DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-01-16
Baltimore, Maryland 21244-1850

CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

Children and Adults Health Programs Group

MAR 2 8 2014

Nirav R. Shah, M.D.
Commissioner
New York State Department of Health
Corning Tower
Governor Nelson A. Rockefeller Empire State Plaza
Albany, NY 12237

Dear Dr. Shah:

This letter is in regards to your section 1115 demonstration, Partnership Plan (Project number 11-W-00114/2). The Centers for Medicare & Medicaid Services (CMS) has reviewed and approved a portion of your attachment to the Special Terms and Conditions (STC) that will serve as the Designated State Health Programs (DSHP) Claiming Protocol.

As a way to support the goals of the state's health systems transformation for its developmentally disabled population, New York may claim federal financial participation on certain state programs in order to assist the state in its health system transformation. As outlined in STC 66, details of program expenditures would be outlined in the attachment before receiving federal financial participation (FFP) for any claiming by the state. This attachment has been included in the STCs, which are enclosed with this letter. CMS is approving the DSHP Claiming Protocol for the following programs listed in STC 66:

Office for People with Developmental Disabilities
- Day Training
- Family Support Services (FSS)

Office of Mental Health
- Licensed Outpatient Programs
- Care Management
- Emergency Programs
- Rehabilitation Services
- Residential (Non-Treatment)
- Community Support Programs

Office of Alcohol and Substance Abuse Services
- Outpatient and Methadone Programs
- Prevention and Program Support Services

We look forward to following up with the state to complete the protocols for programs that remain under these remaining agencies and are committed to final approval of these documents on or before March 31, 2014.

For our records, written acceptance is needed within 30 days of the date of this letter. Please direct correspondence to your project officer, Ms. Jessica Woodard to the following address:

Centers for Medicare & Medicaid Services
Center for Medicaid and CHIP Services
7500 Security Boulevard
Mail-stop: S2-01-16
Baltimore, MD 21244-1850

Simultaneously, please include Region 2 Associate Regional Administrator on any correspondence to Mr. Michael Melendez:

Centers for Medicare & Medicaid Services
New York Regional Office
Division of Medicaid and Children's Health
26 Federal Plaza
New York, New York 10278
Telephone: (212) 616-2430
Email: Michael.Melendez@cms.hhs.gov

If you have any questions regarding this letter, or other questions regarding Partnership Plan please do not hesitate to contact me at (410) 786-9249 or Jessica.Woodard@cms.hhs.gov. We look forward to continuing to partner with you and your staff on the New York Partnership Plan demonstration.

Sincerely,

[redacted]

Diane T. Gerrits, Director
Division of State Demonstrations and Waivers

Cc: Eliot Fishman, Director, Children and Adults Health Programs Group
Michael Melendez, Associate Regional Administrator, CMS New York
Jessica Woodard, CMCS
Jason Helgerson, Medicaid Director, Office of Health Insurance Programs, New York State Department of Health

Appendix L

Reimbursement and Claiming Protocol for New York Designated State Health Programs Expenditures and Determination of Allowable DSHP Costs Per Waiver 11-W-00-0014/2

To support the goals of health system transformation, the State may claim Federal Financial Participation (FFP) for the State programs, subject to the a maximum capped amount of $250 million in FFP and restrictions, described in the Special Terms and Conditions (STCs) # 66 of New York's Partnership Plan Medicaid Section 1115 Demonstration Waiver #11-W-00-0014/2 for the Approval Period April 1, 2013 through March 31, 2014. STC # 66 Paragraph b requires the State to develop a CMS approved protocol for claiming Designated State Health Program (DSHP) expenditures. The State shall claim DSHP expenditures in accordance with the protocol set forth in this appendix up to the maximum capped amount of $250 million in FFP for the period April 1, 2013 through March 31, 2014.

The general claiming process applicable to all net deficit funded programs is set forth in Sections I through IV. Addition detail describing specific steps is in Section V (Net Deficit Program Details).

I. State Documentation of Expenditures for Net Deficit Funded Programs

Documentation provided by the State to CMS for quarterly DSHP expenditures will include the following:

- The agency;
- The program;
- Provider;
- Net deficit payment amount;
- Voucher/contract information;
- Provider costs; and
- Net adjusted deficits.

II. Off-Sets: In accordance with STC 66(b)(ii) DSHP expenditures submitted to CMS will not include payment for:

- Medicaid funded costs and other Federal aid;
- Room and board/IMD;

- Services to undocumented individuals;
- Research;
- Rent and utility subsidies to individuals;
- Forensics; and
- Other funding (e.g. insurance and local aid).

For each off-set the State will indicate the page, line and column reference from the consolidated fiscal report (CFR).

To assure DSHP expenditures do not include coverage of services to undocumented individuals, the State will reduce each service provider's reported program costs by 10 percent unless a more detailed accounting of actual costs for these individuals is provided that is acceptable to CMS.

III. Net Deficits Payments

New York may claim expenditures to purchase DSHP services furnished for the period April 1, 2013 through March 31, 2014. Expenditures for payments to service providers shall not exceed the lesser of (1) the full value of the actual net deficit payment or (2) the provider's reported adjusted net deficit. For each DSHP, service providers will have their revenues and expenses identified using New York's Consolidated Fiscal Reporting System. Under this system, each service provider is required to file a CFR to document expenses and revenues in a uniform process for each program they have contracted to provide. The CFR serves as the year end cost report and will be used to document provider deficits. Where applicable, New York will reduce each service provider's reported expenses to remove the cost of any applicable offset listed in Section II. Net deficits will be recomputed using the adjusted expenses to determine each providers adjusted net deficit.

Upon the availability of the Final CFR, the State will compare DSHP expenditures to each provider's reported adjusted net deficits. Based on this comparison, the State shall adjusts its claim as necessary to assure its does not include any payments that exceeded a service provider's adjusted net deficits. Federal share on any identified overpayments will be refunded by the State making an adjustment on the CMS-64 report by entering an amount in line 10(b) of the Summary Sheet.

All applicable CFRs used for claiming and final expenditure reconciliation (Final - Closeout) will have complied with New York State Consolidated Fiscal Reporting and Claiming Manual: Appendix AA – Audit Guidelines that mandate audited providers financial statements and CFRs be reasonably assured and free from material misstatement.

OASAS - By the definition of net deficit financing, OASAS funds are only used after all revenue sources (including Medicaid) are offset against the approved budget/expenses. In the programs OASAS is claiming under DSHP, there are no room and board costs for individuals and no research funds. The claim is based the net budget minus Federal SAPT Bloc Grant Funding used minus a 10 percent off-set for undocumented immigrants (unless a more detailed accounting of actual costs for these individuals is provided that is acceptable to CMS).

Interim Payments:

OASAS - Advance payments are made on a quarterly basis based on the Budget of Record at the time the payment is made. Within 1 year after the close of a contract year, the advance payments made are reconciled with actual approved costs as submitted in the CFR and future payments are adjusted accordingly.

OPWDD and OMH - Similar to OASAS, advance payments are made per the term of approved contract and reconciled based on the submission of the CFR with future payments adjusted if necessary.

IV. Documentation of State Expenditures for Designated State Health Programs

In claiming DSHP expenditures , New York State will provide CMS with a summary excel sheet by agency, program and provider in an orderly format so that CMS may review and test underlying supporting documentation as detailed in this Section.

A. For all eligible DSHPs claimed New York State will have available for CMS to test as desired behind each NYS DOH-4103 Claim:

   i. Direct control payment sheets for all providers
   ii. Identifying contract number, provider name & code (agency code?), budget period
   iii. Program
   iv. Voucher number
   v. Voucher amount
   vi. Total amount paid to date
   vii. State financial system voucher entry

B. At a timeframe of no less than nine months following receipt of the Final CFR, for the claiming year ending March 31, 2014 New York State will conduct a Final Analysis which will include the following for CMS to review as desired:

   i. For each contract, provider and eligible DSHP program claimed, electronic worksheets will be available and include the following:

1) Variance in amounts between the State's paid claim amount, against both actual expenditures and net deficit funding amount identified within the Final CFR.

2) Based on the Final CFR, a rollup of all programs, units of services provided and number of employees or full time equivalents (FTEs) per program.

NOTE: Since Supported Housing Rental Assistance (6050) and Supported Housing Community Services (6060) are considered one program upon closeout, there will be a discreet closeout presentation separating the program expenditures against the budgeted and paid amounts for each. The State will provide detail similar to subsection A of this section to ensure that no payment is made for this program.

Documentation of expenditures for each DSHP must be clearly outlined in the state's supporting work papers and be made available to CMS in accordance with this claiming protocol.

The State will use its voucher and accounting system to identify the amount it expended to purchase services from each service provider under each program during the period April 1, 2013 – March 31, 2014.

Statewide Financial System (SFS):

SFS is the State's accounting system, the 'book-of-record' for New York State. Each agency enters vouchers into SFS. The Office of the State Comptroller (OSC) reviews, approves and then processes the payments. The OSC process includes budget checks against appropriations/segregations to ensure appropriate authority for the expenditures has been provided by the NYS Division of the Budget through a certificate of approval process that is built into SFS.

OASAS enters vouchers individually by provider into SFS. Individual control sheets are manually maintained in excel to track payments by program components and make adjustments to the Budget of Record as needed.

OMH enters vouchers into SFS through a secure bulk-load file protocol. The bulk-load files create the commensurate entries into the SFS system to generate payments to providers/counties. Once approved and processed, the transaction information is then put into a pre-programmed extract file that is bulk-loaded into OMH's Aid to Localities Financial System (ALFS). Information from the file is loaded into ALFS populating all the relevant payment information into assigned data tables.

OPWDD utilizes the Statewide Financial System (SFS) to process contracts and vouchers for the review, approval and payment by the Office of the State Comptroller (OSC). When NYS transitioned to SFS, OPWDD established unique program codes within SFS for all programs to track expenditure patterns. SFS budget checks the transaction to insure sufficient resources

are available within the segregation/appropriation authority established through an approval process with the Division of the Budget and the State Comptroller.

Consolidated Fiscal Report (CFR):

The CFR is a uniform cost reporting platform which is required to be completed by all service providers/counties receiving funding.

The CFR is used as both a "year-end cost report" and a "year-end claiming document." The year-end cost report includes the Core schedules and Supplemental schedules which are used to set reimbursement rates and financial analysis of program costs. The cost reporting schedules are completed using a consistent reporting methodology in order for the data to be comparable between providers, regions and programs. The consistent methodology includes; using accrual accounting, including the depreciation of equipment and property, and using the ratio value method to allocate agency administration costs. The year-end claiming document includes the Consolidated Claim Report (CCR) which is used to report expenses and revenues for providers receiving State Aid funding through a direct contract with the State Agency and/or through a local contract with a county Local Government Unit (LGU). Providers are also required to file their program budgets utilizing the Consolidated Budget Report (CBR) portion of the CFR. The CBR is the same reporting platform and schedules found in the CFR.

The CFR represents the keystone of the fiscal monitoring processes by requiring the use of independent CPAs to perform comprehensive reviews of the providers' accounting records and to certify their financial reports. A "Full CFR" requires certification by an independent auditor and a copy of the providers' certified financial statements. Further, the certified CFR documents include detailed expenses (by program) to ensure that expenditures have actually been incurred and that they are accurate and related to the contracted program services.

Importantly, the CFR includes staffing reports for personal costs which represent the vast majority of the expenses for the provision of mental health services and, independent CPA's review provider's payroll and accounting records as part of the CFR submission process. While performing CFR Desk Audits, analysts may request that providers submit additional documentation including "other than personal service costs" where large dollar expenditures have been claimed in the CFR (e.g., equipment purchases) and they occasionally identify other significant concerns with the underlying operations of the provider (e.g., the potential misuse of government funds). In the case of the latter, any identified issues are immediately referred to the each agency's Bureau of Audit or the Counsel's Office for further investigation.

<u>OASAS Only Systems</u>

State Aid Auditing and Reporting System (SABRS):

For OASAS payments SABRS is used to maintain and update, as necessary, the Budget of Record (BOR). When quarterly or other payments are made, the latest BOR is reviewed by the Claims Unit to calculate the next payment due. These payment calculations are made manually via control sheets established for each provider breaking down the budget and project payment by each program type and funding source (State and/or Federal). It should be noted that OASAS utilizes mid-year claims for Calendar Year Providers & Counties.

OMH Only Systems

Aid to Localities Financial System (ALFS):
ALFS is an OMH budgeting, financial and contracting management system that tracks $1.3B from the development of the NYS Enacted Budget through the contract reconciliation process. ALFS tracks the authorization of over 100 funding streams for 113 program types that are operated by over 800 not-for-profit providers and all 62 NYS counties. The system provides Internal Controls through a variety of programmed "checks and balances" and there are user id and date/time stamps saved for every transaction in ALFS. Budgetary checks are hard coded into ALFS to ensure sufficient funds are available to make payments. ALFS also provides linkage to Spending Plan Guidelines via the OMH website which governs the allowable uses of State funds for various fund and program codes. Using ALFS has eliminated paperwork for central office, field office and county users with the system issuing electronic authorizations, payment information, county planning documents, and provider budget and claiming information.

ALFS interfaces with the following systems:

- IAMF (Interagency Master File)
- MHPD (Mental Health Provider Directory)
- CONCERTS (OMH Licensing database)
- CFRS (Consolidated Financial Report System); and
- SFS (Statewide Financial System) and OSC Master Vendor File (VendRep)

The County Allocation Tracker (CAT) is a budgeting function imbedded in ALFS and allows counties to file their budgets with the State electronically. These budgets must to conform to the funding level authorized for the County and are reviewed by OMH Field Office fiscal staff through a series of automated and manual budget checks. The budget checks are linked to the programmatic and fiscal requirements outlined in the Spending Plan Guidelines issued annually. Counties are allowed to revise their CAT allocations throughout the current fiscal year and OMH Field Office fiscal staff is required to review, run budget checks and approve the revised CAT. If a county fails to complete a CAT, they can be subjected to a withholding of their State Aid. Providers paid by counties directly are required to use the CBR which is submitted to the county. However, providers are still required to submit a CFR directly to the State through the CFR system. OMH uses the CAT to cross-check both reported county and provider spending submitted in the CFR against provider CBRs and county CATs.

V. Net Deficit Program Details

A. Office of Alcoholism and Substance Abuse Services

State Agency: Office of Alcoholism and Substance Abuse Services
Program Group: Outpatient and Methadone Programs
Program Codes:
Methadone-to-Abstinence (0605)
Methadone Maintenance (2050)
Keep Units (2150)
Outpatient Chemical Dependence for Youth (0140)
Medically Supervised Outpatient (3520)
Enhanced Medically Supervised Outpatient (3528)
Outpatient Rehabilitation Services (3530)
Funding Sources:
Mental Hygiene Program Fund
General Fund

For each program in this program group, the State will perform the following steps to determine the amount of the DSHP expenditure eligible.

1. Process to identify value of applicable offsets - The 10 percent undocumented immigrant off-set is applied (unless a more detailed accounting of actual costs for these individuals is provided that is acceptable to CMS) after the State's net deficit payment is calculated (Budget minus other revenue (including Medicaid) minus State payment using SAPT Bloc Grant funds.

2. Process to identify program net deficit payments - Budget minus other revenue (including Medicaid) minus State payment using SAPT Bloc Grant funds.

Brief Description:

Chemical dependence outpatient services assist individuals who suffer from chemical abuse or dependence and the family members and/or significant others. Outpatient services may be delivered at different levels of intensity responsive to the severity of the problems presented by the client and include medication assisted treatment such as methadone and buprenorphine. These services may be provided in a free standing setting, or may be co-located in a variety of other health and human service settings. Sponsorship may be voluntary, proprietary or county operated.

0140 - Outpatient Chemical Dependence for Youth - Such programs serve youth between the ages 12 and 1 8 by providing a drug-free setting supporting abstinence from alcohol and/or other substances of abuse. Active treatment is rendered through multi- disciplinary clinical

services designed to assist the youth in achieving and maintaining an abstinent lifestyle and to serve youth whose normal adolescent development, in one or more major life areas, has been impaired as a result of the use of alcohol and /or other substances by a parent or significant other.

0605 - Methadone-to-Abstinence – Outpatient Opioid treatment programs (OTPs) where medication assisted treatment is delivered on an ambulatory basis in gradually decreasing doses to the point of abstinence, followed by continued drug-free treatment.

2050 - Methadone Maintenance – Outpatient Opioid treatment programs (OTPs) where medication assisted treatment is delivered primarily on an ambulatory basis, with most programs located in either a community or hospital setting. Medication is administered daily at a stabilized dose over an extended period of time.

2150 - KEEP Units – Outpatient – Methadone Opioid treatment programs (OTPs) where medicated assisted treatment is delivered on an ambulatory basis. KEEP is an interim (not more than 180 days) protocol that provides intensive medical and support services in order to evaluate the long-term treatment needs of patients.

3520 & 3528 - Medically Supervised Outpatient & Enhanced Medically Supervised Outpatient - These programs assist individuals who suffer from chemical abuse or dependence and their family members and/or significant others through group and individual counseling; education about, orientation to, and opportunity for participation in, relevant and available self-help groups; alcohol and substance abuse disease awareness and relapse prevention; HIV and other communicable diseases, education, risk assessment, supportive counseling and referral; and family treatment. In addition, social and health care services, skill development in accessing community services, activity therapies, information and education about nutritional requirements, and vocational and educational evaluation must be available either directly or through written agreements. Procedures are provided according to an individualized assessment and treatment plan. This service mandates that medical staff be part of the multi-disciplinary team and the designation of a Medical Director, which provides for medical oversight and involvement in the provision of outpatient services. These services are Medicaid eligible providing other standards pertaining to fee-for-service Medicaid are met.

3530 - Outpatient Rehabilitation Services - This service level is designed to serve more chronic individuals who have inadequate support systems, and either have substantial deficits in functional skills or have health care needs requiring attention or monitoring by health care staff. These programs provide social and health care services, skill development in accessing community services, activity therapies, information and education about nutritional requirements, and vocational and educational evaluation. Clients initially receive these procedures five days a week for at least four hours per day. There is a richer staff to client ratio for these services compared to other outpatient levels and these services are required to have a half-time staff person qualified in providing recreation and/or occupation al services

as assistant or registered nurse. Like half-time nurse practitioner, physician medically supervised outpatient, outpatient rehabilitation services, mandate that medical staff be part of the multi-disciplinary team and the designation of a Medical Director, which provides for medical oversight and involvement in the provision of outpatient services. These services are Medicaid eligible providing other standards pertaining to fee-for-service Medicaid are met.

The length of stay and the intensity of services as measured by frequency and duration of visits vary from one category of outpatient services to another and intensity will vary during the course of treatment within a specific category. In general, persons are engaged in outpatient treatment up to a year and visits are more frequent earlier in the treatment process becoming less frequent as treatment progresses.

Eligible Population:

Individuals who come to the program are assessed as to whether the service is clinically appropriate. In the most recent year for which data is available, over 56,000 individuals were served in outpatient programs and over 10,000 in methadone programs. Any NYS resident is eligible with no income limitation. The universe of potential individuals is extrapolated from a Needs estimate based on geographic region which compares estimated need versus available capacity.

State Agency: Office of Alcoholism and Substance Abuse Services
Program Group: Prevention and Program Support Services
Program Codes:
Primary Prevention Services (5220)
Other Prevention Services (5550)
Funding Sources:
Mental Hygiene Program Fund
General Fund

Brief Description:

5520 – Primary Prevention Services - Primary Prevention is defined as a collaborative and community focused process to prevent or delay substance use and abuse in individuals, families and communities. Prevention service approaches include education, environmental strategies, community capacity building, positive alternatives and information dissemination. The selection of prevention service activities within these service approaches is based on a community needs assessment that identifies levels of substance use, its consequences, elevated risk factors and decreased protective factors. Prevention counseling and early intervention activities with individuals, families and groups are not included as Primary Prevention Services. Individuals who are diagnosable for substance abuse or dependence are not served with Primary Prevention Services.

5550 - Other Prevention Services- Other Prevention service approaches funded by OASAS

include Prevention Counseling and Early Intervention. Prevention Counseling is an OASAS certified service designed to assess and improve the levels of youth and family risk and protective factors to prevent or reduce substance use, problem gambling and the negative consequences of such behaviors. Prevention Counseling is offered to IOM selected youth who are considered at highest risk for developing substance abuse or gambling problems. Early intervention is offered to IOM Indicated individuals who have already begun to exhibit substance use or gambling behaviors but do not meet the DSM-IV criteria of substance abuse or dependence or problem gambling. Individuals may require referral for assessment and treatment with more intensive services.

These services are designed to improve individual and family risk and protective factors, while others target the community and school environment as a whole. Services include school-based classroom programs using multi-session curricula to increase family and youth understanding of the consequences of substance abuse, improve drug and other problem behavior attitudes and teach drug refusal and other social skills; strategies developed to target environmental factors to improve substance use regulations and policies, increase compliance with regulations and policies to reduce availability of alcohol, tobacco and other substances; and change social norms regarding substance abuse. The evidence-based models delivered by many OASAS providers have been estimated to reduce public costs by $8 to $56 for every $1 of program cost.

Eligible Population:

The majority of services under this program are geared towards school-aged individuals and their parents (guardians), although there are no eligibility requirements. In the most recent year for which data is available, over 460,000 participants received prevention services.

B. Office of Mental Health

For each program in this program group, the State must perform the following steps to determine the amount of the DSHP expenditure eligible for FFP under STC #66. The payments and associated claimed expenditures for the following programs must be commensurate with actual program service delivered.

For DSHP eligible expenditures related to services provided on behalf of the State by local providers and counties.

Step 1 – Identify all expenditures potentially eligible for DSHP claim in the Aid to Localities Financial System (ALFS) for the designated time period: State identifies all expenditures from the Office of Mental Health Aid to Localities Financial System (ALFS) that fall within the liability date period of April 1, 2013 through March 31, 2014 as required in STC# 66. These payments are initiated in the OMH ALFS, reviewed and approved by OMH staff at appropriate levels and bulk-loaded into the NYS Statewide Financial System (SFS). The NY State Office of the State Comptroller (OSC) has internal checks and

approvals built into SFS to ensure payments are authorized and conform to State appropriation authority at appropriate levels. Once reviewed, OSC releases payment to providers/counties. SFS and ALFS will be used to document actual payments to providers/counties for DSHP eligible services provided on behalf of the State and can be used to track State appropriation authority for the expenditures.

Step 2 – Collapse multiple payments (expenditure data) into single line for each provider and/or county and align/compare with the CBR/CAT budget data for each provider and/or county to facilitate offset of DSHP ineligible expenditures: State matches all payments made to providers and/or counties with the service provider budgets (Consolidated Budget Report within the Consolidated Fiscal Report for providers and the County Allocation Tracker (CAT) in the ALFS for counties) for the April 1, 2013 to March 31, 2014 time period to be later compared against actual expenditures reported on a prior year Consolidated Fiscal Report (CFR) (utilizing both main CFR claiming schedules: the DMH 2 CFR schedule displays the fund code specific detail portion of a claim and the DMH 3 CFR schedule displays the program summary level detail of a claim). The State utilizes program, fund and account codes from the SFS and ALFS to match disbursements with reported/budgeted expenditures on the CBR/CAT. (Separate table(s) that crosswalk SFS, ALFS, CFR, CBR and CAT coding (including program and fund codes) will be supplied as an attachment to the final claim submission. The tables will also indicate any other program code/fund code exclusions that are referenced in Steps below).

Step 2a—Compile CBR/CATS data for each provider/county identified in Step 2 and match up against prior year's provider/county CFR expenditure data compiled in Step 2: In order to determine the amount of the initial claim, the State compiles budgets (CBR and/or CAT) submitted by providers and/or counties identifying the specific program/fund codes for all CFR expenditures. All State identified prior year CFR expenditures are matched and verified by provider, program and fund codes to the CBR/CAT budgets for the April 1, 2013 to March 31, 2014 time period. NOTE: For Counties the CAT will serve as the summary reference, but prior year CFR claims data will be used as a proxy to determine allocation of funding across program and fund codes.

Step 2b – Compiled CBR/CAT budget data is adjusted to eliminate DSHP ineligible programs and services: Once the expenditure data has been matched and verified in Step 2a, the State offsets all non-eligible DSHP expenditures based on the provider/county submitted CBR/CAT budget as follows:

1) Medicaid and any other Federal funding (Medicaid expenditures are not in the disbursement data because NYS State Share is paid by the NYS Dept. of Health)

    a. (CBR, schedule DMH-2, lines 14-24);
    b. DMH-2, line 14: Participant Fees;
    c. DMH-2, line 15: SSI & SSA;

d. DMH-2, line 16: Home Relief/Public Assistance;
e. DMH-2, line 17: Medicaid;
f. DMH-2, line 18: Medicare;
g. DMH-2, line 19: Other Third Parties;
h. DMH-2, line 20: OPWDD Residential Room and Board/NYS OPTS (not relevant for OMH);
i. DMH-2, line 21: Transportation, Medicaid;
j. DMH-2, line 22: Transportation, Other;
k. DMH-2, line 23: Sales: Contract Total; and
l. DMH-2, line 24: Federal Grants.

2) Third Party revenue (CBR, schedule DMH-2, lines 29 and 48); DMH-2, line 29: Other Revenue; DMH-2, line 48: Non-Funded

3) Research (There is no local funding for research or research related programs)

4) Forensics (Fund Code 039J) reported on schedule DMH-3

5) Room & board (CBR, schedule DMH-2, line 28, by program code for residential programs); DMH-2, line 28: Net Deficit Funding

6) Rent & Utilities (There are no rent or utility subsidies to individuals outside of the 6050 and 6060 – Supported Housing Program)

7) Other Exclusions (identified by program and funding code combinations) that are not DSHP eligible. (Separate table(s) that crosswalk SFS, ALFS, CFR, CBR and CAT coding (including program and fund codes) will be supplied as an attachment to the final claim submission. The tables will also indicate all other program code/fund code exclusions that are not already referenced above).

8) Undocumented individuals – a 10 percent bottom-line reduction to account for undocumented individuals (unless a more detailed accounting of actual costs for these individuals is provided that is acceptable to CMS) per CMS' request.

Step 2c—OMH compiles all prior year CFR expenditure data for providers/counties identified in Step 1-2. OMH will claim the lesser of the CBR/CAT budgeted expenditure calculated from Steps 2a-2b OR the prior year's providers/counties CFR reported claim as calculated from Steps 2c – 2d below: State compiles certified CFR information found in the DMH-2 and DMH-3 CFR claiming schedules for all providers/Counties identified in Step 2A for the April 1, 2013 through March 31, 2014 time period consistent with STC# 66. All reported prior year CFR expenditures are matched and verified by provider, program and fund codes.

Step 2d – Compiled prior year's providers/counties CFR expenditure data from Step 2c is adjusted to eliminate DSHP ineligible programs and services: State offsets non-eligible DSHP expenditures from reported CFR expenditures as follows:

1) Medicaid and any other Federal funding (Medicaid expenditures are not in the disbursement data because NYS State Share is paid by the NYS Dept. of Health)

    a. (CBR, schedule DMH-2, lines 14-24);
    b. DMH-2, line 14: Participant Fees;
    c. DMH-2, line 15: SSI & SSA;
    d. DMH-2, line 16: Home Relief/Public Assistance;
    e. DMH-2, line 17: Medicaid;
    f. DMH-2, line 18: Medicare;
    g. DMH-2, line 19: Other Third Parties;
    h. DMH-2, line 20: OPWDD Residential Room and Board/NYS OPTS (not relevant for OMH);
    i. DMH-2, line 21: Transportation, Medicaid;
    j. DMH-2, line 22: Transportation, Other;
    k. DMH-2, line 23: Sales: Contract Total; and
    l. DMH-2, line 24: Federal Grants.

2) Third Party revenue (CBR, schedule DMH-2, lines 29 and 48); DMH-2, line 29: Other Revenue; DMH-2, line 48: Non-Funded

3) Research (There is no local funding for research or research related programs)

4) Forensics (Fund Code 039J) reported on schedule DMH-3

5) Room & board (CBR, schedule DMH-2, line 28, by program code for residential programs); DMH-2, line 28: Net Deficit Funding

6) Rent & Utilities (There are no rent or utility subsidies to individuals outside of the 6050 and 6060 – Supported Housing Program)

7) Other Exclusions (identified by program and funding code combinations) that are not DSHP eligible. (Separate table(s) that crosswalk SFS, ALFS, CFR, CBR and CAT coding (including program and fund codes) will be supplied as an attachment to the final claim submission. The tables will also indicate all other program code/fund code exclusions that are not already referenced above).

8) Undocumented individuals – a 10 percent bottom-line reduction to account for undocumented individuals (unless a more detailed accounting of actual costs for these individuals is provided that is acceptable to CMS) per CMS' request.

Step 2c—Compare adjusted CBR/CAT budgeted expenditures from 2a – 2b to adjusted prior year providers/counties CFR claims from Steps 2c -2d. OMH will claim the lesser of the calculated from Steps 2a-2b OR the prior year's providers/counties CFR reported claim as calculated from Steps 2c – d.

Step 3 – The state submits an initial claim for the adjusted CBR/CAT budgeted expenditures from Steps 2a-2b or the adjusted prior year's providers/counties CFR claim calculated in Step 2c-2d, whichever is less. The claim must be submitted in accordance with STC #66 and the individual DSHP program as allowed by Waiver 11-W-00-0014/2.

The State attests expenditures used are correct and verifiable as DSHP allowable. The State further attests state fund only funds expended per STC #66 are used for DSHP allowable program services. (Separate table(s) that crosswalk SFS, URC and Program coding will be provided as an attachment to the final claim submission).

Step 4 – Final analysis of submitted claims to determine DSHP eligibility and submission of an adjusted/final claim to CMS: No less than nine months following the receipt of the Final CFR, for the claiming year ending March 31, 2014, OMH will conduct a final analysis of the CFR claims submitted by the providers/counties identified in the initial claim.

Step 4a - OMH will compile final CFR expenditure data for all providers/counties included in the initial claim submitted to CMS as determined in Step 3.

Step 4b – Compiled final CFR expenditure data from Step 4a is adjusted to eliminate DSHP ineligible programs and services: State offsets non-eligible DSHP expenditures from reported CFR expenditures as follows:

1) Medicaid and any other Federal funding (Medicaid expenditures are not in the disbursement data because NYS State Share is paid by the NYS Dept. of Health)

    a. (CBR, schedule DMH-2, lines 14-24);
    b. DMH-2, line 14: Participant Fees;
    c. DMH-2, line 15: SSI & SSA;
    d. DMH-2, line 16: Home Relief/Public Assistance;
    e. DMH-2, line 17: Medicaid;
    f. DMH-2, line 18: Medicare;
    g. DMH-2, line 19: Other Third Parties;
    h. DMH-2, line 20: OPWDD Residential Room and Board/NYS OPTS (not relevant for OMH);
    i. DMH-2, line 21: Transportation, Medicaid;
    j. DMH-2, line 22: Transportation, Other;
    k. DMH-2, line 23: Sales: Contract Total; and

1. DMH-2, line 24: Federal Grants.

2) Third Party revenue (CBR, schedule DMH-2, lines 29 and 48); DMH-2, line 29: Other Revenue; DMH-2, line 48: Non-Funded

3) Research (There is no local funding for research or research related programs)

4) Forensics (Fund Code 039J) reported on schedule DMH-3

5) Room & board (CBR, schedule DMH-2, line 28, by program code for residential programs); DMH-2, line 28: Net Deficit Funding

6) Rent & Utilities (There are no rent or utility subsidies to individuals outside of the 6050 and 6060 – Supported Housing Program)

7) Other Exclusions (identified by program and funding code combinations) that are not DSHP eligible. (Separate table(s) that crosswalk SFS, ALFS, CFR, CBR and CAT coding (including program and fund codes) will be supplied as an attachment to the final claim submission. The tables will also indicate all other program code/fund code exclusions that are not already referenced above).

8) Undocumented individuals – a 10 percent bottom-line reduction to account for undocumented individuals (unless a more detailed accounting of actual costs for these individuals is provided that is acceptable to CMS) per CMS' request.

Step 4c— Compare initial Claim submitted to CMS (from Step 3) to final CFR claims compiled and adjusted for exclusions in Steps 4a-4c. State compiles the actual disbursements included in the initial claim (Step 3) by provider/locality from 4/1/13 through 3/31/14 and matches against the compiled CFR reported expenditures (after exclusions in Step 4b) for the same time period. State identifies the difference between the amount claimed for DSHP and the final certified CFR claim submitted by the provider. The State submits a final adjusted claim to CMS with agreed upon back-up materials.

OMH Source Data:

Statewide Financial System (SFS): is the State's accounting system, the 'book-of-record' for New York State. OMH enters vouchers into SFS through a secure bulk-load file protocol. The bulk-load files create the commensurate entries into the SFS system to generate payments to providers/counties.

Aid To Localities Financial System (ALFS): An OMH budgeting, financial and contracting management system that tracks $1.3B from the development of the NYS Enacted

Budget through the contract reconciliation process. Expenditures data is populated from bulk-load files received from SFS daily.

Consolidated Fiscal Report (CFR): The Consolidated Fiscal Report (CFR) is a uniform cost reporting platform which is required to be completed by all service providers/counties receiving OMH funding.

OMH Program Groups:

State Agency: Office of Mental Health
Program Group: Licensed Outpatient Programs
Program Codes:
Continuing Day Treatment (CDT) (1310)
Clinic Treatment (2100)
Clinic-Plus (0790)
Day Treatment services for children and adolescents (0200)
Partial Hospitalization (2200)
Intensive Psychiatric Rehabilitation and Treatment (IPRT) (2320)
Funding Sources: State Appropriations

Brief Description:

Outpatient funds are used to provide treatment designed to reduce symptoms, improve functioning and ensure ongoing support for individuals experiencing serious and persistent mental illness and ensure that their basic needs are met. This program has a focus on improving an individual's quality of life in the community and reducing the need for inpatient care through the provision of community based treatment services.

Some of the specific services provided by the Outpatient program include: (1) Continuing Day Treatment (CDT) (1310), which provides active treatment and rehabilitation designed to maintain or enhance current levels of functioning and skills, to maintain community living and to foster development of self-awareness and self-esteem; (2) Clinic Treatment (2100), which provides assessment and treatment planning, health screening and referral, discharge planning, verbal therapy, medication therapy, medication education, symptom management, and psychiatric rehabilitation readiness determination; (3) Clinic-Plus (0790), which represents an enhancement of traditional clinic services such that the Clinic-Plus programs adopt a public health approach which enables earlier identification of children with emotional disturbance as well as earlier intervention; (4) Child and Family Clinic-Plus Outreach and Screening Services, which takes a broad-based approach to identify children and adolescents with emotional disturbances and to intervene at the earliest possible opportunity; (4) Day Treatment services for children and adolescents(0200), which provide intensive, non-residential services, including a blend of mental health and special education provided in a fully integrated service; (5) Partial Hospitalization (2200), which provides treatment to stabilize and ameliorate acute symptoms, serve as an alternative to inpatient hospitalization,

and reduce the length of a hospital stay within a medically supervised program; and (6) Intensive Psychiatric Rehabilitation and Treatment (IPRT)(2320), which is designed to assist a patient in forming and achieving mutually agreed-upon goals in living, learning, working and social environments; to intervene with psychiatric rehabilitation technologies to overcome functional disabilities; and to improve environmental supports.

Eligible Population:

Programs serve adults and/or children diagnosed with a Serious Mental Illness or Serious Emotional Disturbance. In the most recent year for which data is available, the Outpatient program served approximately 111,200 clients, excluding Medicaid and Medicare clients.

State Agency: Office of Mental Health
Program Group: Care Management
Program Codes:
Intensive Case Management (ICM) (1810)
Supportive Case Management (SCM) (6810)
Blended Case Management (BCM) (0820)
Adult Home Case Management (6820)
Residential Treatment Facility (RTF) Transition Coordinators (2880)
Transition Management (TM) Services (1970)
Non-Medicaid Care Coordination activities (2720)
Funding Sources: State Appropriations

Brief Description:

Care Management funds are used to coordinate services for individuals experiencing serious and persistent mental illness and ensure that their basic needs are met. Care managers play a major role in identifying, engaging in services, advocating for, and helping clients to find their way through complex health care and social services systems; they also provide on-site crisis intervention and skills teaching when other services are not available. These services, which include some specialized care management for the elderly, are an essential support for many individuals currently living in community settings. Care management is aimed at linking the individuals to the service system and coordinating the various services necessary for successful outcomes. The objective of care management in a mental health system is continuity of care. Services provided may include linking, monitoring and case-specific advocacy.

Some of the specific services provided by the Care Management program include: (1) Health Home Care Management, which provides coordinated, comprehensive medical and behavioral health care to Medicaid-enrolled adults with chronic conditions through care management and integration that assures access to appropriate services, improves health outcomes, reduces preventable hospitalizations and emergency room visits, promotes use of health information technology (HIT), and avoids unnecessary care; (2) Intensive Case

Management (ICM) (1810), where case workers assist recipients to develop and maintain viable living, working and social situations in their communities through intensive interaction with the participants; (3) Supportive Case Management (SCM) (6810); which is a variant of the ICM program, is designed to provide services to individuals who require less support than provided under ICM; (4) Blended Case Management (BCM) (0820); which facilitates a team approach to case management services by combining the caseloads of multiple Intensive Case Managers and/or Supportive Case Managers; (4) Adult Home Case Management(6820), which promotes optimal health and wellness by implementing a person-centered approach to service delivery and ensuring linkages to and coordination of essential community resources; (5) Residential Treatment Facility (RTF) Transition Coordinators (2880), which exist within each RTF to ensure family engagement as well as timely, successful discharges of children and adolescents; (6) Transition Management (TM) Services(1970) (discharge planning); which provide support for improved community service linkages and timely filing of Medicaid applications for seriously and persistently mentally ill (SPMI) consumers being released from local correctional facilities; and (7) Non-Medicaid Care Coordination activities (2720), which are aimed at linking the consumer to the service system and at coordinating the various services in order to achieve a successful outcome.

Eligible Population:

Programs serve adults and/or children diagnosed with a Serious Mental Illness or Serious Emotional Disturbance. In the most recent year for which data is available, the Care Management program served approximately 25,200 clients, excluding Medicaid and Medicare clients.

State Agency: Office of Mental Health
Program Group: Emergency Programs
Program Codes:
Respite Services (0650)
Crisis intervention services (2680)
Crisis Residence (0910)
Crisis Respite Beds (1600)
Home-Based Crisis Intervention (HBCI) (3040)
Funding Sources: State Appropriations

Brief Description:

The Emergency program provides emergency safety net services for individuals with mental illness including crisis services, intervention and outreach. Funds support emergency safety net services for individuals who would otherwise be at risk of hospitalization or more costly Medicaid services requiring increased Federal Financial Participation, which is consistent with Olmstead. All programs serve individuals who are indigent, uninsured or underinsured. As the Medicaid portion of this program is largely budgeted within DOH, the OMH budget includes a higher proportion of non-Medicaid expenses.

Some of the specific services provided by the Emergency program include: (1) Comprehensive Psychiatric Emergency Program (CPEP); which is designed to directly provide or ensure the provision of a full range of psychiatric emergency services, including: crisis intervention, extended observation beds in the hospital, crisis outreach services, and crisis residence; (2) Respite Services (0650); which are temporary services (not beds) provided by trained staff in the consumer's place of residence or other temporary housing arrangement; (3) Crisis intervention services (2680); which provide screening, assessment, stabilization, triage, and/or referral to an appropriate program or programs; (4) Crisis Residence (0910), which is a licensed residential, 24 hours/day, time-limited stabilization service, which provides for acute symptom reduction and the restoration of an individual's condition to a pre-crisis level of functioning; (5) Crisis Respite Beds (1600), which are dedicated beds within a larger licensed service, which provide a homelike environment with room, board and supervision in cases where individuals must be removed temporarily from their usual residence; and (6) Home-Based Crisis Intervention (HBCI)(3040), which is a clinically oriented program with support services by a MSW or Psychiatric Consultant which provides short-term, intensive in-home crisis intervention services to a family in crisis due to the imminent risk of their child being admitted to a psychiatric hospital.

Eligible Population:

Programs serve adults and/or children diagnosed with a serious mental illness or serious emotional disturbance. In the most recent year for which data is available, the Emergency program served approximately 80,200 clients, excluding Medicaid and Medicare clients.

State Agency: Office of Mental Health
Program Group: Rehabilitation Services
Program Codes:
Personalized Recovery-Oriented Services (PROS) (9340)
Treatment Congregate (6070)
Treatment Apartment Based Residential Program (7070)
Children and Youth (C&Y) Community Residences (7050)
Teaching Family Homes (4040)
Funding Sources: State Appropriations

Brief Description:

The Rehabilitation Services program provides an array of services designed to promote the recovery of individuals with severe and persistent mental illness through the integration of treatment, support, and rehabilitation; with a focus on improving an individual's quality of life in the community and reducing the need for inpatient care through the provision of community based treatment services.

Some of the specific services provided by the Rehabilitation Services program include: (1) Personalized Recovery-Oriented Services (PROS) (9340), which is a comprehensive service which integrates treatment, support and rehabilitation in a manner that facilitates the individual's recovery, including improving functioning, reducing inpatient utilization, reducing emergency services, reducing contact with the criminal justice system, increasing employment, attaining higher levels of education and securing preferred housing; (2) Treatment Congregate (6070), which is a group-living designed residential program which focuses on intensive goal-oriented interventions necessary to address the specific functional and behavioral deficits which prevent residents from accessing generic housing; (3) Treatment Apartment based residential program(7070), which focuses on intensive goal-oriented interventions necessary to address the specific functional and behavioral deficits which prevent residents from accessing generic housing; (4) Children and Youth (C&Y) Community Residences(7050), which provide a supervised, therapeutic environment for six to eight children or adolescents, between the ages of 5 and 18 years, that includes structured daily living activities, problem solving skills development, a behavior management system and caring consistent adult interactions; and (5) Teaching Family Homes(4040), in which specially trained parents live and work with four children and youth with serious emotional disturbances in a home-like setting, where the teaching parents are responsible for the social education of the children and the implementation of a service plan developed in conjunction with the family and clinical service provider.

Eligible Population:

Programs serve adults and/or children diagnosed with a Serious Mental Illness or Serious Emotional Disturbance. In the most recent year for which data is available, the Rehabilitation Services program served approximately 500 clients, excluding Medicaid and Medicare clients.

State Agency: Office of Mental Health
Program Group: Residential (Non-Treatment)
Program Codes:
Congregate Support programs (6080)
Community Residence/Single-Room Occupancy (CR-SRO) programs (8050)
Supported/Single-Room Occupancy (SP-SRO) programs (5070)
Support Apartment programs (7080)
Supported Housing Community Services (6080, 6060, 6050)
Funding Sources: State Appropriations

Brief Description:

Some of the specific services provided by the Residential (Non-Treatment) program include: (1) Congregate Support programs (6080), which are single-site residential programs that provide support designed to improve or maintain an individual's ability to live as independently as possible and eventually access generic housing; (2) Community

Residence/Single-Room Occupancy (CR-SRO) programs (8050), which provide service-enriched, licensed, extended-stay housing with on-site services for individuals who want private living units, but who have minimal self-maintenance and socialization skills (3) Supported/Single-Room Occupancy (SP-SRO) programs (5070), which provide long-term or permanent housing in settings where residents can access the support services they require to live successfully in the community; (4) Support Apartment programs (7080), which provide support designed to improve or maintain an individual's ability to live as independently as possible, and eventually access generic housing; and (5) Supported Housing Community Services(6080, 6060, 6050), which assist individuals in locating and securing housing of their choice and in accessing the supports necessary to live successfully in the community through assistance with choosing housing, roommates, and furniture; providing financial assistance with purchasing apartment furnishings; assistance with resolving roommate or landlord issues; and linking residents to a comprehensive community support system of case management, mental health and general health supports.

Eligible Population:

Programs serve adults and/or children diagnosed with a serious mental illness or serious emotional disturbance. In the most recent year for which data is available, the Residential (Non-Treatment) program served approximately 9,400 clients, excluding Medicaid and Medicare clients.

State Agency: Office of Mental Health
Program Group: Community Support Programs
Program Codes:
Advocacy/support services (1760)
Psychosocial Club (0770)
Drop in Centers (1770)
Self-Help (2770)
Outreach services (0690)
On-site Rehabilitation (0320)
Multicultural Initiatives (3990)
Supported Education (5340)
MICA Networks (5990)
Geriatric Demo Gatekeeper (1410)
Geriatric Demo Physical Health-Mental Health Integration (1420)
Transportation (0670)
Recreation (0610)
Transitional Employment Placement (TEP) (0380)
Enclave in Industry (1340)
Assisted Competitive Employment (ACE) (1380)
Affirmative business/Industry (2340)
Work program (3340)
Ongoing Integrated Supported Employment Services (2340)

Family Support Services (1650)
School-based mental health (1510)
Coordinated Children's Services Initiative (CCSI) (2990)
Vocational and Educational Services (Children and Family) (1320)
Home-based family treatment (1980)
Homeless placement services (1960)
Recovery centers (2750)
Day Training (XX48)
Mobile Mental Health Teams (MMHTs) (XX86)
The Client Worker program (3429)
Funding Sources: State Appropriations

Brief Description:

The Community Support program includes a wide range of community mental health services, which provide services for individuals in community settings who are considered severely and persistently mentally ill. Funds support non-residential safety net services for individuals who would otherwise be at risk of out of home placement or hospitalization and increased Federal Financial Participation for more costly Medicaid services, which is consistent with Olmstead. The Community Support program provides treatment to help reduce symptoms, improve functioning, and provide ongoing support while maintaining adults in the community.

Some of the specific services provided by the Community Support program include: (1) Advocacy/support services (1760); (2) Psychosocial Club (0770); (3) Drop in Centers(1770); (4) Self-Help (2770); (5) Outreach services (0690); (6) On-site Rehabilitation (0320); (7) Multicultural Initiatives (3990); (8) Supported Education (5340); (9) MICA Networks(5990); (10) Geriatric Demo Gatekeeper(1410); (11) Geriatric Demo Physical Health-Mental Health Integration(1420); (12) Transportation (0670); (13) Recreation (0610); (14) Transitional Employment Placement (TEP) (0380); (15) Enclave in Industry (1340); (16) Assisted Competitive Employment (ACE) (1380); (17) Affirmative business/Industry (2340); (18) Work program (3340); (19) Ongoing Integrated Supported Employment Services(2340); (20) Family Support Services (1650); (21) School-based mental health (1510); (22) Coordinated Children's Services Initiative (CCSI) (2990); (23) Vocational and Educational Services (Children and Family) (1320); (24) Home-based family treatment (1980); (25) Homeless placement services (1960); (26) Recovery centers (2750); (27) Day Training (XX48); (28) Mobile Mental Health Teams (MMHTs) (XX86); and the (29) Client Worker program (3429). Program descriptions for listed programs are available in Appendix F of the New York State Consolidated Fiscal Reporting and Claiming Manual.

Eligible Population:

Programs serve adults and/or children diagnosed with a Serious Mental Illness or Serious Emotional Disturbance. In the most recent year for which data is available, the Community

Support program served approximately 121,400 clients, excluding Medicaid and Medicare clients.

C. Office for People with Developmental Disabilities

State Agency: Office for People with Developmental Disabilities
Program: Day Training
Program Code: 0330
Funding Sources: State Appropriations

Brief Description:

A program or planned combination of services provided to developmentally disabled persons whose level of disability is not so severe as to require more intensive services but whose functional behavior deficits limit their ability to function independently. The goal of day training programs is to provide program interventions that will assist developmentally disabled persons in the acquisitions of knowledge and skills that will enable them to improve their personal, social, and vocational skills and their ability to function independently. Day training also includes programs consisting of specialized developmental services that are operated with the goal of providing developmentally disabled persons with habilitation and social skills which will enable the individual to maintain gains made in other programs or to gain entry to a level of programming requiring more independent functioning such as supported employment or if possible, competitive employment.

Eligible Population:

Eligible individuals are those with developmental disabilities as defined by Mental Hygiene Law and who benefit from day training services consistent with their individual service plan.

State Agency: Office for People with Developmental Disabilities
Program: Family Support Services
Program Code: 0150
Funding Sources: State Appropriations

Brief Description:

The purpose of Family Support Services (FSS) is to enable families to provide in-home care to their family members with a developmental disability. Crisis intervention services help prevent emergency admissions to Medicaid-funded community homes or institutional facilities. Consistent with the *Olmstead* decision, these services also enable families to continue to care for a family member with a developmental disability in the least restrictive environment, at home. In addition to these critical services, FSS also provides non-Medicaid funded services, such as training to family members, information and referral services, support groups, recreation, transportation, and other in-home services for individuals with

and without Medicaid. These supports also help individuals to stay with their families and do so at a very modest cost of care compared to living in a Medicaid-funded community home.

Specific services available to FSS participants include:

- Behavior Management: Planned, systematic application of the methods and findings of behavior science with the intent of altering observable behaviors, including increasing, decreasing, extending, restricting, teaching and maintaining behaviors.

- Respite (Overnight/Day/Evening): These services provide the family with temporary relief from the care of a person with a developmental disability in order to permit the caregivers to be absent during overnight to conduct business, deal with an emergency or pursue a leisure activity. This service may be provided in or out of the home.

- Family Reimbursement/Cash Subsidy: Services and goods which are not funded through other sources can be purchased through family reimbursement or cash subsidy. For family reimbursement services, the family and provider agency or Developmental Disabilities Regional Office (DDSR) agree to a plan for purchase of services and goods, the family makes the purchase, provides a receipt and is reimbursed. For cash subsidy services, the family and provider agency or DDRO agree to a plan for purchase of services and goods and then the family is given a set amount of funding to make the purchase. After the services and goods are purchased, the family must provide receipts in order to receive additional family reimbursements or cash subsidy services.

- Other: At times a family or an individual may need a unique service, which is not included in the group of services listed, including:

    - Financial and Life Planning Assistance: Financial assistance services assist families in accessing necessary assistance from generic and OPWDD funding, benefits, entitlements, and other sources. Life planning assistance services assist a family to develop a plan, with input from the individual with a developmental disability, as possible, and with assistance from professionals, which will provide the family with some assurance about future life options available to the individual with a developmental disability and selection of these options.

    - Service Access Assistance: Contact with the individual, family member or primary care giver and service providers on a regular basis to assist with planning and accessing services and supports. Service access assistance can include assessment of service needs, planning and coordination, linkage and referral, follow-up, monitoring and advocacy.

- Free-Standing Respite: These services provide temporary room, board and supervision of an individual with a developmental disability in an out-of-home setting, or supervision in the natural home, when the family member or primary care giver is absent or needs relief.

- Counseling: Face-to-face, individual, group, or family counseling or therapy in a planned, structured session intended to help an individual or family gain insight, resolve problems, develop alternate behaviors or address other issues of concern. This includes counseling provided over the telephone with individuals or with their families.

- Training: Training and education activities offered to the parents, siblings and care givers, designed to augment or improve their knowledge of, and ability to promote the development of their family member, and to aid in their ability to care for their family member at home. Training in activities of daily living which enable individuals to increase their level of independence and improve the quality of their lives.

- Vacation/Day/Sleep Away Camp: Vacation is a scheduled period of time away from the daily routine usually spent on recreational and leisure activities. Camps are licensed through the Department of Health. Camps, usually operated in the summer, provide for the physical and social needs of campers and offer recreation and leisure activities.

- Recreation (Day/Evening): A planned program of social, recreational and leisure activities which are enjoyable and often include opportunities to interact with and participate as part of a community. Recreation offers children and adults the chance to play, experience good times, and identify and pursue activities in which they are interested. It promotes development of a wide range of skills and helps create balance and well-being.

- Home Care: Services provided by a Home Care Agency licensed through the Department of Health. Employment of a Home Care Agency staff person in an individual's place of residence to aid in carrying out housekeeping functions in order to assist the individual in reaching identified goals, offer assistance and relief to a caregiver or family member, or provide a temporary substitute for a care giver or family member.

- Information/Referral/Outreach: Information and referral services provide information on programs and services for individuals and their families. Linkages can be made to diagnostic, residential, habilitative, educational, vocational, medical, and recreational services, and to entitlement programs such as Medicaid SSI. Includes activities undertaken to ensure the individual's use of a service or acceptance in a program and may include accompanying the individual. Outreach services identify unserved or underserved individuals with developmental disabilities or their families who are eligible to use all appropriate services offered through OPWDD generic and specialized services delivery systems.

- Transportation: Provides an individual and/or family member with the proper mode of transportation to and from his/her residence and programs and services.

- Items Purchased, Rented or Leased:

  - Special Adaptive Equipment: Any item, product or piece of equipment that can be used by persons with disabilities to maintain or improve their functional abilities. Such equipment might include: bathtub lifts, transfer boards, modified eating utensils, communication devices, adapted toys or accessible vans. Includes assistive technology services to help a person know about, acquire and use the appropriate adaptive equipment, e.g., demonstration, assessment, funding, training, maintenance, and repairs.

  - Environmental Modification: Environmental modification services provide assistance to families with the removal of barriers which limit accessibility and remodeling to enhance the independent or assisted functioning of individuals with developmental disabilities within their home. Such services include the installation of ramps, lifts or grab bars, widening of doorways, kitchen and bathroom cabinetwork, and counter or appliance changes (e.g., special sink handles).

  - Supplies: Can include the following:

    - Medication expenses such as cost of prescription and nonprescription substances which are necessary as a result of the individual's disability. Must have a receipt from the pharmacy. (Note: For those eligible, costs of prescription drugs are reimbursable through Medicaid.)

    - Continence products (e.g., diapers, wipes): products generally of a disposable nature, used to assist in caring for the individual, who, due to the disability, has a continence problem. Examples include diapers, wipes, chucks, draw sheets, and other bed linens. Must have a receipt of purchase.

    - Special clothing: the cost for extra clothing required for an individual with night time incontinence, or for an individual whose garments wear out quickly due to abnormal movement patterns resulting from a disability. Can include specially designed clothing for individuals with physical disabilities, and medically prescribed articles for which other funding is not available (e.g., orthopedic shoes, helmets for head protection). Must have a receipt of purchase.

    - Special dietary needs: food and supplements cost for special diets prescribed by a physician. The need for dietary supplements must be directly related to the individual's disability and must not be reimbursable through other funding sources. Must have a receipt of purchase.

- Other: There are a number of supply items needed to properly maintain persons with disabilities but are too numerous and varied to categorize. These items might include things such as batteries, program supplies, or other items reasonably related to the care of the family member with a disability. Must have a receipt of purchase.

Eligible Population:

Eligible individuals are those with developmental disabilities as defined by Mental Hygiene Law and who live in a home environment with their primary caregiver(s). Supports and services are provided to children and families caring for a child or adult family member with developmental disabilities in an effort to maintain the family member at home and strengthen the family's care giving capacity.