet – County Summary Version (See Attachment T-2 for Instructions on Using the County Planning Model Tool)

(Electronic format: Tool – Excel spreadsheet; provided on the enclosed computer disk and CD.)

This attachment provides instructions for completing the county summary version of the County Planning Model Tool spreadsheet, which is to be submitted electronically along with the rest of the county plan documents. A blank hard copy printout of the spreadsheet is also provided.

After running all of the county's proposed PROS programs through the County Planning Model Tool, the data for the final configuration of each PROS is to be transferred to consecutive

columns in a clean copy of the Model (data entry) spreadsheet. The spreadsheet will then calculate the county's total PROS capacity and gross cost, which are to be entered on the County PROS Implementation Plan Summary Form (Described under Attachment P-1, above). Each column on the spreadsheet is to be labeled with the provider and PROS program name, and assigned a control number that will be entered as instructed on the County Fiscal Profile Spreadsheet (Attachment P-2) and the Individual PROS Data Sheet (Attachment P-3).

### **Tools and Supporting Information (Attachments T-1 – T-10)**

#### Attachment T-1 PROS Program Description

This attachment provides a detailed description of the PROS program and fiscal models, arranged in the following sections:

- K. Personalized Recovery Oriented Services – Draft Standards
  - *Appendix 1 – Co-enrollment Rules*
  - *Appendix 2 – Rates of Payment*
  - *Appendix 3 – Definitions*
- B. Programs Eligible for PROS Licenses
- C. PROS Case Example

**Highlights of recent changes:** The following changes have been made to the PROS program and fiscal models since the distribution of Senior Deputy Commissioner Linda Rosenberg's May 6, 2003 letter, which outlined the program design revisions made as of that date in response to stakeholder input. These latest changes have also been based on stakeholder questions and suggestions, as well as the results of ongoing consultation with the New York State Department of Health:

- The fee structure has been changed to include the establishment of regional fees, the elimination of the \$1/hour fee, and revision of the hour tiers (See Summary of Standards, Appendix 2).
- The Intensive Rehabilitation component has been defined in more detail, including an articulation of specific services that are eligible for IR reimbursement, and requirements for more intensive professional staff involvement in providing IR (See Summary of Standards, pages 2 and 3).
- The co-enrollment rules have been modified (See Summary of Standards, Appendix 1).
- A PROS must have at least one full-time staff person who is a licensed practitioner of the healing arts (See Summary of Standards, page 3).
- A limited license PROS must have a minimum of 20% professional staff, not just a professional program supervisor (See Summary of Standards, page 3).
- The employment threshold for Vocational Support (VS) billing has been reduced from 17.5 hours/week to 15 hours/week (See Summary of Standards, page 8).
- The Wellness Recovery Plan (WRP) is renamed the Individualized Recovery Plan (IRP).
- The 15 months out of 24 months billing limitation on Intensive Rehabilitation (IR) in a limited license PROS has been eliminated.

- The limit on group size for off-site IR services has been eliminated.

#### Attachment T-2 PROS County Planning Model Tool

(Electronic formats: Tool – Excel spreadsheet; Instructions – Microsoft Word document; both are provided on the enclosed computer disk and CD.)

The PROS County Planning Model Tool is a series of Excel spreadsheets, designed to assist counties and providers in creating budgets for individual PROS programs by projecting revenues and expenses, and to roll up all of the individual PROS budgets into a county-wide total.

This attachment provides:

- Instructions for Use of the PROS County Planning Model Tool
- Printout of the Data Entry Screen for the PROS County Planning Model Tool

#### Attachment T-3 CFR 2000 Supporting Cost Data for the County Planning Model Tool

This attachment includes five reports that provide a general summary of past administrative expenditures in programs eligible for PROS conversion (based on 2000 CFR submissions). There is also a detailed description of the data elements and calculations contained in the reports.

Information has been compiled for all mental health providers within a county that operate mandatory PROS conversion programs and/or CDTs. There is a detail report broken down by program within provider, and summary reports at the provider, countywide, regional and Statewide levels. All of the reports display the current ratios of seven categories of administrative expenditures to total expenditures, and the detail report also displays the data used to calculate the ratios.

These reports can assist counties and providers in developing PROS budget projections to be used in the County Planning Model Tool, and can help determine whether individual provider estimates of administrative expenses are reasonable compared to countywide and Statewide averages.

Please note that any providers/programs identified in the County Fiscal Profile Spreadsheet (Attachment P-2) that did not file CFRs in 2000 will not appear in these reports.

#### Attachment T-4 Additional Fiscal Profile Information

This attachment includes the following spreadsheets containing additional fiscal profile information that may be useful to counties in developing their PROS implementation plans:

- A. Net Deficit County Totals by Funding Source – Displays the countywide total amount of state share of net deficit for all PROS eligible programs by OMH funding source.
- B. County Fiscal Profile of Additional Non-PROS Community Support Programs – Displays the current funding for the following CSP programs by provider: Recreation (Program Code 0610), Transportation (Program Code 0670), and Advocacy (Program Code 1760).

#### Attachment T-5 County Mental Health Program Site Map

This attachment provides a map of the mental health programs within a single county, and contiguous areas of other counties, to assist in determining the geographic proximity of various potential PROS program sites.

NOTE: The map was developed based on the 2000 Consolidated Fiscal Report (CFR), so there will likely be some discrepancies with the County Fiscal Profile Spreadsheet (Attachment P-2), which was developed using the 2002 Consolidated Budget Report (CBR).

#### Attachment T-6 PROS Services Checklist

This chart is provided as a potential tool to help counties and providers think through and document how each individual PROS service would be delivered. The format of the chart could be particularly useful for PROS programs that are being established by combining elements from multiple providers, via consolidation and/or contracting arrangements. This chart is not required to be submitted as part of the county PROS implementation plan.

#### Attachment T-7 PROS Local Share and Overburden Explanation

This attachment describes the processes that will be used to ensure that counties are held harmless for the local share of Medicaid associated with conversion of existing IPRT and net deficit financed rehabilitation programs to PROS, and are protected from loss of overburden relief associated with the conversion of existing CDT programs to PROS.

#### Attachment T-8 Incentives for Providers Opting to Convert to PROS During the First Phase of Implementation

This attachment lists three incentives for providers willing to participate in the first phase of PROS implementation, including a limited hold harmless protection against revenue shortfalls. All providers should be made aware of these incentives, and the likelihood that much of what is being offered during Phase 1 may not be available for providers that convert at a later time, since the initial implementation issues will have been addressed.

#### Attachment T-9 Time Line for Phase 1 of PROS Implementation

This attachment outlines the schedule for the county PROS implementation plan and PAR application processes. In addition, the time line includes tentative dates for some of the other critical actions related to PROS implementation, including the approvals necessary to begin billing Medicaid for PROS services.

#### Attachment T-10 Review of Phase 1 of PROS Implementation

This attachment describes how the experiences of providers during Phase 1 of PROS

implementation will be reviewed, and changes to the program and fiscal models made as necessary, before beginning to license all of the mandatory PROS conversion programs.

**ATTACHMENT P-1**

**COUNTY PROS IMPLEMENTATION PLAN SUMMARY**

**COUNTY NAME** \_\_\_\_\_

\*\*\*\*\*

		# Programs	Average # Individuals Served/Month
I	Total County Comprehensive PROS Capacity (Sum of a) and b) below)	_____	_____
	a) PROS with clinical treatment	_____	_____
	b) PROS without clinical treatment	_____	_____
	(Calculate individuals served by summing Row 13 of the county summary version of the Planning Model Tool Spreadsheet separately for the columns reflecting each of the two licensing categories above)		
II	Total County Limited License PROS Capacity (Individuals served = Sum of cells AB93 and AB100 from the county summary version of the Planning Model Tool Spreadsheet)	_____	_____
III	Total PROS Medicaid Revenue (Sum of cells AB78 and AB125 from the county summary version of the Planning Model Tool Spreadsheet)		_____
IV	Total Funding of Programs not included in III Above (Sum of "Total Funding" column amounts from County Fiscal Profile Spreadsheet, for all programs not identified as part of a licensed PROS)		_____
V	Grand Total (Sum of III and IV above)		_____

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1. Describe and provide a brief rationale for any significant differences between the "Before Picture" for the county, as reflected in the County Fiscal Profile Spreadsheet (Attachment P-2) and the County Mental Health Program Site Map (Attachment T-5) and the "After Picture" represented by the county's PROS implementation plan. Significant differences include the following:

- Existing mandatory PROS conversion programs (as identified in Attachment T-1B) that are not recommended for licensing as a PROS
- Existing optional PROS conversion programs (CDT) that are not recommended for licensing as a PROS
- Programs that are projected to experience a major change in service capacity or revenue from existing levels
- Programs that are projected to experience a major change in service capacity or revenue from existing levels
- Programs that are expected to change organizational auspice
- Programs that are projected to change geographical location/catchment area

2. Providers that operate a licensed clinic or CDT in addition to a PROS in the same geographic location will only be able to provide and bill for clinical treatment for PROS clients under the PROS clinical treatment component. If any such provider is being recommended for licensing as a comprehensive PROS without clinical treatment, please identify the provider, explain the rationale for this decision and describe the alternative plan for providing clinical treatment to the individuals enrolled in the PROS.

Please feel free to provide any additional information that will assist OMH in understanding the County's vision for PROS implementation, and/or in reviewing the Prior Approval Review (PAR) applications submitted by service providers requesting to be licensed to operate PROS programs in the county.

## ATTACHMENT P-2

### EXPLANATION OF COUNTY FISCAL PROFILE SPREADSHEET

**Agency Name** - the name of the agency from the CFR.

**Agency Code** - the five digit agency code from the CFR.

**Facility Name** - the CFR site specific name associated with each program.

**Site Address** - the CFR street address associated with each site.

**Site City** - the CFR city associated with each site.

**Program Code** - the CBR four digit code associated with each PROS eligible program, as follows:

<u>Mandatory Conversion Programs</u>	<u>Codes</u>
Affirmative Business	2340
Assisted Competitive Employment (ACE)	1380
Client Worker	3340
Enclave in Industry	1340
Intensive Psychiatric Rehabilitation Treatment (IPRT)	2320
On Site Rehabilitation	0320
Ongoing Integrated Supported Employment (OISE)	4340
Psychosocial Club	0770
Supported Education	5340
Transitional Employment Program (TEP)	0380
<u>Optional Conversion Programs</u>	<u>Codes</u>
Continuing Day Treatment (CDT) Clinic <sup>1</sup>	1310 2100

<sup>1</sup> At this time, existing clinic programs are not eligible for a PROS license. However, it is expected that some existing clinic capacity may be converted to establish PROS with Clinical Treatment Programs.

**Net Deficit** - the current State aid associated with each program. Does not include any local funding provided to these programs. In most cases, this amount was submitted by counties in response to an OMH survey. In some cases, OMH has added or modified data that was not included in the county submission (e.g., OMH direct contracts). This column includes:

- Approval letter funding for local fiscal year 2003;
- Direct contract funding between OMH and the provider for local fiscal year 2003;
- Both of the above include the full annual 2002-03 3% COLA.

**Base Medicaid** - the base gross Medicaid (i.e., without COPS, non-COPS or CSP add-ons)

associated with each outpatient program eligible for conversion to PROS (i.e., Clinic, CDT, IPRT). This information was extracted from MMIS for Calendar year 2002.

**COPS/non-COPS Medicaid** - the full annual COPS and/or non-COPS Medicaid threshold for each outpatient program (i.e., clinic, CDT, and IPRT) beginning April 1, 2003 (please note that for clinic, the amount detailed as COPS may also include net deficit funding that continues to be allocated due to the constraint imposed by the current COPS rate cap). The amount attributed to each outpatient program reflects the historical net deficit (adjusted for COLAs and other budget actions) associated with each program that was converted to COPS, plus additional COPS associated with initiatives included in the 2003-04 Enacted Budget (i.e., conversion of Reinvestment funded programs and Shared Staffing to COPS).

**CSP Medicaid** - the net deficit that was already converted to Medicaid in 1998 for those CSP programs that are eligible for PROS conversion. This amount was extracted from OMH records.

**DSH** - the net deficit that was already converted to DSH in 1998 for those CSP programs that are eligible for PROS conversion. This amount was extracted from OMH records.

**Total Funding** - aggregates the “Net Deficit” column through the “DSH” column for each program.

**VESID Vendor** - OMH records indicate that programs marked with “X” are currently receiving VESID funding. This information is provided for use in determining other potential sources of revenue for PROS conversion programs, to the extent that this is helpful to the county planning process.

**Control Number** - In each row that contains a PROS eligible program site, post the control number of the licensed PROS into which that program will be converted. The number to be entered in this column is the control number assigned to the PROS on the County Planning Model Tool spreadsheet (Row 8 for a Comprehensive PROS and row 90 for a Limited License PROS). Instructions for assigning control numbers are found in Attachment P-4. This same control number will also be entered on the Individual PROS Data Sheet (Attachment P-3).

## **ATTACHMENT P-3**

### **HELPFUL HINTS IN COMPLETING THE COUNTY PROS IMPLEMENTATION PLAN INDIVIDUAL PROS DATA SHEET**

P-3 is lock protected so the only cells that can be altered are data entry cells (which are not locked).

Some cell data from Attachment P-2 can be copied and pasted into applicable cells in P-3. However, due to a formatting relationship issue between P-2 and P-3, there are some cells that cannot be copied and pasted. In these instances, manual data entry in P-3 will be necessary.

If data are being copied from Attachment P-2, please note that the "Facility Name" column in Attachment P-2 is referred to as "Program Name" on Attachment P-3.

Navigation throughout the table (from cell to cell) is made easiest by using the tab key.

Certain cells (such as address cells) are wrap text formatted. This will enable you to enter data longer than what the cell length appears to be.

The Gross Revenue cell is already currency formatted.

P-3 is set up for landscape printing on 8.5" x 11" paper.

With the exception of the header, Times New Roman 12 point is the default font.

If you have questions regarding completion of this form, call Kelly Haskin-Tenenini at 518-474-6614 or e-mail at [cocbkkh@omh.state.ny.us](mailto:cocbkkh@omh.state.ny.us).



## **ATTACHMENT P-4**

### **INSTRUCTIONS FOR CREATING THE COUNTY SUMMARY VERSION OF THE PROS COUNTY PLANNING MODEL TOOL SPREADSHEET**

The PROS County Planning Model Tool has two express purposes: 1) To allow a provider to test different scenarios for the development of a PROS budget; and 2) To enable a county to develop a summary reflecting all of the county's anticipated PROS programs. This attachment provides instructions for the second purpose. Attachment T-2 provides instructions for the first purpose.

After running all of the county's proposed PROS programs through the County Planning Model Tool, the county will create the county summary by entering the final provider budget information for each anticipated PROS in consecutive columns on a clean copy of the Model (data entry) spreadsheet. The tool will calculate the county's total PROS capacity and gross cost, which are to be entered on the County PROS Implementation Plan Summary Form (Attachment P-1).

The completed county summary must be submitted to OMH electronically, in the original format in which it was provided in this package.

#### **Accessing the Tool**

**IMPORTANT! THE TOOL MUST BE SAVED TO DESKTOP IN ORDER TO WORK PROPERLY.**

1. Insert disk in disk drive.
2. Double click on the "My Computer" icon on the desktop.
3. Open disk drive A.
4. Put cursor over "County PROS Fiscal Model." Left click on the file once and hold the click while dragging the file to the desktop. Another option is to right click on the file, select copy, then right click on the desktop and select paste.
5. On the computer screen desk top, there should now be an Excel file named "County PROS Fiscal Model.xls."
6. Double click on this file to open.

#### **Completing the Model Sheet for the County Summary**

- 1) Complete the identifying information at the top of the spreadsheet.

Cell B3: Enter the County/Borough name in which the PROS program will be located.

Cell B4: Indicate whether the county is considered to be Upstate (1) or Downstate (2) from a PROS rate perspective. Downstate includes: Nassau, Suffolk, the five boroughs of New York City, Westchester, Rockland and Putnam. Upstate includes all counties/boroughs not considered downstate.

- 2) Label consecutive columns on the spreadsheet for each anticipated PROS program. **Note: The same column cannot contain data for both a Comprehensive PROS and a Limited License PROS.**

Rows 7 (Comprehensive PROS) and/or 89 (Limited License PROS): Enter both the name of the sponsor agency that will hold the license and the name of the PROS program.

Rows 8 (Comprehensive PROS) and/or 90 (Limited License PROS): Enter the county assigned control number for each PROS according to the following protocol:

**First character** – C (for Comprehensive PROS) or L (for Limited License PROS)

**Second character** – C (for PROS with clinical treatment) or W (for PROS without clinical treatment)

**Third and fourth characters** – County code [If code is less than 2 digits, fill with zeros, e.g., 01]

**Fifth character** – 1 (for Phase 1 providers) or 2 (for all other providers)

**Sixth, seventh and eighth characters** – Sequentially number all of the individually licensed PROS programs in the county [If number is less than 3 digits, fill with zeros, e.g., 001]

For example, an Albany county comprehensive PROS without clinical treatment that will not be in Phase 1, and whose budget information is in the first column on the county summary version of the Planning Model Tool spreadsheet would be assigned the control number CW012001.

The control number from each column needs to be entered, as instructed, on the County Fiscal Profile Spreadsheet (Attachment P-2) and the Individual PROS Data Sheet (Attachment P-3).

Rows 9 (Comprehensive PROS) and/or 91 (Limited License PROS): Enter Yes or No, depending on whether or not this PROS will submit a PAR in Phase 1.

Row 10 (Comprehensive): Enter the appropriate capital add-on for any Article 28 hospital program converting to a PROS. This estimated capital add-on is found on the spreadsheet tab labeled “Article 28 Capital Add-on” at the bottom of the screen. The Revenue spreadsheet will add this capital add-on to the basic PROS fees.

- 3) Input the final provider budget information for each anticipated PROS in the appropriate column. The data for each PROS can be input into the model spreadsheet in one of two ways:
- By direct entry.
  - By blocking, copying and pasting the values in the yellow highlighted fields from another copy of the spreadsheet.

Please note that, because the calculation cells in the spreadsheet are protected from change, it is not possible to copy and paste an entire column from one spreadsheet to another without disrupting the calculations.

### **Verifying and Reporting County Summary Totals**

- 1) Check the spreadsheet calculated totals in column AB to ensure that they appropriately reflect the county's plan, and enter the totals, as instructed below, in the other planning documents.

Cell AB13: This cell displays the total capacity for Comprehensive PROS programs in the county. This cell value should match the value under "Average # of Individuals Served/Month" in row I on the County PROS Implementation Plan Summary (Attachment P-1).

Row 13: The County PROS Implementation Plan Summary (Attachment P-1) asks for capacity information for Comprehensive PROS programs with clinical treatment and without clinical treatment. The spreadsheet does not make this distinction, so these totals need to be calculated by separately summing the values in row 13 for the columns reflecting PROS with clinical treatment and the columns reflecting PROS without clinical treatment. Enter the calculated totals under "Average # of Individuals Served/Month" in rows I(a) and I(b), respectively, on the County PROS Implementation Plan Summary (Attachment P-1).

Cells AB93 and AB100: These cells display capacity information for the IR and VS components, respectively, of Limited License PROS programs. Add these cells together and enter the total under "Average # of Individuals Served/Month" in row II on the County PROS Implementation Plan Summary (Attachment P-1).

Cells AB78 and AB125: These cells display the total Medicaid revenue for Comprehensive PROS programs and Limited License PROS programs, respectively. Add the amounts in these cells together and enter the total in row III on the County PROS Implementation Plan Summary (Attachment P-1).

### Saving and Printing the Spreadsheet

1. Select the “Save As” icon at the top of the Excel window.
2. Choose a drive and file to save the edited spreadsheet to.
3. **GIVE THE SPREADSHEET A UNIQUE NAME SO THAT THE CURRENT DESKTOP SPREADSHEET IS NOT OVERWRITTEN AND REMAINS CLEAN FOR FUTURE USE.**
4. The spreadsheet is already formatted for printing.
5. Insert legal sized paper in the printer.
6. Click on the print icon at the top of the Excel window.

## ATTACHMENT T-1A

### PERSONALIZED RECOVERY-ORIENTED SERVICES DRAFT STANDARDS

#### Program Operations

The purpose of Personalized Recovery-Oriented Services (PROS) programs is to assist individuals in recovery from the disabling effects of mental illness through the coordinated delivery of a customized array of rehabilitation, treatment and support services. Such services are expected to be available both in traditional program settings and in off-site locations where such individuals live, learn, work or socialize. Providers must create a therapeutic environment which fosters awareness, hopefulness and motivation for recovery, and which supports a harm reduction philosophy.

Depending upon program configuration and licensure category, PROS programs include the following components:

***Community Rehabilitation and Support (CRS):*** designed to engage and assist individuals in managing their illness and in restoring those skills and supports necessary to live in the community.

***Intensive Rehabilitation (IR):*** 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.

***Vocational Support (VS):*** designed to assist individuals in managing symptoms and overcoming functional impairments as they integrate into a competitive workplace. VS interventions focus on supporting individuals in maintaining competitive integrated employment. Such services are provided off-site.

***Clinical Treatment:*** designed to help stabilize, ameliorate and control an individual's symptoms of mental illness. Clinical Treatment interventions are expected to be highly integrated into the support and rehabilitation focus of the PROS program. The frequency and intensity of Clinical Treatment services must be commensurate with the needs of the target population.

PROS programs include the following licensure categories and program components:

COMPREHENSIVE PROS WITH CLINICAL TREATMENT	COMPREHENSIVE PROS WITHOUT CLINICAL TREATMENT	LIMITED LICENSE PROS
CRS IR VS CLINICAL TREATMENT	CRS IR VS	IR VS

It is the preference of the Office of Mental Health (OMH) to establish fully-integrated Comprehensive PROS programs. However, applications for Limited License PROS programs will be considered on a case-by-case basis. Upon justification of continued need, operating certificates for Limited License PROS programs may be renewed. Each PROS program site must be authorized by a separate operating certificate, with renewals issued for terms of up to three years.

PROS providers must establish mechanisms for the coordination of rehabilitation, treatment and support services for individuals, including linkage agreements with other providers as appropriate. These mechanisms must address:

- coordination among any of the PROS components which are delivered by the same PROS provider;
- coordination among any of the PROS components which are delivered by multiple PROS providers; and
- coordination of PROS services with other service providers.

Services to be offered within each program component are as follows:

<b>CRS Component</b>	<b>IR Component</b>	<b>VS Component</b>
<p><i>Comprehensive PROS:</i></p> <ul style="list-style-type: none"> <li>➤assessment</li> <li>➤basic living skills training</li> <li>➤benefits and financial management</li> <li>➤community living exploration</li> <li>➤crisis intervention</li> <li>➤engagement</li> <li>➤individual recovery planning</li> <li>➤information and education regarding self help</li> <li>➤structured skill development and support</li> <li>➤wellness self-management</li> </ul> <p><i>Clinical Treatment Enhancement:</i></p> <ul style="list-style-type: none"> <li>➤clinical counseling and therapy</li> <li>➤health assessment</li> <li>➤medication management</li> </ul>	<p><i>Comprehensive PROS:</i></p> <ul style="list-style-type: none"> <li>➤family psychoeducation</li> <li>➤intensive rehabilitation goal acquisition</li> <li>➤intensive relapse prevention</li> </ul> <p><i>Limited License PROS:</i></p> <ul style="list-style-type: none"> <li>➤intensive rehabilitation goal acquisition (limited to employment and education-oriented goals)</li> </ul> <p><i>Clinical Treatment Enhancement:</i></p> <ul style="list-style-type: none"> <li>➤integrated treatment for co-occurring mental health and substance abuse disorders</li> </ul>	<p><i>Comprehensive PROS or Limited License PROS:</i></p> <ul style="list-style-type: none"> <li>➤vocational support</li> </ul>

All PROS providers are required to offer individualized recovery planning services and pre-admission screening services. Any additional services may be offered if they are clinically appropriate and approved by OMH. An example of a potential additional service is cognitive remediation.

A PROS provider may offer services pursuant to a sub-contract with another provider. Such contracts require prior approval of OMH.

## **Admission**

Persons eligible for admission to a PROS program must:

- be 18 years of age or older;
- have a designated mental illness diagnosis;
- have a functional disability due to the severity and duration of mental illness; and
- have been recommended for admission by a licensed practitioner of the healing arts. Such recommendation may be made by a member of the PROS staff, or pursuant to a referral from another provider.

Prior to admission to a PROS program, pre-admission screening services may be provided. A screening and admission note must be written upon a decision to admit and must include the following:

- reason for admission;
- primary service-related needs and services to meet those needs; and
- admission diagnosis.

When admission is not indicated, a notation must be made of the reason for not admitting the individual, and any referrals made to other programs or services. Admission criteria must conform to applicable state and federal law governing discrimination, and cannot exclude individuals because of past histories of incarceration or substance abuse.

The program's admission process must be available for review by participants, their families or significant others. Providers of service must not use coercion in regard to program admission or discharge, referral to other programs, or the level of service provision.

## **Staffing**

A PROS provider must continuously employ an adequate number and appropriate mix of clinical 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.

PROS providers must maintain an adequate and appropriate number of professional staff relative to the size of the clinical staff.

- A Comprehensive PROS provider will 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.
- A Limited License PROS program will be deemed to have met such standard if at least 20 percent of the total clinical staff FTEs are represented by professional staff.

For the purpose of calculating professional staff ratios, a provider may include staff credentialed by the International Association of Psychosocial Rehabilitation Services (IAPSRS) for up to 20 percent of the professional staffing requirements.

At least one of the members of the provider's professional staff must be a licensed practitioner of the healing arts, and must be employed on a full-time basis. IR services must be provided by, or under the direct supervision of, professional staff.

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

- For CRS, a ratio of one clinical staff member to every 12 individuals receiving CRS services.
- For IR, a ratio of one clinical staff member to every 8 individuals receiving IR services.
- For VS, a case load of no more than 22 individuals per clinical staff member.
- For Comprehensive PROS programs with Clinical Treatment, the following additional standards apply:
  - PROS staffing must include a minimum of .125 FTE psychiatrist and .125 FTE registered professional nurse for every 40 individuals receiving Clinical Treatment services.
  - Additional psychiatry, nursing and other staff must be included, as necessary, to meet the volume and clinical needs of persons receiving Clinical Treatment services.

If a PROS provider has recipient employees, they must be included in the provider's staffing plan. Recipient employees must adhere to the same requirements as other PROS staff, and must receive training regarding confidentiality requirements. Ongoing supervision of recipient employees must address, as necessary, boundary issues, transition between roles, and potential conflicts of interest.

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 must not be reflected in the PROS provider's staffing plan.

### **Individualized Recovery Planning**

The individualized recovery planning process must be carried out by, or under the direct supervision of, a member of the professional staff, and must be in collaboration with the individual and any persons the individual has identified for participation. This process

must address the differences in individuals' cognitive abilities and/or learning style, culture, gender, age and other issues which may impact service delivery.

The individualized recovery planning process must include, but not be limited to, the following activities:

- meetings between the individual and relevant others;
- identification and completion of any necessary screenings or assessments (for Comprehensive PROS programs, this must include a substance abuse screening);
- linkage and coordination activities with other service providers for the purpose of assessing plan progress;
- development of any advance directives, as desired by the individual, including the creation of a relapse prevention plan; and
- development of an Individualized Recovery Plan (IRP).

Each individual's IRP must include, at a minimum, the following:

- a statement of recovery goals and program participation objectives;
- the individualized course of action to be taken, including the identification of services to be provided, which must be for the purpose of promoting the individual's recovery goals;
- results of any assessments and screenings including identification of the individual's strengths and challenges related to program participation;
- descriptions and goals of any linkage and coordination activities with other service providers;
- criteria to determine when goals and objectives have been met;
- the identification of any collaterals who will assist in the person's recovery;
- any advance directives expressed by the individual, including a description of his or her wishes to be served in the event of a crisis;
- the recipient's signature; and
- the signature of the clinical staff member who prepared the IRP. If such person is not a member of the professional staff, the signature of the professional staff member supervising or participating in the IRP process must also be included. For persons receiving Clinical Treatment, the IRP must also include a physician's signature.

For individuals receiving IR, VS or Clinical Treatment, the IRP must identify, by program component, the specific services to be provided, as well as the associated needs, goals, expected duration and anticipated outcome for each service. For persons receiving treatment services from a licensed clinic, the IRP must include a description of how such services are integrated with the individual's IRP.

An initial IRP must be developed within 30 days of the individual's admission to the program. IRPs must be reviewed and updated, at a minimum, every six months. For individuals receiving IR or VS services, the IR or VS component of the IRP must be

reviewed, at a minimum, every three months. Reviews must occur more frequently, consistent with any significant events or changes in goals.

If a PROS participant is receiving PROS services from multiple PROS providers:

- the provider of CRS services is responsible for forwarding copies of the IRP and related updates to the provider of IR or VS services; and
- the provider of IR or VS services is responsible for developing an IR or VS plan, as a component of the IRP, which is consistent with the IRP developed by the CRS provider.

If a PROS participant receives PROS services from no more than one PROS provider, and receives only IR or VS services, the provider of IR or VS services shall be responsible for the completion, review and update of an IRP.

Progress notes must be completed at least every two weeks and must include, at a minimum, the following:

- identification of services and interventions received;
- a description of the progress made toward goals identified in the IRP; and
- identification of any necessary changes to the IRP and services related to such changes.

### **Case Records**

There must be a complete case record maintained for each person admitted to a PROS program. With appropriate consent, case records may include relevant history and assessment documents completed by other providers. The case record must include the following information:

- identifying information and history;
- pre-admission screening notes;
- mental illness diagnosis;
- assessment of the individual's psychiatric, physical, social, and psychiatric rehabilitation needs, and dated and signed records of all medications prescribed (for individuals receiving Clinical Treatment);
- assessment of the individual's social and psychiatric rehabilitation needs (for individuals receiving services in a Comprehensive PROS program without Clinical Treatment);
- vocational assessment (for individuals receiving IR or VS services);
- reports of any mental and physical diagnostic exams, assessments, tests and consultations;
- IRP and IRP reviews;
- record of service that identifies all on-site and off-site face-to-face contacts with the recipient and/or collaterals, the service(s) provided and the duration of each daily contact;

- dated progress notes;
- referrals to other programs and services;
- consent forms; and
- discharge plan and/or summary.

### **Organization and Administration**

The provider must identify a governing body which has 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.

The governing body is responsible for the following duties:

- to meet at least four times a year;
- to review, approve and maintain minutes of all official meetings;
- 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;
- to review the program's compliance with the terms and conditions of its operating certificate, applicable laws and regulations;
- 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;
- to develop a mechanism for PROS program participants, and any individuals they identify, to participate in the development and ongoing review of the IRP;
- to develop, approve, and periodically review and revise as appropriate, all programmatic and administrative policies and procedures. Examples of such policies and procedures relate to the following:
  - verification of employment history, references and qualifications of job applicants;
  - prohibition of discrimination;
  - prescription and administration of medication (when applicable);
  - confidentiality and retention of records;
  - admission and discharge criteria;
  - recipient grievance process; and
  - use of recipient employees.

Providers are responsible for the following administrative functions:

- reporting, investigation, review, monitoring and documentation of incidents;
- creation of an emergency evacuation plan;
- creation of a utilization review procedure to monitor the appropriateness of service provision;
- completion of an annual audit of the financial condition and accounts of the program performed by an independent, certified public accountant; and

- compliance with applicable data submission requirements of the New York Interagency Supported Employment Reporting System (NYISERS) (applicable to providers offering VS services).

The provider must establish mechanisms for:

- the meaningful participation of current or former recipients either through direct participation on the governing body, or through the creation of an advisory board;
- providing a notice of rights to each individual upon admission;
- priority access by individuals who are enrolled in an assisted outpatient treatment program; and
- promoting the competency of its workforce.

Comprehensive PROS programs must develop a plan for appropriately responding to individuals enrolled in the program who need assistance when the program is not in operation. Such plans for programs offering Clinical Treatment must include a mechanism to provide, or arrange for, face-to-face contact with individuals in need of assistance.

### **Provider Reimbursement**

Reimbursement will be made only for services provided, face-to-face, to individuals who:

- have been admitted to the PROS program or are in pre-admission status; or
- are collaterals, on behalf of persons who have been admitted to the PROS program or are in pre-admission status.

Pre-admission screening services are limited to the month preceding the month of admission, and the month of admission. If pre-admission screening services are provided in the month preceding the month of admission, reimbursement for such services will not exceed Level 1 of the Monthly Base Fee. A minimum of two hours of pre-admission screening services must be provided. If pre-admission screening services are provided during the month of admission, the hours associated with such services may be included in the total billable hours for all services provided by the program.

Reimbursement will be made only for:

- services identified in, and provided in accordance with, the individual's IRP; or
- pre-admission screening services; or
- crisis intervention services.

PROS programs will be reimbursed on a monthly case payment basis in accordance with the total number of hours of service provided to participants and collaterals in the specific program components. Programs will be reimbursed for a maximum of five hours per day per individual. All services provided must be for the purpose of promoting the achievement of the individual's recovery goals, must be consistent with the individual's

IRP, and must be representative of the services which the program is authorized to provide (as listed in the table on page 2). Although social and recreational activities may be used as a method or setting for the delivery of the above services, only the time associated with the delivery of such services will be reimbursed.

A PROS participant must receive at least two hours of PROS services per monthly bill. In aggregating periods of service to determine the monthly total, the minimum service period is 15 continuous minutes, unless otherwise noted. When available and appropriate, providers must maximize the use of funding from the Office of Vocational and Educational Services for Individuals with Disabilities.

A Comprehensive PROS program may bill for one monthly payment per individual, in accordance with the type, combination and frequency of service provided during the month. In instances where a Comprehensive PROS program provides IR or VS services to an individual, but CRS services are provided by another provider, the Comprehensive PROS provider may submit an IR-only or VS-only bill.

A Limited License PROS program may bill for one monthly payment, per individual, for either IR or VS services.

Reimbursement requirements for Comprehensive PROS program components are as follows:

Community Rehabilitation and Support:

- An individual must have received at least two hours of PROS services during the month.

Intensive Rehabilitation:

- An individual must have received at least six hours of any PROS component of service during the month. The total number of hours of service provided, and the related intensity, must be consistent with good clinical practice.
- Medicaid may reimburse for IR services for up to 50 percent of a provider's total number of CRS bills submitted annually. Medicaid reimbursement received by a provider for IR services in excess of the 50 percent limit will be recovered from the provider.

Vocational Support:

- Programs may only bill VS for individuals who work in an integrated competitive job for a minimum of 15 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 15 hours per week and have worked at least one week within the month for 15 hours qualify for reimbursement.
- A minimum of two face-to-face contacts per month must be provided. A minimum contact is 30 continuous minutes in duration.

### Clinical Treatment:

- Individuals receiving Clinical Treatment must have, at a minimum, one face-to-face contact with the psychiatrist on a quarterly basis, or more frequently as clinically appropriate.
- Clinical Treatment services may be reimbursed only when provided in association with the CRS component of service.

Reimbursement requirements for Limited License PROS programs are as follows:

- Services provided will be reimbursed through a monthly case payment for IR or VS.
- Programs may be reimbursed in a given month for either one monthly IR component or one monthly VS component per individual.
- To bill IR services in a given month, at least six hours of IR services must be provided.
- To bill VS services in a given month, a minimum of two face-to-face contacts must be provided, with each contact at least 30 continuous minutes in duration.

PROS programs may only bill VS for individuals who work in an integrated competitive job for a minimum of 15 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 15 hours per week and have worked at least one week within the month for 15 hours qualify for reimbursement.

If a recipient employee provides a clinical or non-clinical service within the PROS program:

- a bill may not be submitted on behalf of the recipient employee which includes the time in which he or she provided such service; and
- a bill may be submitted on behalf of the participants, other than the recipient employee, if an allowable clinical service was provided.

Individuals attending a PROS program may receive, in some instances, PROS services from other PROS providers, as well as other community-based mental health services from other mental health programs. (See Appendix 1 for a summary of the co-enrollment rules.)

### **Premises**

The provider must maintain premises which are adequate and appropriate for the safe and effective operation of the program in accordance with the following:

- Adequate space must be allocated for the number of persons served.
- Occupancy must not exceed the capacity stated in the program's operating certificate by more than 15 percent.
- There must be sufficient types and arrangements of spaces to provide individual and group activities, and there must be appropriate furnishings and equipment.

- Comprehensive PROS programs with Clinical Treatment must provide for controlled access to and maintenance of medication and supplies.
- There must be controlled access to and maintenance of records.
- The provider must be in compliance with local building codes.

### **Quality Improvement**

Providers must establish a process for collecting and analyzing data on program and individual outcomes, and a process for routinely using data for decision-making purposes.

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

- Each local governmental unit may decide the level of its participation in the oversight and evaluation of PROS programs. Such participation must include the development of provider agreements, which may include performance indicators.
- If a provider fails to substantially comply with any applicable performance indicators identified in a provider agreement, the provider must be notified in writing and given an opportunity to correct the problem. If the situation is not corrected within the specified time period, the provider may be subject to a withholding of up to 20 percent of its monthly Medicaid payment.
- In regard to performance indicators which are related to the outcome of individual usage of PROS services, no withholding of Medicaid revenue will occur earlier than the 12<sup>th</sup> month following the month in which the operating certificate was issued for that provider, or the 12<sup>th</sup> month following the effective date of the agreement, whichever is later.

### **Waivers**

Psychiatric coverage may be waived under the following circumstances:

- OMH may approve the use of a physician in lieu of a psychiatrist in circumstances where the program can demonstrate that a psychiatrist is unavailable to meet the requirement. Such physician must have specialized training or experience in the treatment of mental illness.
- If the above requirements cannot be met, OMH may approve a plan for the provision of an equivalent level of care which must 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, a registered professional nurse or a licensed social worker who is experienced in the treatment of adults with a diagnosis of mental illness.

### **Transition Period**

To allow a period of adjustment to co-enrollment limitations, the provisions related to the recovery of Medicaid will not become effective until three months after the issuance of the

provider's operating certificate. This exception does not apply to multiple providers operated by the same sponsor.

To allow a period of adjustment to the professional staffing requirements, staff employed by a provider at the time of its application for an operating certificate will be deemed to have met such requirements, subject to the following conditions:

- Such staffing plan must be described in the application for an operating certificate.
- Programs must employ at least one full-time professional staff member.
- When a staff member included in the staffing plan leaves the provider's employment, he or she must be replaced with an individual who will bring the program closer to compliance with the staffing requirements.

## APPENDIX 1

### CO-ENROLLMENT RULES

	<b>COMPREHENSIVE PROS</b>	<b>LIMITED LICENSE PROS</b>
<b>PROS</b>	Co-enrollment is permitted for unduplicated service components. IR and VS may not be provided in the same month. For multiple claims not allowed, the claim with the earlier processing date will be paid.	Co-enrollment is permitted for unduplicated service components. IR and VS may not be provided in the same month. For multiple claims not allowed, the claim with the earlier processing date will be paid.
<b>CLINIC</b>	Co-enrollment is permitted only if providers are not operated by the same sponsor and PROS Clinical Treatment is not billed. If Medicaid has paid for services not permitted, funds will be recovered from the PROS provider; up to \$140 (other than any supplemental funds) for services to other clinics and everything for clinics operated by the PROS sponsor.	Co-enrollment is permitted.
<b>CDT</b>	Co-enrollment is not permitted. If Medicaid has paid for services not permitted, funds paid to the CDT (other than supplemental funds) will be recovered from the PROS provider, up to the amount paid to the PROS provider.	Co-enrollment is permitted for providers which are not operated by the same sponsor. If Medicaid has paid for services not permitted, funds paid to the CDT (other than supplemental funds) will be recovered from the PROS provider, up to the amount paid to the PROS provider.
<b>PH</b>	Co-enrollment is permitted.	Co-enrollment is permitted.
<b>IPRT</b>	Co-enrollment is not permitted. If Medicaid has paid for services not permitted, funds paid to the IPRT will be recovered from the PROS provider, up to the amount paid to the PROS provider.	Co-enrollment is not permitted. If Medicaid has paid for services not permitted, funds paid to the IPRT will be recovered from the PROS provider, up to the amount paid to the PROS provider.
<b>ACT</b>	When approved by OMH, co-enrollment is permitted for up to 3 months in a 12-month period. A PROS provider may bill at Level 1, 2 or 3 of the PROS Monthly Base Fee for services without Clinical Treatment. An ACT provider may bill for the supportive or partial payment level of services. If Medicaid has paid for services not permitted, funds paid to the ACT provider will be recovered, up to the amount paid to the PROS provider.	Co-enrollment is not permitted. If Medicaid has paid for services not permitted, funds paid to the ACT provider will be recovered, up to the amount paid to the PROS provider.
<b>ICM/SCM</b>	Co-enrollment is permitted.	Co-enrollment is permitted.
<b>PMHP</b>	Co-enrollment is not permitted. If Medicaid has paid for services, funds paid to the PMHP will be recovered.	Co-enrollment is not permitted. If Medicaid has paid for services, funds paid to the PMHP will be recovered.

NOTE: When co-enrollment is permitted, services may be provided in each program on the same day.

## APPENDIX 2

### RATES OF PAYMENT

Rates of payment will be established on a prospective basis. Each rate of payment will be a monthly fee determined by the Commissioner and approved by the Division of the Budget.

The Downstate Region includes the following counties: Bronx, Kings, New York, Queens, Richmond, Nassau, Putnam, Rockland, Suffolk and Westchester. The Upstate Region includes those counties of New York State which are not included in the Downstate Region.

#### Comprehensive PROS programs:

Downstate Region:

	Monthly Base Fee*					Component Add-On	
	Level 1 2-12 Hrs.	Level 2 13-27 Hrs.	Level 3 28-43 Hrs.	Level 4 44-60 Hrs.	Level 5 61+ Hrs.	IR	VS
<b>Services without Clinical Treatment</b>	\$142	\$333	\$558	\$816	\$999	\$385	\$330
<b>Services with Clinical Treatment</b>	\$282	\$473	\$698	\$956	\$1139	\$385	\$330

Upstate Region:

	Monthly Base Fee*					Component Add-On	
	Level 1 2-12 Hrs.	Level 2 13-27 Hrs.	Level 3 28-43 Hrs.	Level 4 44-60 Hrs.	Level 5 61+ Hrs.	IR	VS
<b>Services without Clinical Treatment</b>	\$129	\$303	\$507	\$742	\$908	\$350	\$300
<b>Services with Clinical Treatment</b>	\$269	\$443	\$647	\$882	\$1048	\$350	\$300

\* The *Monthly Base Fee* is associated with the total of all Community Rehabilitation and Support, Intensive Rehabilitation, Vocational Support and Clinical Treatment service hours provided to a single PROS participant and his or her collateral(s) in a given month.

**Limited License PROS programs:**

Downstate Region:

<b>Reimbursement Category</b>	<b>Monthly Fee</b>
<b>Intensive Rehabilitation</b>	<b>\$440</b>
<b>Vocational Support</b>	<b>\$363</b>

Upstate Region:

<b>Reimbursement Category</b>	<b>Monthly Fee</b>
<b>Intensive Rehabilitation</b>	<b>\$400</b>
<b>Vocational Support</b>	<b>\$330</b>

## APPENDIX 3

### DEFINITIONS

#### **General Definitions:**

***Average Attendance*** means the number of individuals, on average, receiving services from an individual PROS provider at any given time.

***Capacity*** means a provider's approved average attendance.

***Collateral*** means a person who is:

- 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 condition; and
- identified in the IRP, 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
- not a staff member of the PROS program, or any other mental health service provider.

***Designated Mental Illness Diagnosis*** means a DSM-IV diagnosis other than: alcohol or drug disorders; developmental disabilities; organic brain syndromes; or social conditions.

***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.

***Off-site*** means any clinically appropriate location in the community, other than a PROS site, where an individual may require PROS services.

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

***Sponsor*** means the provider of service or an entity that substantially controls or has the ability to substantially control the provider of service. Factors used to determine whether there is substantial control shall include, but are not limited to, the following:

- the right to appoint and remove directors or officers;
- the right to approve bylaws or articles of incorporation;
- the right to approve strategic or financial plans for a provider of service; or
- the right to approve operating or capital budgets for a provider of service.

## **Service Definitions:**

Each of the following services, offered by PROS providers in accordance with their licensure category, are provided face-to-face.

**Assessment** is a service designed to identify an individual's primary psychiatric condition and co-occurring health conditions, and the effects on the individual's ability to function in specific life roles. This 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.

**Basic Living Skills Training** is a service designed to support an individual's functioning at a level of maximum independence within relevant community settings. The topics which may be covered include, but are not limited to, instruction on grooming and personal hygiene, nutrition, homemaking skills, building relationships, childcare, transportation, use of community resources, and support for engaging in social interactions.

**Benefits and Financial Management** is a service designed to support an individual's functioning in the community through understanding and skill in handling his or her 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.

**Clinical Counseling and Therapy** is a service designed to provide goal-oriented verbal counseling or therapy, including individual, group and family counseling or therapy, for the purpose of addressing the emotional, cognitive and behavioral symptoms of a mental health or co-occurring mental health and substance abuse disorder, and the related effects on role functioning. Such service may also include cognitive behavioral therapy.

**Community Living Exploration** is a service designed to assist individuals in determining the types of activities they would prefer to participate in within their communities. Topics may include, but are not limited to, options for satisfactory experiences with living environments, work or career opportunities, educational opportunities, and resources for use of leisure time.

**Crisis Intervention** is a service 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.

**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 in participating in program services.

**Family Psychoeducation** is a service designed to provide information, clinical guidance and support to collaterals, including individuals admitted to the PROS program when desired and appropriate, for the purpose of assisting and enhancing the capacity of a collateral to facilitate an individual's recovery. Such service includes, but is not limited to, education about mental illness and its treatment, information on community resources, guidance on how to manage or cope with difficult behaviors, emotional support and counseling, crisis planning, and problem-solving skills training.

**Health Assessment** is a service 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 physical health status and need for referral. The assessment of the data shall be done by a nurse practitioner, physician, physician's assistant, psychiatrist or registered professional nurse.

**Individual Recovery Planning** is a service designed to assist an individual in the ongoing development, review and modification of a course of care which supports his or her identified path to recovery. Such course of care is reflected in an Individualized Recovery Plan.

**Information and Education Regarding Self-Help** is a service designed to encourage individuals to participate in self-help and mutual aid groups. The service may be conducted by people who have common experiences and 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.

**Integrated Treatment for Co-Occurring Mental Health and Substance Abuse Disorders** is a service designed to simultaneously address the mental health and substance abuse needs of persons with co-occurring disorders. Such service includes, but is not limited to, motivational and harm reduction approaches, and promotion of cognitive-behavioral skills.

**Intensive Rehabilitation Goal Acquisition** is a service designed to assist an individual in identifying, attaining and retaining over time personally meaningful goals which help the person resume normal functioning in adult life roles. Examples of rehabilitation goals include returning to work or school, returning to adult care giving or parenting roles, resuming roles as a spouse or significant other, and resuming a role as a community volunteer.

**Intensive Relapse Prevention** is a service designed to address an exacerbation of acute symptoms, or manage existing symptoms which are not responsive to medication. This service involves the execution of a series of predetermined steps identified in the Individualized Recovery Plan.

**Medication Management** is a service 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 providing individuals with information concerning the effects, benefits, risks and possible side effects of a proposed course of medication.

***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.

***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. This service is often provided in structured “club-like” settings, such as a work-ordered day or an activity center format, where staff employ supportive counseling techniques to assist the individual in completion of essential tasks. Services may also be provided off-site.

***Vocational Support*** is a service designed to provide ongoing counseling, mentoring and advocacy for the purpose of sustaining an individual’s role in competitive, integrated employment.

***Wellness Self-Management*** (also known as Illness Management and Recovery) is a service 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:

- ***coping skills training*** which means teaching individuals strategies to address symptoms, manage stress and reduce exposure and vulnerability to stress;
- ***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;
- ***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;
- ***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;
- ***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
- ***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.

**Staffing Definitions:**

***Clinical Staff*** means all staff members, including any recipient employees, who provide services directly to individuals admitted to PROS programs or 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 OMH.

***Licensed Practitioner of the Healing Arts*** means the following persons, licensed by the New York State Education Department:

- nurse practitioner;
- physician;
- physician's assistant;
- psychiatrist;
- psychologist;
- registered professional nurse; and
- social worker.

***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 mental illness diagnosis, and includes the following:

- creative arts therapist
- credentialed alcoholism and substance abuse counselor
- nurse practitioner
- occupational therapist
- pastoral counselor
- physician
- physician's assistant
- psychiatrist
- psychologist
- registered professional nurse
- rehabilitation counselor
- social worker
- therapeutic recreation specialist
- other staff may be included as professional staff with the prior written approval of OMH,

when such individuals have specified training or experience in the care or treatment of individuals diagnosed with mental illness. Such staff may include, but is not limited to, persons who are registered or certified by the International Association of Psychosocial Rehabilitation Services.

***Recipient Employee*** means an individual who is financially compensated for providing clinical or non-clinical PROS services in the same program where the individual also receives PROS services.

## ATTACHMENT T-1B

### PROGRAMS ELIGIBLE FOR PROS LICENSES

<u>Program Type</u>	<u>Program Codes</u>
<b>Mandatory Conversion</b>	
Affirmative Business	2340
Assisted Competitive Employment (ACE)	1380
Client Worker	3340
Enclave in Industry	1340
Intensive Psychiatric Rehabilitation Treatment (IPRT)	2320
On Site Rehabilitation	0320
Ongoing Integrated Supported Employment (OISE)	4340
Psychosocial Club	0770
Supported Education	5340
Transitional Employment Program (TEP)	0380
<b>Optional Conversion</b>	
Continuing Day Treatment (CDT)	1310
Clinic*	2100

\* At this time, clinic programs are not eligible for a PROS license. However, it is expected that some existing clinic capacity may be converted to establish PROS with Clinical Treatment Programs.

## **ATTACHMENT T-1C**

### **PROS CASE EXAMPLE**

In New York State, quality recovery oriented services have evolved in various service environments, including clubhouses, comprehensive rehabilitation providers, hospitals, and speciality providers (e.g., employment services). The flexibility of the PROS license will allow various providers to build on the foundation and values of their organizations and improve on the effectiveness of their service. The license combines 10 service categories, eliminates artificial distinctions across funding and program budgeting rules, and eliminates the need to move consumers from one service setting to another.

The PROS reimbursement structure has been designed to support the comprehensive, flexible and individualized goals of the PROS license. Providers will bill based on monthly utilization for the basic rehabilitation and support services of a PROS (CRS services). For individuals who express an interest in working towards a specific goal (e.g., work, school, independent apartment) or need intensive services to stabilize symptoms, providers will receive additional reimbursement to deliver these focused, goal oriented services. Employment support reimbursement acknowledges the off-site nature of this support and reimburses based on off site contacts. If treatment is provided an additional case payment is offered to allow for varying intensity of clinical interventions across a program's population.

#### **Case Example**

A case example may be helpful in illustrating how the PROS license combines flexible service requirements and reimbursement approaches to assist consumers, families and providers in facilitating and supporting recovery over time.

James is a 27 year old man who lives with his parents and was diagnosed with schizophrenia five years ago. Since that time he has been admitted to psychiatric inpatient settings eight times and receives treatment in an outpatient clinical setting. He has not been able to work or go to school. He has had several contacts with the police for bizarre or disruptive behavior in public settings.

At the time of his last discharge from an inpatient setting he was referred to a comprehensive PROS program. An initial assessment determined that James felt isolated, was afraid to relate to others, wanted a focus for his life and wished that his recurring symptoms of hearing voices, paranoia, fear and anxiety could be brought under control. He visited the PROS program and agreed to give it a try, working on his interpersonal skills, problems with concentration and organization, and wellness management techniques. He became involved in club type activities and some social events.

The Individual Recovery Plan (IRP) reflected these basic recovery and stabilization goals. The services offered (from the list of PROS services) included assessment, individual recovery planning, basic living skills training, structured skill development and support, and wellness self-management. James also chose to get his treatment services at this PROS so he received

medication management too. (If this was a PROS that did not offer treatment then the program, with James' permission, would coordinate with his treatment provider). James attended the program 36 hours a month and the PROS billed at the third tier of reimbursement.

The program's psychiatrist recommended a trial on an atypical medication, and James agreed to it. Using science-based prescribing practices, the trial followed proper dose and duration standards to determine the effectiveness of the medication in stabilizing James' symptoms.

After eight months James had been hospitalized twice. Prior to the hospitalizations, as his symptoms became more acute, the stress and tension at home increased.

The PROS staff kept in touch with James while he was hospitalized and after discharge spent time with him to sort out ways to support him and stop the readmission cycles. He agreed to a meeting with his parents. The assessment showed James had trouble remembering to take his medication. When he did take it he still would hear voices, but at less intensity. His parents noticed when his symptoms began to increase but did not know what to do. After discussion, it was determined that James would begin to receive Intensive Rehabilitation Services (IR) for the goal of intensive symptom stabilization. Also, his parents and James would enroll in an evidence based family psycho-education group for a nine month period. The psychiatrist would review James' medication and work with him and his support team regarding the importance of taking the medication regularly.

James began to attend the PROS service more often and the provider billed at the fourth tier of reimbursement plus received the IR enhancement to cover the cost of family psycho-education, some individual and small group work around symptom management skills and made a few home visits to help James and his parents incorporate the learning into the home environment. Also, a relapse prevention plan was developed.

During this period James began to experience an exacerbation of symptoms. Between the wellness management skills he learned and the support skills his parents developed through family psycho-education these early signs were noticed and addressed, avoiding a relapse. The home environment became supportive rather than more stressful during periods of symptom exacerbation. Also, James and his family learned approaches to taking medication regularly.

With these skills and supports in place James' symptoms became stable. The IR level of service was terminated with the symptom stabilization goal achieved. James attended the PROS club-like service regularly, developing confidence, concentration, and interpersonal skills.

Two years later James started to express interest in a job and eventually moving to his own apartment. His Individual Rehabilitation Plan was reviewed. Community Living Exploration was added as a service under CRS and he was re-opened to IR services, this time for Intensive Rehabilitation Goal Acquisition. The intensive service helped him get a part time job (20 hours a week). Then the IR services were again terminated and the provider began billing for vocational support (VS) services because it was determined ongoing support at the workplace and in the community was critical for James to keep his job.

## **ATTACHMENT T-2**

### **INSTRUCTIONS FOR USE OF THE PROS COUNTY PLANNING MODEL TOOL**

#### **General Description of the Tool**

The enclosed PROS planning model tool has been developed for use by counties and providers. The express intent of the tool is to assist in establishing individual PROS budgets (revenues and expenses) for agency PROS programs. The tool also allows counties to roll up these agency budgets into county summaries (See Attachment P-4 for instructions on using the tool to create a county summary).

The tool utilizes CFR concepts for the development of revenue and expenditure data elements.

The tool has been created on multiple spreadsheets utilizing Excel. The package includes a summary data entry page (labeled "Model Sheet"), which is supported by additional spreadsheets that calculate revenue and expenses based on assumptions input by counties and provider agencies. The package also includes definitions of all the data elements utilized in the tool, as well as a crosswalk to the CFR.

#### **Accessing the Tool**

**IMPORTANT! THE TOOL MUST BE SAVED TO DESKTOP IN ORDER TO WORK PROPERLY.**

1. Insert disk in disk drive.
2. Double click on the AMy Computer@ icon on the desktop.
3. Open disk drive A.
4. Put cursor over ACounty PROS Fiscal Model.@ Left click on the file once and hold the click while dragging the file to the desktop. Another option is to right click on the file, select copy, then right click on the desktop and select paste.
5. On the computer screen desk top, there should now be an Excel file named ACounty PROS Fiscal Model.xls.@
6. Double click on this file to open.

#### **Saving and Printing the Spreadsheet**

1. Select the "Save As" icon at the top of the Excel window.
2. Choose a drive and file to save the edited spreadsheet to.

3. **Give the spreadsheet a unique name so that the current desktop spreadsheet is not overwritten and remains clean for future use.**
4. The spreadsheet is already formatted for printing.
5. Insert legal size paper in the printer.
6. Click on the print icon at the top of the Excel window.

### **Spreadsheet Format and Features**

1. All data entry is done on the Model Sheet. Other spreadsheets (Revenue, Expense) are visible and show the formulas associated with each cell, but are protected from data entry.
2. Key for the color coding of cells (visible only in the electronic format):  
  
Yellow B denotes a variable for data entry  
White B denotes a calculation  
Blue/Purple B denotes a calculation value brought from or sent to another spreadsheet  
Gray B denotes data value, hardcoded into spreadsheet  
Light Orange B used in supporting spreadsheets to denote a data entered variable taken from the Model spreadsheet.
3. Most cells in column A have a red triangle in the upper right hand corner. When the cursor is put on that spot, the cell definition appears on the user's screen. A complete set of definitions are also found in separate notes for each spreadsheet on tabs at the bottom of the screen (labeled Model notes, Revenue notes and Expense notes).
4. Columns D through AA enable a provider to test up to 24 scenarios for the development of PROS budgets. Insert a unique name for each scenario in cells D7 through AA7 (for a Comprehensive PROS) or D89 through AA89 (for a Limited License PROS). Utilize as many of these columns as needed to work through all of the possible scenarios. **The same column should not be used to model both a Comprehensive PROS program and a Limited License PROS program.**
5. Column AB totals data entered in columns D through AA. This total is intended to provide an agency with a financial overview if more than one PROS license is being requested.

**CAUTION:** If columns D through AA are used to model revenues and expenses based on individual existing programs (for example, a CDT, an IPRT, and an affirmative business) that will be combined to form one PROS, the total calculated in column AB will not accurately reflect the total revenues and expenses of the new licensed PROS, for the following reasons:

- § There may be duplication among the clients presently served in each of the existing components, which would inflate the total number served in the new PROS.
- § There are potential economies of scale in combining the component programs that will not be taken into account (e.g., redistribution of staff).
- § If the same individual is presently utilizing 10 hours of service in one component program and 20 hours in another, the total column will reflect this as two separate individuals, one to be billed at Level 1 and one to be billed at Level 2 (total revenue = \$475), when in reality the total column should reflect one individual billed at Level 3 (total revenue = \$558).

Therefore, it is imperative that another column on the spreadsheet be used to model the budget for the final, combined PROS program, based on refined assumptions about the new program=s configuration, capacity, utilization, staffing and other costs, rather than relying on the calculated totals in Column AB.

#### *Comprehensive PROS*

1. Rows 6 - 85 are used to calculate a budget for a Comprehensive PROS. Rows 11 - 52 are for the CRS/IR/VS service components and Rows 54 - 75 are for the optional Clinical Treatment component.
2. Various rows from 8 - 81 require data entry in order for the model to work. These rows are highlighted in yellow on the spreadsheet.
3. Rows 77 - 85 provide a summary of the budget for the PROS.

#### *Limited License PROS*

1. Rows 88 - 132 are used to calculate a budget for a Limited License PROS.
2. Various rows from 90 - 128 require data entry in order for the model to work.
3. These rows are highlighted in yellow on the spreadsheet.
4. Rows 124 - 132 provide a summary of the budget for the PROS.

### **Instructions for Completing the Model Sheet**

#### **Identification**

Cell B3: Enter the County/Borough name in which the PROS program will be located.

Cell B4: Indicate whether the county is considered to be Upstate (1) or Downstate (2) from a PROS rate perspective. Downstate includes: Nassau, Suffolk, the five boroughs of New York City, Westchester, Rockland and Putnam. Upstate includes all counties/boroughs not considered downstate.

Rows 8 (Comprehensive) and/or 90 (Limited): FOR THE COUNTY SUMMARY ONLY. Enter the county assigned control number (See Attachment P-4 for instructions).

Rows 9 (Comprehensive) and/or 91 (Limited): FOR THE COUNTY SUMMARY ONLY. Enter Yes or No, depending on whether or not this PROS will submit a PAR in Phase 1.

Row 10 (Comprehensive): Enter the appropriate capital add-on for any Article 28 hospital program converting to a PROS. This estimated capital add-on is found on the spreadsheet tab labeled AArticle 28 Capital Add-on@ at the bottom of the screen. The Revenue spreadsheet will add this capital add-on to the basic PROS fees.

### **Persons Served Monthly**

Rows 13, 14 (Comprehensive), 56 (Optional Clinical Treatment) and/or 93, 94, 100 & 101 (Limited): Enter the number (or % for row 56) of persons expected to be served in the particular PROS program/component in a month and the percentage of those individuals who are expected to be Medicaid eligible.

### **CRS, IR and VS Utilization Monthly**

Rows 17 - 21 (Comprehensive): Enter the CRS average utilization percentages for the number of persons expected to be served in a month by tier. The percentages spread across the 5 hourly tiers (2-12 hours, 13-25 hours, 26-41 hours, 42-60 hours and 61+ hours) must total 100%. Row 22 sums these percentages and Row 23 provides a caution if the sum does not equal 100%. **NOTE: Hours counted in the hourly tiers must be for services listed on page 2 of Attachment T-1A, and identified in a particular PROS client=s Individualized Recovery Plan (IRP).**

Row 26 (Comprehensive): Enter the average percentage of persons utilizing IR services in a month. Row 27 provides a caution if the percentage exceeds 50%.

Rows 28 (Comprehensive) and/or 97 (Limited): Enter the average number of IR hours/month expected to be utilized by persons served in the program.

Row 31 (Comprehensive): Enter the average percentage of persons utilizing VS services in a month.

### **Staffing Hours**

Rows 34 (Comprehensive) and/or 104 (Limited): Enter the number of hours the program is open per week.

Rows 35 (Comprehensive) and/or 105 (Limited): Enter the number of hours a full-time equivalent (FTE) employee works per day.

Rows 37 (Comprehensive) and/or 107 (Limited): Enter the number of direct care staff the provider will employ in the PROS.

Rows 61 & 62 (Optional Clinical Treatment): Enter the FTEs of nursing and psychiatry that will provide services in the PROS clinical treatment component.

### **Program Expenditures**

(In general, program expenditure data should be consistent with agency experience as captured in the CFR.)

Rows 40 (Comprehensive) and/or 110 (Limited): Enter the percentage of professional staff employed. Rows 41 and 111 calculate the percentage of non-professional staff based on the data entered in the rows above. Rows 42 and 112 caution the user if the professional percentage drops below 40% or 20% respectively (the professional staffing levels required in the PROS regulations.) These data are used to calculate staffing costs.

Rows 43 & 44 (Comprehensive) and/or 113 & 114 (Limited): Enter the average salaries for professional staff and other direct care staff.

Rows 45 - 48 (Comprehensive), 68 - 70 (Optional Clinical Treatment) and/or 115 - 118 (Limited): Enter the percentages of non-direct care costs attributable to program administration, fringe benefits, other than personal service and agency administration (For the Optional Clinical Treatment component this last value is taken from the entry in row 48, since it is assumed that the agency administration percentage is constant across all agency programs.) The CFR definitions associated with each of these categories have been included in the tab labeled ACFR definitions@ at the bottom of the screen.

Rows 49 & 50 (Comprehensive), 72 & 73 (Optional Clinical Treatment) and/or 119 & 120 (Limited): Enter the program expenses associated with equipment and property as defined in the CFR. Rows 52, 75 and 122 caution if the percentage of other expenses to operating expenses exceeds 25%.

Rows 66 & 67 (Optional Clinical Treatment): Enter the average salaries for nurses and psychiatrists.

### **Revenue**

Rows 79 - 81 (Comprehensive) and/or 126 - 128 (Limited): Enter any additional non-

Medicaid revenue received by the program. Refer to the CFR definitions associated with Third Party and VESID revenues, and aggregate all other revenue into Miscellaneous.

## ATTACHMENT T-3

### CFR 2000 SUPPORTING COST DATA FOR THE COUNTY PLANNING MODEL TOOL

The five attached reports provide a general summary of past administrative expenditures in programs eligible for PROS conversion (based on 2000 CFR submissions), to be used as a guide in developing PROS program budgets.

Information has been compiled for all mental health providers within a county that operate programs that are mandated to convert to PROS and/or CDTs. There is a detail report broken down by program within provider, and summary reports at the provider, countywide, regional and Statewide levels. The summary reports display the current ratios of seven categories of administrative expenditures across six categories of agencies (described under Column H below). The detail report also displays the data used to calculate the ratios.

Please note that because the 2000 CFR is the most recent finalized data set available there may be providers/programs that are identified in the County Fiscal Profile Spreadsheet (Attachment P-2) that did not file CFRs in 2000. Those providers/programs will not appear in these reports.

#### **DEFINITIONS**

The definitions in this section relate to the columns on the attached 2000 CFR Detail Data report. The summary reports extract and display columns P, T, W, Z, AB, AD, and AF from the Detail Data report.

Complete definitions of data elements identified below as “DATA” can be found in the Consolidated Fiscal Reporting (CFR) Manual and in the PROS Planning Model Tool tab labeled “CFR definitions.” Formulas for calculated fields are shown below.

#### **Column Letter**

- D Agency Code – DATA – The five-digit code assigned to the corporate organization that will operate the PROS.
- E Agency Name – DATA – The incorporated name of the corporate organization that will operate the PROS.
- F Program Code – DATA – The program code associated with the type of program operated consistent with codes defined in the CFR.
- G Program Description – DATA – The type of program operated using program names consistent with CFR definitions.

- H PROS Code – CALCULATION – This code sorts agencies in the reports into six categories:
- 1 – Agencies that operate any programs mandated to convert to PROS
  - 2 – Agencies that operate any CDT programs that also have programs mandated to convert to PROS
  - 3 – Agencies that operate any CDT programs that do not have programs mandated to convert to PROS
  - 4 – Agencies that operate a Clinic that also have programs mandated to convert to PROS
  - 5 – Agencies that operate a Clinic that also have CDT programs
  - 6 – Agencies that operate a Clinic that also have programs mandated to convert to PROS and have CDT programs
- I Direct Care FTEs – DATA – Includes Direct Care, Clinical and Production staff as defined in the CFR Manual.
- J Program Administration FTEs – DATA – Includes Support, Program Administration and LGU staff as defined in the CFR Manual.
- K Subtotal FTEs – CALCULATION – The sum of Direct Care and Program Administration FTEs.
- L Direct Care Salaries – DATA – Total salaries for Direct Care, Clinical and Production staff as defined in the CFR.
- M Direct Care Salaries/FTE – CALCULATION – The average Direct Care salary per FTE.
- N Program Administration Salaries – DATA – Total salaries for Support, Program Administration and LGU staff as defined in the CFR.
- O Program Administration Salaries/FTE – CALCULATION – The average Program Administration salary per FTE.
- P % Program Administration to Direct Care – Calculation – Program Administration expenses as a percent of Direct Care expenses.
- Q Subtotal Salaries – CALCULATION – The sum of Direct Care and Program Administration salaries.
- R Subtotal Salaries/FTE – CALCULATION – The average total staff salary per total FTE.
- S Fringe Benefits – DATA – The cost of all mandated and non-mandated employer contribution fringe benefits as defined in the CFR.
- T % Fringe to Salaries – CALCULATION – Fringes as a percent of Direct Care and Program Administration salaries.

- U Subtotal Salaries and Fringes – CALCULATION – The sum of salaries and fringes.
- V Other Than Personal Service (OTPS) – DATA – The sum of all expenses defined in the CFR as OTPS.
- W % OTPS to Salaries – CALCULATION – OTPS expenses as a percent of Direct Care and Program Administration salaries.
- X Subtotal Operating Expenses – CALCULATION – The sum of salaries, fringes and OTPS.
- Y Agency Administration – DATA – The cost of agency administration as calculated in the CFR using the ratio value factor.
- Z % Agency Administration to Operating Expenses – CALCULATION – Agency Administration expenses as a percent of Operating expenses.
- AA Equipment – DATA – The total of all equipment costs as defined in the CFR.
- AB % Equipment to Total Expenses – CALCULATION – Equipment costs as a percent of total expenses.
- AC Property – DATA – The total of all property costs as defined in the CFR.
- AD % Property to Total Expenses – CALCULATION – Property costs as a percent of total expenses.
- AE Subtotal Other Expenses – CALCULATION – The sum of Agency Administration, Equipment and Property.
- AF % Other Expenses to Total Expenses – CALCULATION – Other expenses as a percent of total expenses.
- AG Subtotal Non-Salary Expenses – CALCULATION – Sum of OTPS and Other expenses.
- AH Total Expenses – CALCULATION – Sum of Operating and Other expenses.

## ATTACHMENT T-5

### COUNTY MENTAL HEALTH PROGRAM SITE MAP

A map of the mental health programs in each county has been developed based on the 2000 Consolidated Fiscal Report (CFR). The map focuses on a single county while also displaying information for contiguous counties.

PROS mandatory and optional program sites are represented by colored dots (Note: C&Y Vocational programs are no longer considered PROS eligible, but were when the maps were printed). Each color represents a different program as outlined on the map's legend.

All Non-PROS mental health program sites are represented by black triangles.

In addition to the map, this attachment includes two lists of county mental health programs. The first list contains the names and addresses of programs that were reported on the 2000 CFR. All of these programs should be displayed on the map. The second list contains the names and, in some cases, addresses of programs that were added since 2000. These programs are not reflected on the map.

#### Limitations

There were limitations in the ability of the mapping software to show multiple program sites at the same address (the symbols would have overlapped each other). To overcome this shortcoming, addresses were incremented to allow a slight offset in the symbols.

If the site address was a PO Box or non-standard (e.g., "The County Office Building"), the mapping software located it in the center of a zip code. In this case, only one symbol is displayed even if there were multiple programs at that address.

#### Definitions

**Program Site** is a site (a specific address) that provides one mental health program.

**Program** is a set of services categorized by law, regulation or policy into a generic description, e.g., Clinic, Psychosocial Club, Case Management, Continuing Day Treatment. Programs can be located at one or more sites.

**Agency** is the entity that administers programs at program sites. An agency can operate one or more programs in one or more counties. The agency is not necessarily located at the same address as any program/site. Numerous agencies also provide services to other disabilities, or in the case of a general hospital, other medical services. The maps and related information focus only on mental health related services and locations.

**ATTACHMENT T-6**

**PROS SERVICES CHECKLIST**

COMPREHENSIVE PROS SERVICES	PROVIDER
<b>1. COMMUNITY REHABILITATION &amp; SUPPORT (CRS)</b>	
a) Assessment	
b) Basic Living Skills Training	
c) Benefits & Financial Management	
d) Community Living Exploration	
e) Crisis Intervention	
f) Engagement	
g) Individual Recovery Planning	
h) Information & Education Regarding Self-Help	
i) Structured Skill Development & Support	
j) Wellness Self-Management including:	
i. coping skills training	
ii. disability education	
iii. dual disorder education	
iv. medication education and self management	
v. problem-solving skills training	
vi. relapse prevention planning	
<b>2. INTENSIVE REHABILITATION (IR)</b>	
a) Family Psychoeducation	
b) Intensive Rehabilitation Goal Acquisition	
c) Intensive Relapse Prevention	
<b>3. VOCATIONAL SUPPORT (VS)</b>	
a) Vocational Support Services	
<b>4. WITH CLINICAL TREATMENT</b>	
a) Clinical Counseling and Therapy (CRS)	
b) Health Assessment (CRS)	
c) Medication Management (CRS)	

d) Integrated Treatment for Co-occurring MH/SA (IR)	
<b>LIMITED LICENSE PROS SERVICES</b>	<b>PROVIDER</b>
<b>1. INTENSIVE REHABILITATION (IR) AND VOCATIONAL SUPPORT (VS)</b>	
a) Intensive Rehabilitation Goal Acquisition (IR)	
b) Vocational Support Services (VS)	

## ATTACHMENT T-7

### PROS LOCAL SHARE AND OVERBURDEN EXPLANATION

#### Conceptual Description of Local Share Hold Harmless Associated with Conversion of IPRT and Net Deficit Funded CSP Programs to PROS

1. As Medicaid-funded IPRT programs and net deficit funded CSP programs convert to PROS, which will be funded by Medicaid, OMH will fund increases to the local share of Medicaid resulting from the implementation of this initiative. This hold harmless funding will be quantified on a county by county basis by calculating the full local share of Medicaid associated with this conversion and reducing it by 1) overburden that is already being paid for individuals in the IPRT and CSP programs above and 2) the currently required maintenance of effort utilized in the following programs:
  - **Local Assistance Regular:** One net-deficit funding stream utilized by programs converting to PROS is Local Assistance Regular, which currently requires a local dollar match to each dollar of State aid utilized to fund the program. As these State and local funds are converted to Medicaid, counties will be required to continue to make this local match available at commensurate levels.
  - **IPRT:** Counties will be required to fund the local share of Medicaid associated with existing IPRT expenditures at commensurate levels.
  
2. There are two mechanisms currently under consideration for reimbursing the counties for increases to the local share of Medicaid as a result of IPRT/CSP conversions to PROS. The Executive Budget included language which would allow for direct reimbursement to the Local Department of Social Services (LDSS) for the local share increase (Option #1). However, since the necessary statutory authority was omitted from the Enacted Budget, as a result of Legislative changes, it may be necessary to consider an administrative approach (Option #2). This would involve multiple steps and will also require a cooperative agreement between the county and the LDSS. After the enactment of the 2003-04 Budget, the Executive resubmitted the language allowing for direct reimbursement to the LDSS, but this is, once again, contingent on Legislative action.
  - **Option 1:** After each county's hold harmless total has been quantified, OMH will include this funding in its quarterly Medicaid transfer to DOH. DOH, in turn, will directly reimburse the LDSS the local share increase, thus holding the county harmless. The first transfer from OMH to DOH for the local share of Medicaid (with a county-specific supporting schedule) will be made six months after the conversion of a CSP or IPRT to PROS.
  - **Option 2:** After each county's hold harmless total has been quantified, OMH will reimburse this funding by making a direct payment to the Local Social Services

District (LSSD). The first hold harmless payment will be made six months after the conversion of a CSP or IPRT to PROS.

### **Effect of PROS on Overburden**

As existing CDT programs convert to the new PROS license, there will be a corresponding decrease in Overburden eligible individuals associated with high CDT utilization (45 CDT visits in a calendar quarter). To counteract this trend, OMH and DOH are developing an approach that will equate PROS high utilization criteria with the current 45-day CDT utilization criteria.

### **Net Effect of County Medicaid Relief Associated with PROS Implementation**

The sum of a county's previous average annual Overburden payment and the adjusted local share hold harmless (see number 1 above) associated with the county's approved CSP to PROS conversion plan is the maximum amount available to provide Medicaid relief to the county. OMH will implement a methodology which ensures that the amount of local share relief that each county receives from a combination of Overburden and PROS adjusted local share hold harmless does not exceed this maximum.

## ATTACHMENT T-8

### INCENTIVES FOR PROVIDERS OPTING TO CONVERT TO PROS DURING PHASE 1 OF IMPLEMENTATION

#### 1. Cash Flow and Potential Revenue Shortfall Relief

Early adopters of PROS will be assisted with cash flow and potential revenue shortfalls during the first year of operation utilizing the following approach:

- Providers with PROS-eligible CSP programs will be advanced four months of funding equal to their existing net deficit financing. They may retain and spend the first two months of the advance to address cash flow needs during the first two months of PROS operation caused by the two month Medicaid lag from date of service to date of payment. The third and fourth month of the advance may be used to offset any shortfalls in Medicaid reimbursement during the first year of operation, subject to the conditions below.
- Providers will be guaranteed 100% of their **existing net deficit funding** during the first year after licensing, if they:
  - actively facilitate the enrollment of Medicaid-eligible individuals into the Medicaid system
  - continue to provide at least the same volume of service
  - submit a legitimate Medicaid bill each month for every eligible individual
  - make every attempt to reconcile any rejected bills
  - achieve, through Medicaid billings, at least 70% of their existing net deficit financing
  - continue to maximize VESID revenues, if applicable.

#### 2. Start-up Funding

- Providers who currently do not have the capability for electronically billing Medicaid may request reimbursement for hardware, software, installation of equipment and training of staff.
- Providers who currently have the capability for electronically billing Medicaid may request reimbursement for software and training of staff only.
- In the PAR, providers will be required to describe the program's need for reimbursement of Medicaid billing development costs (i.e. costs incurred prior to program operation), including justification for all items requested. Reimbursement will be determined based on provider need and available funding. OMH's ability to reimburse start-up costs is contingent on the availability of appropriations.

### **3. Enhanced Technical Assistance**

Early adopters will be given the opportunity to receive enhanced technical assistance which could include:

- executive staff development in such areas as quality improvement, incident reporting, licensing compliance, policy manual requirements, and organizational change
- direct care staff development in such areas as clinical competencies in specific evidence-based practices (e.g., Wellness Self-Management, Family Psychoeducation, Integrated Dual Disorders Treatment), generic competencies for the implementation of evidence-based practices (e.g., program planning and implementation skills), medical record documentation, and utilization review
- participation in learning consortiums, specialty consultation for implementation of evidence-based practices, and opportunities to participate in select training programs.

**ATTACHMENT T-9**  
**TIME LINE FOR PHASE 1 OF PROS IMPLEMENTATION**

<b>ACTION</b>	<b>TIMEFRAME</b>	<b>TENTATIVE DATES</b>
<b>County Plans and PARs</b>		
County Planning Package Released		September 29, 2003
PAR Application Released	4 Weeks after the County Planning Package is released	October 27, 2003
County Plans Due	8 weeks from release of the County Planning Package	November 24, 2003
Review/Approve County Plans	2 weeks from receipt of plans	December 8, 2003
Begin Accepting Phase 1 PAR Applications	Upon approval of county plans	December 8, 2003
Phase 1 PAR Applications Deadline/End of Incentives Eligibility Window*	Acceptance of Phase 1 PARs will cease 12 weeks after county plans are due	February 16, 2004
PAR Application Review	Takes 50 - 75 days to review and submit PARs to the MH Services Council	January - April, 2004
MH Services Council Review	Usually scheduled for the first month after all PAR reviewer comments are received	January - May, 2004
Final Internal Approvals	Takes 10-20 days for sign-off by OMH Commissioner	January - July, 2004
Licenses Issued	After pre-operational review takes place	January - September, 2004
End of Phase 1 Incentives	12 months from date of provider's license	January - September, 2005
<b>Concurrent Actions</b>		
State Plan Amendment Submitted to CMS	Pending DOH approval to release	September 30, 2003
Regulations Released for Public Comment	As soon as possible	October 7, 2003
State Plan Amendment Approved	Can take between 3 and 12 months, but is anticipated to be completed in 4 months	January 1, 2004
Regulations Promulgated	Must be in place by the time PAR applications are approved	January 1, 2004

\* Providers may continue to submit PAR applications after this date, and be approved for a PROS license. However, applicants filing after the deadline will not be eligible for the Phase 1 incentives.

NOTE: Implementation Phase 2 (conversion of mandatory programs) is projected to begin no later than January 1, 2005.

## ATTACHMENT T-10

### REVIEW OF PHASE 1 OF PROS IMPLEMENTATION

OMH, in collaboration with the counties and providers participating in Phase 1 of PROS implementation, will collect and review information about the implementation experience and make refinements and changes to the PROS program and fiscal models as needed to help improve viability before beginning mandatory program conversions. The Phase 1 review will include:

- An analysis of the representativeness of the sample of programs electing to participate in Phase 1.
- A comparison between pre-PROS total funding levels for affected programs and post-PROS total revenues.
- An accounting at the individual provider level of how actual revenue compares to PAR revenue projections.
- An assessment of recipient satisfaction.

**It is anticipated that Implementation Phase 2 (conversion of mandatory programs) will begin no later than January 1, 2005.**