

Rate Rationalization for Community Residences (CRs) / Individualized Residential Alternatives (IRAs) Habilitation and Day Habilitation

Effective date: 7/1/14

**SUMMARY OF EXPRESS TERMS**

This regulation establishes a new reimbursement methodology for Supervised and Supportive Community Residences (including Individualized Residential Alternatives) and Day Habilitation programs which will be effective July 1, 2014.

The methodology for these programs will include the following elements:

- 1) The use of a base period Consolidated Fiscal Report (CFR) for the period of January 1, 2011 – December 31, 2011 for calendar year filers or the period of July 1, 2010 through June 30, 2011 for fiscal year filers.
- 2) The assignment of geographic location, based on CFR information and consistent with Department of Health regions.
- 3) Operating, facility and capital components. The operating component recognizes a blend of actual provider costs and average regional costs. The facility component recognizes actual provider costs. The methodology for the capital component has not been significantly changed from that of the previous reimbursement methodology. One adjustment to the methodology for the capital component is that initial reimbursement will only remain in the rate for two years from the date of site certification unless actual costs are verified with the Office for People with

Developmental Disabilities. The other adjustment to the methodology is that the thresholds identified are the maximum allowable amounts and will not be exceeded.

- 4) Wage Equalization factors.
- 5) A Budget Neutrality factor.
- 6) A three year phase-in period for transition to the methodology.

For Supervised and Supportive Community Residences (including IRAs) only, the methodology will include:

An acuity factor developed through a regression analysis and based on Developmental Disabilities Profile information.

For Supervised Community Residences (including IRAs) only, the methodology will incorporate:

- 1) A change in the unit of service from monthly to daily. Commensurate with that change, the methodology will recognize retainer days, therapeutic leave days and vacant bed days.
- 2) The recognition of an evacuation score factor.

For Day Habilitation programs only, the methodology will include:

The recognition of actual provider to-from transportation costs.

Pursuant to the authority vested in the Commissioner of Health by section 363-a of the Social Services Law (SSL) and section 201(1)(v) of the Public Health Law (PHL), Subpart 86-10 of Title 10 of the Official Compilation of Codes, Rules and Regulations of the State of New York is hereby added, to be effective July 1, 2014 and upon publication of a Notice of Adoption in the New York State Register to read as follows:

86-10. Rates for Non-State Providers of Residential Habilitation in Community Residences, Including Individualized Residential Alternatives (IRAs) and for Non-State Providers of Day Habilitation.

86-10.1. Applicability. On and after July first, two thousand fourteen, rates of reimbursement for residential habilitation services provided in community residences, including IRAs, and for day habilitation services, other than those provided by the Office for People with Developmental Disabilities, shall be determined in accordance with this Subpart.

86-10.2. Definitions. As used in this Subpart, the following terms shall have the following meanings:

(a) Allowable capital costs. Capital costs that are allowable under 14 NYCRR Subpart 635-6.

(b) Allowable operating costs. In the case of residential habilitation services, operating costs that are allowable under 14 NYCRR sections 635-10.4 (b)(1) and 686.13(b); in the case of day habilitation services, operating costs that are allowable under 14 NYCRR section 635-10.4(b)(2).

(c) Acuity factor. Factor developed through a regression analysis utilizing components of Developmental Disabilities Profile (DDP) scores, average residential bed size, Willowbrook

class indicators and historical utilization data to predict direct care hours needed to serve individuals.

(d) Base year. The consolidated fiscal report period from which the initial period rate will be calculated. Such period shall be January first, two thousand eleven through December thirty-first, two thousand eleven for providers reporting on a calendar year basis and July first, two thousand ten through June thirtieth, two thousand eleven for providers reporting on a fiscal year basis.

(e) Base operating rate. Reimbursement amount calculated by dividing annual reimbursement by applicable annual units of service, both in effect on June thirtieth, two thousand fourteen.

(f) Community residence. A facility operated as a community residence under 14 NYCRR Part 686, including an individualized residential alternative.

(g) Day habilitation services. Day habilitation services provided under the home and community based services waiver operated by OPWDD and pursuant to 14 NYCRR Subpart 635-10.

(h) Department of Health (DOH) Regions. Regions as defined by the Department, assigned to providers based upon the geographic location of the provider's headquarters as reported on the consolidated fiscal report. Such regions are as follows:

- (1) Downstate: 5 boroughs of New York City, Nassau, Suffolk and Westchester;
- (2) Hudson Valley: Dutchess, Orange, Putnam, Rockland, Sullivan, Ulster;
- (3) Upstate Metro: Albany, Erie, Fulton, Genesee, Madison, Monroe, Montgomery, Niagara, Onondaga, Orleans, Rensselaer, Saratoga, Schenectady, Warren, Washington, Wyoming;

(4) Upstate Non-Metro: Any counties not listed in subparagraphs (1), (2) or (3) of this paragraph.

(i) Developmental Disabilities Profile (DDP). The document titled Developmental Disabilities Profile and issued by OPWDD.

(j) Evacuation Score (E-Score). The score for a supervised community residence that is certified under Chapters 32 or 33 of the Residential Board and Care Occupancies of the NFPA 101 Life Safety Code (2000 edition) that is provided to the Department by OPWDD once a year. The Life Safety Code is available from the National Fire Protection Association, One Batterymarch Park, Quincy, MA 02169-7471; or is available during business hours and by appointment at the following locations:

(1) the Department of State, Division of Administrative Rules, One Commerce Plaza, 99 Washington Avenue, Albany, NY 12231-0001

(2) OPWDD, Attention Public Access Officer, 44 Holland Avenue, Albany, NY 12229.

(k) E-Score Factor. Factor derived from analysis of Evacuation Scores to adjust staffing needs necessary to address health and safety needs.

(l) Financing expenditures. Interest expense and fees charged for financing of costs related to the purchase/acquisition, alteration, construction, rehabilitation and/or renovation of real property.

(m) Individual. Person receiving a residential or day habilitation service.

(n) Initial period. July first, two thousand fourteen through December thirty-first, two thousand fourteen for providers reporting on a calendar year basis or July first, two thousand fourteen through June thirtieth, two thousand fifteen for providers reporting on a fiscal year basis.

(o) Lease/rental and ancillary payments. A provider's annual rental payments for real property and ancillary outlays associated with the property such as utilities and maintenance.

(p) Occupancy factor. Beginning July first, two thousand fifteen such factor will be an adjustment made prospectively at the beginning of the applicable rate year, based upon the previous years' experience. Such adjustment shall be provider specific and shall be the lower of the provider's actual vacancy or five percent.

(q) Operating costs. Provider costs related to the provision of day habilitation and residential habilitation services provided in a community residence and identified in such provider's cost reports. With the exception of Live-In Caregiver services, allowable operating costs shall not include the costs of board.

(r) Provider. An individual, corporation, partnership or other organization to which OPWDD has issued an operating certificate pursuant to Article 16 of the Mental Hygiene Law to operate a community residence, and for which the NYS Department of Health has issued a Medicaid provider agreement, or an individual, corporation, partnership or other organization to which OPWDD has issued an operating certificate pursuant to article 16 of the Mental Hygiene Law or approval to operate a day habilitation program, and for which the NYS Department of Health has issued a Medicaid provider agreement.

(s) Rate sheet capacity. The number of individuals for whom a provider is certified or approved by OPWDD to provide residential habilitation.

(t) Reimbursable cost. The final allowable costs of the rate year after all audit and/or adjustments are made. Reimbursable cost will be reduced by any rent and other charges as described in 14 NYCRR 671.7.

(u) Residential habilitation. Residential habilitation services provided in a community residence, under the home and community based services waiver operated by OPWDD and pursuant to 14 NYCRR Subpart 635-10.

(v) Room and board. Room means hotel or shelter type expenses including all property related costs such as rental or depreciation related to the purchase of real estate and furnishings; maintenance, utilities and related administrative services. Board means three meals a day or any other full nutritional regimen.

(w) Target rate. The final rate in effect at the end of the transition period for each waiver service determined using the rate year final reimbursable cost for each respective provider for each respective service divided by the final total of actual units of service for all individuals, regardless of payor.

(x) Units of service. The unit of measure for the following waiver services shall be:

- (1) Residential habilitation provided in a supervised community residence - daily
- (2) Residential habilitation provided in a supportive community residence - monthly
- (3) Day habilitation - daily

#### 86-10.3. Rates for residential habilitation services and for day habilitation services.

(a) There shall be one provider-wide rate for each provider of residential habilitation service and one provider-wide rate for each provider of day habilitation services, except that rates for residential habilitation or day habilitation services provided to individuals identified as specialized populations by OPWDD shall not be determined under this Subpart.

Adjustments may be made to the rate resulting from any final audit findings or reviews.

(b) Rates shall be computed on the basis of a full twelve month base year CFR, adjusted in accordance with the methodology as provided in this section. The rate shall include

operating cost components, facility cost components and capital cost components as identified in applicable subdivisions. Such base year may be updated periodically, as determined by the Department.

(c) Rates for residential habilitation provided in supervised community residences.

(1) Operating component. The operating component shall be based on allowable operating costs identified in the consolidated fiscal reports. The operating component shall be inclusive of the following components:

(i) Regional average direct care wage, which shall mean the quotient of base year salaried direct care dollars for each provider in a DOH region, aggregated for all such providers in such region, for all residential habilitation-supervised IRA, residential habilitation-supportive IRA, day habilitation services and intermediate care facility for the developmentally disabled services (ICF/DD), divided by base year salaried direct care hours for each provider in a DOH region, aggregated for all such providers in such region, for all residential habilitation-supervised IRA, residential habilitation-supportive IRA, day habilitation services and ICF/DD services.

(ii) Regional average employee-related component, which shall mean the sum of vacation leave accruals and total fringe benefits for the base year for each provider of a DOH region, aggregated for all such providers in such region, such sum to be divided by base year salaried direct care dollars for each provider of a DOH region, aggregated for all such providers in such region, and then multiplied by the applicable regional average direct care wage as determined by subparagraph (i) of this paragraph.

(iii) Regional average program support component, which shall mean the sum of transportation related-participant staff travel, participant incidentals, expensed adaptive equipment, sub-contract raw materials, participant wages-non-contract, participant wages-contract, participant fringe benefits, staff development, supplies and materials-non-household, other-OTPS, lease/rental vehicle, depreciation-vehicle, interest-vehicle, other-equipment, other than to/from transportation allocation, salaried support dollars (excluding housekeeping and maintenance staff) and salaried program administration dollars for the base year for each provider of a DOH region, aggregated by all such providers in such region. Such sum shall be divided by the total base year salaried direct dollars of all providers in a DOH region, and then multiplied by the applicable regional average direct care wage as determined pursuant to subparagraph (i) of this paragraph.

(iv) Regional average direct care hourly rate-excluding general and administrative, which shall mean the sum of the applicable regional average direct care wage as determined pursuant to subparagraph (i) of this paragraph, the applicable regional average employee-related component as determined pursuant to subparagraph (ii) of this paragraph, and applicable regional average program support component as determined pursuant to subparagraph (iii) of this paragraph.

(v) Regional average general and administrative component, which shall mean the sum of the insurance-general and provider administration allocation for the base year for each provider in a DOH region, aggregated for all such providers in such region, divided by (the sum of total program/site costs and other than to/from transportation allocation, less the sum of food, repairs and maintenance, utilities, expensed

equipment, household supplies, telephone, lease/rental equipment, depreciation, total property-provider paid, housekeeping and maintenance staff, salaried clinical dollars, contracted clinical dollars and program administration property for the base year for each provider in a DOH region, aggregated for all providers in such region). The regional average direct care hourly rate-exclusive of general and administrative costs, as determined pursuant to subparagraph (iv) of this paragraph, shall then be divided by (one minus the applicable regional average general and administrative quotient), from which the applicable regional average direct care wage hourly rate-excluding general and administrative, as computed in subparagraph (iv) of this paragraph shall be subtracted.

(vi) Regional average direct care hourly rate, which shall mean the sum of the applicable regional average direct care wage, as determined pursuant to subparagraph (i) of this paragraph, the applicable regional average employee-related component as determined pursuant to subparagraph (ii) of this paragraph, the applicable regional average program support component as determined pursuant to subparagraph (iii) of this paragraph, and the applicable regional average general and administrative component computed in subparagraph (v) of this paragraph.

(vii) Provider average direct care wage, which shall mean the quotient of base year salaried direct care dollars divided by the base year salaried direct care hours of a provider.

(viii) Provider average employee-related component, which shall mean the sum of vacation leave accruals and fringe benefits the base year for each provider, divided by base year salaried direct care dollars of a provider, such quotient to be multiplied by

the provider average direct care wage as computed in subparagraph (vii) of this paragraph.

(ix) Provider average program support component, which shall mean the sum of transportation related-participant, staff travel, participant incidentals, expensed adaptive equipment, sub-contract raw materials, participant wages-non-contract, participant wages-contract, participant fringe benefits, staff development, supplies and materials-non-household, other-OTPS, lease/rental vehicle, depreciation-vehicle, interest-vehicle, other-equipment , other than to/from transportation allocation, salaried support dollars (excluding housekeeping and maintenance staff) and salaried program administration dollars for the base year for an provider. Such sum shall be divided by the base year salaried direct care dollars of such provider and such quotient shall be multiplied by the provider average direct care wage as computed in subparagraph (vii) of this paragraph.

(x) Provider average direct care hourly rate-excluding general and administrative, which shall mean the sum of the provider average direct care wage as determined pursuant to subparagraph (vii) of this paragraph, the provider average employee-related component as determined pursuant to subparagraph (viii) of this paragraph, and the provider average program support component as determined pursuant to subparagraph (ix) of this paragraph for each provider.

(xi) Provider average general and administrative component, which shall mean the sum of insurance-general and provider administration allocation for the base year for an provider, such sum to be divided by (the sum of total program/site costs and other than to/from transportation allocation less the sum of food, repairs and maintenance,

utilities, expensed equipment, household supplies, telephone, lease/rental equipment, depreciation, insurance – property and casualty, total property-provider paid, housekeeping and maintenance staff, salaried clinical dollars, contracted clinical dollars and program administration property for the base year for an provider). The provider average direct care hourly rate-excluding general and administrative, as computed in subparagraph (x) of this paragraph, shall then be divided by (one minus the applicable regional average general and administrative quotient), from which the provider average direct care wage hourly rate-excluding general and administrative, as computed in subparagraph (x) of this paragraph, shall be subtracted.

(xii) Provider average direct care hourly rate, which shall mean the sum of the provider average direct care wage, as determined pursuant to subparagraph (vii) of this paragraph, the provider average employee-related component as determined pursuant to subparagraph (viii) of this paragraph, the provider average program support component as determined pursuant to subparagraph (ix) of this paragraph, and the provider general and administrative component as determined pursuant to subparagraph (xi) of this paragraph.

(xiii) Statewide average direct care hours per person, which shall mean the total salaried and contracted direct care hours for the base year for all providers divided by total capacity for all providers, as such capacity is determined from the rate sheets for the base year and as pro-rated for partial year sites.

(xiv) Statewide average direct hours per provider, which shall mean the product of the statewide average direct care hours per person, as determined pursuant to subparagraph (xiii) of this paragraph, the applicable E-Score factor of an provider, the

applicable provider acuity factor and the applicable provider rate sheet capacity for the base year, as pro-rated for partial year sites.

(xv) Statewide budget neutrality adjustment factor for hours, which shall mean the quotient of the total salaried and contracted direct care hours for the base year for all providers, divided by the total of statewide average direct hours for all providers as determined pursuant to subparagraph (xiv) of this paragraph.

(xvi) Calculated direct care hours, which shall mean the product of the statewide average direct care hours per provider, as determined pursuant to subparagraph (xiv) of this paragraph, and the statewide budget neutrality adjustment factor for hours, as determined pursuant to subparagraph (xv) of this paragraph. Such product shall then be divided by the rate sheet capacity for the base year, pro-rated for partial year sites and such quotient multiplied by rate sheet capacity for the initial period.

(xvii) Regional average clinical hourly wage, which shall mean the quotient of base year salaried clinical dollars for each provider of a DOH region, aggregated for all such providers in such region, divided by base year salaried clinical hours for each provider of a DOH region, aggregated for all such providers in such region.

(xviii) Provider average clinical hourly wage, which shall mean the quotient of base year salaried clinical dollars of a provider divided by base year salaried clinical hours of a provider.

(xix) Provider salaried clinical hours, which shall mean the quotient of base year salaried clinical hours of an provider, divided by the rate sheet capacity for the base year, pro-rated for partial year sites, such quotient to be multiplied by the rate sheet capacity for the initial period for such provider.

(xx) Regional average contracted clinical hourly wage, which shall mean the quotient of base year contracted clinical dollars of a provider divided by the base year contracted clinical hours for each provider of a DOH region, aggregated for all such providers in such region.

(xxi) Provider contracted clinical hours, which shall mean the quotient of base year contracted clinical hours of a provider divided by rate sheet capacity for the base year, pro-rated for partial year sites, such quotient to be multiplied by rate sheet capacity for the initial period.

(xxii) Provider direct care hourly rate-adjusted for wage equalization factor, which shall mean the sum of the provider average direct care hourly rate, as determined pursuant to subparagraph (xii) of this paragraph multiplied by seventy-five hundredths and the applicable regional average direct care hourly rate, as determined pursuant to subparagraph (vi) of this paragraph multiplied by twenty-five hundredths..

(xxiii) Provider clinical hourly wage-adjusted for wage equalization factor, which shall mean the sum of the provider average clinical hourly wage, as determined pursuant to subparagraph (xviii) of this paragraph, multiplied by seventy-five hundredths and the applicable regional average clinical hourly wage, as computed in subparagraph (xvii) of this paragraph multiplied by twenty-five hundredths.

(xxiv) Provider reimbursement for direct care hourly rate, which shall mean the product of the calculated direct care hours, as determined pursuant to subparagraph (xvi) of this paragraph, and the provider direct care hourly rate-adjusted for wage equalization factor, as computed in subparagraph (xxii) of this paragraph.

(xxv) Provider reimbursement for clinical hourly wage, which shall mean the product of the provider salaried clinical hours, as determined pursuant to subparagraph (xix) of this paragraph and the provider clinical hourly wage-adjusted for wage equalization factor, as determined pursuant to subparagraph (xxiii) of this paragraph.

(xxvi) Provider reimbursement for contracted clinical hourly wage, which shall mean the product of the provider contracted clinical hours, as determined pursuant to subparagraph (xxi) of this paragraph and the applicable regional average contracted clinical hourly wage, as determined pursuant to subparagraph (xx) of this paragraph.

(xxvii) Provider operating revenue, which shall mean the sum of the provider reimbursement from direct care hourly rate, as determined pursuant to subparagraph (xxiv) of this paragraph, the provider reimbursement from clinical hourly wage, as determined pursuant to subparagraph (xxv) of this paragraph, and the provider reimbursement from contracted clinical hourly wage, as determined pursuant to subparagraph (xxvi) of this paragraph.

(xxviii) Statewide budget neutrality adjustment factor for operating dollars, which shall mean the quotient of the operating revenue from all provider rate sheets in effect on June thirtieth, two thousand fourteen, divided by provider operating revenue for all providers, as computed in subparagraph (xxvii) of this paragraph.

(xxix) Total provider operating revenue- adjusted, which shall mean the product of the provider operating revenue, as determined pursuant to subparagraph (xxvii) of this paragraph, and the statewide budget neutrality adjustment factor for operating dollars, as determined pursuant to subparagraph (xxviii) of this paragraph.

The final daily operating rate shall be determined by dividing the total provider operating revenue- adjusted, as subject to adjustments made in paragraph (6) of this subdivision, by the applicable rate sheet capacity for the initial period and such quotient to be further divided by three hundred sixty-five, or three hundred sixty-six in the case of a leap year.

(2) Alternative operating cost component. For providers that did not submit a cost report for residential habilitation services for the base year, the final daily operating rate shall be a regional daily operating rate. This rate shall be the sum of:

(i) The product of the applicable regional average direct care hourly rate, as determined pursuant to subparagraph (vi) of paragraph (1) of this subdivision, and the applicable regional average direct care hours, which shall mean the quotient of salaried and contracted direct care hours for the base year for each provider of a DOH region, aggregated for all such providers in such region, divided by the rate sheet capacities for the base year, pro-rated for partial year sites for each provider of a DOH region, aggregated for all such providers in such region divided by three hundred sixty-five, or three hundred sixty-six in the case of a leap year.

(ii) The product should then be added to the product of the applicable regional average clinical hourly wage, as determined pursuant to subparagraph (xvii) of paragraph (1) of this subdivision and the applicable regional average clinical hours, which shall mean the quotient of salaried and contracted clinical hours for the base year for each provider of a DOH region, aggregated for all such providers in such region, divided by the rate sheet capacities for the base year, pro-rated for partial year sites for each provider of a DOH region, aggregated for all such providers in such

region divided by three hundred sixty-five, or three hundred sixty-six, in the case of a leap year.

Such sum shall be multiplied the statewide budget neutrality adjustment factor for operating dollars, as determined pursuant to subparagraph (xxviii) of paragraph (1) of this subdivision to determine the final regional daily operating rate.

(3) Facility cost component. The facility cost component shall include allowable facility costs identified in the consolidated fiscal reports, and shall be inclusive of the following components:

(i) Provider facility reimbursement, which shall mean the sum of food, repairs and maintenance, utilities, expensed equipment, household supplies, telephone, lease/rental equipment, depreciation, insurance-property and casualty, housekeeping and maintenance staff, and program administration property, for the base year for an provider divided by rate sheet capacity for the base year, pro-rated for partial year sites and such quotient multiplied by rate sheet capacity for the initial period.

(ii) Statewide budget neutrality adjustment factor for facility reimbursement, which shall mean the quotient of total room and board reimbursement (excluding provider paid property) from all provider rate sheets in effect on June thirtieth, two thousand fourteen, divided by total provider facility reimbursement, as computed in subparagraph (i) of this paragraph.

(iii) Total provider facility revenue-adjusted, which shall mean the product of the provider facility reimbursement, as determined pursuant to subparagraph (i) of this paragraph and the statewide budget neutrality adjustment factor for facility reimbursement, as determined pursuant to subparagraph (ii) of this paragraph.

The final monthly facility rate shall be the total provider facility revenue-adjusted, as subject to adjustments made in accordance with paragraph (6) of this subdivision, divided by twelve.

(4) Alternative facility cost component. For providers that did not submit a cost report for residential habilitation services provided in a supervised community residence for the base year, the final monthly facility rate shall be a regional monthly facility rate which shall mean the quotient of the sum of food, repairs and maintenance, utilities, expensed equipment, household supplies, telephone, lease/rental equipment, depreciation, insurance-property and casualty, housekeeping and maintenance staff, and program administration property for the base year divided by the rate sheet capacity for the base year, pro-rated for partial year sites for each provider of a DOH region, aggregated for all such providers in such region. Such quotient shall be multiplied by rate sheet capacity for the initial period. Such product shall be multiplied by the statewide budget neutrality adjustment factor for facility reimbursement, as determined pursuant to subparagraph (ii) of paragraph (3) of this subdivision and divided by twelve.

(5) Capital component.

(i) General principles. Capital costs shall be included in the rate at the lower of the amount determined pursuant to 14 NYCRR Subpart 635-6 or thresholds as determined pursuant to subparagraph (iv) of this paragraph.

The Department may retroactively adjust the capital component.

(ii) Initial rate. The rate shall include the approved appraised costs of a lease or acquisition, and estimated costs for renovations, interest, soft costs and start-up expenses. Such costs shall be included in the rate as of the date of certification of

such costs, continuing until such time as actual costs are submitted to the office for people with developmental disabilities. The amount included in the rate shall not exceed the regional threshold rates for such period. Estimated costs shall be submitted in lieu of actual costs for a period no greater than two years. If actual costs are not submitted to the office for people with developmental disabilities within two years from the date of certification of estimated costs, the amount of capital costs included in the rate shall be zero for each period in which actual costs are not submitted. The Department may retroactively adjust the capital component.

(iii) Cost verified rates. Actual costs shall be verified by the office for people with developmental disabilities and supporting documentation of such costs shall be submitted to the office for people with developmental disabilities, which shall transmit such information to the Department. A provider submitting such actual costs shall certify that the reimbursement requested reflects allowable capital costs and that such costs were actually expended by such provider. Under no circumstances shall the amount included in the rate under this subparagraph exceed the threshold rates established in subparagraph (iv) of this paragraph. Capital costs may be amortized over a maximum fifteen year period for acquisition of properties or the life of the lease for leased sites, but in no circumstance shall the amortization exceed the length of the loan taken. Amortization shall begin upon certification by the provider of such costs. For community residences start-up costs may be amortized over a one-year period and for day habilitation sites start-up costs may be amortized over a five-year period beginning with certification. Limitations on reimbursement for such costs shall be the following:

(a) Allowable acquisition, rehabilitation and new construction costs shall be determined in accordance with 14 NYCRR Subpart 635-6. Acquisition costs are limited to the appraised value and acquisition and construction cannot exceed regionally based Hard Caps and thresholds; thresholds are based on number of individuals that reside in the residence. Residential Reserve for Replacement (RRR) funding is used for renovations/improvements in existing sites.

(b) Bids. Completion of the construction identified on the architect designed feasibility requires a minimum of three bids and selection must be the first responsible bidder.

(c) Change orders. Change orders are limited to fifteen percent of actual cost of rehabilitation or new construction costs. Change orders due to the error or omission of an architect are not reimbursable.

(d) Design costs-architectural fees. Design fee may not exceed five percent above the DASNY architectural fee schedule and is based on the lesser of the architect's estimated feasibility or actual bid plus approved change orders.

(e) Financing interest rates. Fixed rates are limited to prime plus four percent. Variable rates are limited to no more than five percent of the initial rate. Mortgages which do not amortize over the nominal mortgage term are not allowable.

(f) Lease costs. Allowable lease costs shall be determined in accordance with 14 NYCRR Part 635-6.

- (g) Loan closing costs. Reimbursement is limited to actual closing costs and cannot exceed more than twelve percent of the mortgage amount. Site survey or soil inspection costs and not included
- (h) Other costs. Maximum of \$20,000 with defined threshold of other legal fees limited to five percent over the cost of bank attorney fees.
- (i) Pre-operational utilities. Reimbursement is limited to three months of utilities for day and residential leased sites and not to exceed \$10,000.
- (j) Purchase options. Limited to twelve months in length with a maximum of \$15,000 in cost.
- (k) Short term interest. Reimbursement is limited up to twelve months (three months for site acquisition and nine months for construction/rehabilitation) of provable interest for a loan obtained prior to program certification.
- (l) Soft costs. Allowable soft costs may include site survey, soil inspection, builder's risk insurance, property casualty insurance, performance bond, clerks of the works.
- (iv) Thresholds. Thresholds for renovations are not inclusive of renovations specific to maintaining an existing site. These renovations shall be funded through the Residential Reserve for Replacement (RRR). Thresholds shall be determined pursuant to the following schedules:

Residential rental sites

<i>Threshold for Residential Rental sites- leases less than 5-year term</i>				
Counties	certified capacity of 1	certified capacity of 2	certified capacity of 3	Each Increase in Certified Capacity by 1
Orange, Rockland, Putnam, Dutchess, Ulster	\$11,692	\$13,853	\$16,903	\$3,050
Nassau, Suffolk and Westchester Counties	\$15,251	\$18,809	\$22,495	\$3,686
New York City except Manhattan	\$21,351	\$24,909	\$28,468	\$3,558
Manhattan	\$28,341	\$32,153	\$35,585	\$3,431
All other Counties	\$9,023	\$10,548	\$12,200	\$1,652
<i>Heat Allowance</i>	<i>+\$900</i>	<i>+\$1,200</i>	<i>+\$1,500</i>	<i>4 or more +\$1,500</i>

<i>For rentals which include Heat</i>				<i>+\$300 additional</i>
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<i>Threshold for leases greater than 5 years</i>	
New York City	\$13,217 per unit of certified capacity
Westchester, Nassau, Rockland and Suffolk Counties	\$10,548 per unit of certified capacity
Putnam, Orange, Dutchess and Ulster Counties	\$7,752 per unit of certified capacity
Upstate (all other counties)	\$5,465 per unit of certified capacity

Allowable renovation costs for new/relocating residential sites with leases less than 5- year term

<i>Renovation costs for residential leases less than 5 years</i>	
Counties	Threshold
New York City and the counties of Suffolk, Rockland Nassau, Westchester, Putnam, Orange, Dutchess and Ulster	Contract Costs for Renovation: The lesser of \$5,000 per person, or \$25,000 per unit,
	Contingency Allowance: where required by contract, an additional allowance for contingency funds to address cost overages

	with a limit of the lesser of actual cost overage or 10% of the contract cost.
All other Counties	Contract Costs for Renovation: The lesser of \$3,000 per person, or \$15,000 per unit
	Contingency Allowance: where required by contract, an additional allowance for contingency funds to address cost overages with a limit of the lesser of actual cost overage or 10% of the contract cost

Capital Thresholds for Residential Acquisitions- New or Relocation  
(including Condominium and Cooperative Apartments).

County	Capital Threshold Cost per UNIT OF Certified Capacity  Average Needs Threshold	Capital Threshold Cost per UNIT OF Certified Capacity  High Needs threshold
Manhattan	\$ 212,021	\$228,161
Bronx, Kings, Queens, Richmond, Nassau and Westchester	\$ 145,645	\$159,182
Putnam, Rockland, Suffolk	\$ 123,835	\$135,424

Columbia, Dutchess, Orange, Sullivan, Ulster	\$ 109,010	\$117,605
Albany, Greene, Rensselaer, Saratoga, Schenectady, Warren	\$ 75,411	\$84,343
Upstate (all other)	\$ 69,397	\$77,622

Renovation costs in existing leased sites

County	Renovation Threshold - Existing Leased Sites Cost per unit of Certified Capacity
Manhattan	\$ 114,081
Bronx, Kings, Queens, Richmond, Nassau and Westchester	\$ 79,591
Putnam, Rockland, Suffolk	\$ 67,712
Columbia, Dutchess, Orange, Sullivan, Ulster	\$ 58,803
Albany, Greene, Rensselaer, Saratoga, Schenectady, Warren	\$ 42,172
Upstate (all other)	\$ 38,811

Capital Review Guidelines for Residential Start-Up Allowance

<i>Residential Start-up Allowance per bed</i>			
Counties	Supportive	Supervised	Relocations

New York City, Suffolk, Nassau, Westchester, Putnam, Rockland	\$5,100	\$5,800	\$1,000
Rest of the State	\$4,900	\$5,500	\$900

Pre-Operational Rent Allowance

<i>Pre-operational rent allowance</i>		
Program type	Supervised and Supportive Community Residences without Renovations	Supportive or Supervised with Renovations
Pre-operational rent allowance	1 month	Up to 3 months

DASNY Architect/Engineer Design Fee Schedule

<i>Design fees for New/Ground Up construction projects</i>		
Approved Construction Costs	Architect's Fee	
To \$70,000		8.75% of cost
\$70,001 to \$100,000	\$6,125	Plus 8.00% of cost over \$70,000

\$100,001- \$150,000	\$8,525	Plus 7.50% of cost over \$100,000
\$150,001 to \$250,000	\$12,275	Plus 7.00% of cost over \$150,000
\$250,001 to \$500,000	\$19,275	Plus 6.50% of cost over \$250,000
\$500,001 to \$1,000,000	\$35,525	Plus 6.10% of cost over \$500,000
\$1,000,001 to 2,000,000	\$66,025	Plus 5.80% of cost over \$1,000,000
\$2,000,001 to \$3,500,000	\$124,025	Plus 5.40% of cost over \$2,000,000
\$3,500,001 to \$5,000,000	\$205,025	Plus 5.00% of cost over \$3,500,000
\$5,000,001 to \$7,500,000	\$280,025	Plus 4.50% of cost over \$5,000,000
\$7,500,001 to \$9,999,999	\$392,525	Plus 4.30% of cost over \$7,500,000

Design Fees

<i>Design fees for rehabilitation/acquisition projects</i>		
Approved Construction Costs	Architect's Fee	
\$0 to \$15,000	\$3,000	Subject to OPWDD approval
\$15,001 to \$50,000	\$3,000	Plus 17.50% of cost over \$15,000
\$50,001 to \$100,000	\$9,125	Plus 15.50% of cost over \$50,000
\$100,001 to \$150,000	\$16,875	Plus 12.50% of cost over \$100,000
\$150,001 to \$200,000	\$23,125	Plus 10.00% of cost over \$150,000
\$200,001 to \$250,000	\$28,125	Plus 8.0% of cost over \$200,000
\$250,001 to \$300,000	\$32,125	Plus 4.75% of cost over \$250,000
\$300,001 to \$350,000	\$34,500	Plus 10.80% of cost over \$300,000
\$350,001 to \$400,000	\$39,900	Plus 10.60% of cost over \$350,000

\$400,001 to \$450,000	\$45,200	Plus 10.40% of cost over \$400,000
\$450,001 to \$500,000	\$50,400	Plus 10.20% of cost over \$450,000
\$500,001 to \$550,000	\$55,500	Plus 10% of cost over \$500,000
\$550,001 to \$600,000	\$60,500	Plus 9.80% of cost over \$550,000
\$600,001 to \$650,000	\$65,400	Plus 9.60% of cost over \$600,000
\$650,001 to \$700,000	\$70,200	Plus 9.40% of cost over \$650,000
\$700,001 to \$750,000	\$74,900	Plus 9.20% of cost over \$700,000
\$750,001 to \$1,000,000	\$79,500	Plus 10.20% of cost over \$750,000
\$1,000,001 to \$1,500,000	\$105,000	Plus 9.90% of cost over \$1,000,000
\$1,500,001 to \$2,000,000	\$154,500	Plus 9.90% of cost over \$1,500,000
\$2,000,001 to \$2,500,000	\$204,000	Plus 9.20% of cost over \$2,000,000

\$2,500,001 to \$3,000,000	\$250,000	Plus 7.60% of cost over \$2,500,000
\$3,000,001 to \$3,500,000	\$288,000	Plus 7.50% of cost over \$3,000,000
\$3,500,001 to \$4,000,000	\$325,500	Plus 6.90% of cost over \$3,500,000
\$4,000,001 to \$4,500,000	\$360,000	Plus 6.30% of cost over \$4,000,000
\$4,500,001 to \$5,000,000	\$391,500	Plus 5.70% of cost over \$4,500,000
\$5,000,001 to \$5,500,000	\$420,000	Plus 5.10% of cost over \$5,000,000
\$5,500,001 to \$6,000,000	\$445,500	Plus 4.50% of cost over \$5,500,000
\$6,000,001 to \$7,000,000	\$468,000	Plus 5.70% of cost over \$6,000,000
\$7,000,001 to \$8,000,000	\$525,000	Plus 3.50% of cost over \$7,000,000
\$8,000,001 to \$9,000,000	\$566,000	Plus 2.50% of cost over \$8,000,000
\$9,000,001 to \$9,999,999	\$585,000	Plus 1.50% of cost over \$9,000,000

Soft costs

<i>Soft costs</i>
Site survey \$500 for existing site or \$5,000 (new construction)
Builders risk insurance \$2,000 for existing site, or \$4,000 (new construction)
Property casualty insurance \$2,000
Bank site inspection \$5,100 (new construction)
Performance Bond at 3% of the approved rehabilitation costs over \$99,999

(a) Capital Review Thresholds for Residential Leased Space – Apartments (Lease term is less than 5 years) For apartment leases of five years or less, the thresholds are applied against the annual rent costs excluding any ancillary costs identified in the lease that are required to be paid to the landlord for services such as lawn care or maintenance. The average annual rent cost is calculated by multiplying the average monthly rent for the entire period of the lease by twelve. The annual property amount included in the rate is the lesser of their actual rental costs or the threshold rate, subject to the limitations in 14 NYCRR Subpart 635-6. Actual ancillary lease costs that are required to be paid to the landlord for services shall be included in the rate.

(b) Costs of residential acquisitions are included in the rate at the provider’s actual cost, or the thresholds described below. The threshold is based on the number of units of certified capacity and includes the costs of building, land and

rehabilitation costs (excluding contingency). The high needs threshold is limited to acquisitions involving rehabilitation of the property for populations needing specialized adaptations for physical or behavioral health needs as determined by the DDRO.

(c) For renovation costs in existing leased sites, allowable costs are limited to the provider's actual costs or the threshold values listed. In addition, where required by contract, the provider is eligible for an additional allowance for contingency funds to address renovation cost overages with a limit of the lesser of actual cost overage or ten percent of the contract cost.

(d) Allowable soft costs may include site survey, soil inspection, builder's risk insurance, property casualty insurance, and performance bond and are limited to the thresholds described herein.

(6) Adjustments. Rates described in this subdivision shall be subject to a reimbursement offset. Such offset shall be determined as follows:

(i) The sum of the total provider facility revenue, as determined by subparagraph (iii) of paragraph (3) of this subdivision, and the capital reimbursement, as determined by paragraph (5) of this subdivision.

(ii) Supplemental security income, as determined by 14 NYCRR 671.7(a)(9)(xxi), and multiplied by three hundred sixty-five, or in the case of a leap year three hundred sixty-six, such product to be multiplied by a provider's initial period rate sheet capacity.

(iii) Supplemental nutrition assistance, as determined by 14 NYCRR 671.7(a)(10)(i)(c), and multiplied by twelve, such product to be multiplied by a provider's initial period rate sheet capacity.

(iv) The sum of subparagraphs (ii) and (iii) of this paragraph shall be deducted from the amount determined pursuant to subparagraph (i) of this paragraph. If such amount is negative a provider's operating reimbursement, as calculated in subparagraph (i) of this paragraph, shall be reduced by such amount. If such amount is positive, a provider shall receive state supplemental dollars in that amount.

(d) Rates for residential habilitation provided in supportive community residences.

(1) Operating component. The operating component shall be based on allowable operating costs identified in the consolidated fiscal reports, and shall be inclusive of the following components:

(i) Regional average direct care wage, which shall mean the quotient of base year salaried direct care dollars for each provider in a DOH region, aggregated for all such providers in such region, for all residential habilitation-supervised IRA, residential habilitation-supportive IRA, day habilitation services and ICF/DD services, divided by base year salaried direct care hours for each provider in a DOH region, aggregated for all such providers in such region, for all residential habilitation-supervised IRA, residential habilitation-supportive IRA, day habilitation services and ICF/DD services.

(ii) Regional average employee-related component, which shall mean the sum of vacation leave accruals and total fringe benefits for the base year for each provider of a DOH region, aggregated for all such providers in such region, such sum to be

divided by salaried direct care dollars for the base year for each provider of a DOH region, aggregated for all such providers in such region, and then multiplied by the applicable regional average direct care wage as determined by subparagraph (i) of this paragraph.

(iii) Regional average program support component, which shall mean the sum of transportation related-participant staff travel, participant incidentals, expensed adaptive equipment, sub-contract raw materials, participant wages-non-contract, participant wages-contract, participant fringe benefits, staff development, supplies and materials-non-household, other-OTPS, lease/rental vehicle, depreciation-vehicle, interest-vehicle, other-equipment, other than to/from transportation allocation, salaried support dollars (excluding housekeeping and maintenance staff) and salaried program administration dollars for the base year for each provider of a DOH region, aggregated by all such providers in such region. Such sum shall be divided by the total base year salaried direct dollars for all providers in a DOH region, and then multiplied by the applicable regional average direct care wage as determined pursuant to subparagraph (i) of this paragraph.

(iv) Regional average direct care hourly rate-excluding general and administrative, which shall mean the sum of the applicable regional average direct care wage as determined pursuant to subparagraph (i) of this paragraph, the applicable regional average employee-related component as determined pursuant to subparagraph (ii) of this paragraph, and applicable regional average program support component as determined pursuant to subparagraph (iii) of this paragraph.

(v) Regional average general and administrative component, which shall mean the sum of the insurance-general and provider administration allocation for the base year for each provider in a DOH region, aggregated for all such providers in such region, divided by (the sum of total program/site costs and other than to/from transportation allocation, less the sum of food, repairs and maintenance, utilities, expensed equipment, household supplies, telephone, lease/rental equipment, depreciation, total property-provider paid, housekeeping and maintenance staff, salaried clinical dollars, contracted clinical dollars and program administration property of a DOH region, aggregated for all such facilities in such region). The regional average direct care hourly rate-exclusive of general and administrative costs, as determined pursuant to subparagraph (iv) of this paragraph, shall then be divided by (one minus the applicable regional average general and administrative quotient), from which the applicable regional average direct care wage hourly rate-excluding general and administrative, as computed in subparagraph (iv) of this paragraph shall be subtracted.

(vi) Regional average direct care hourly rate, which shall mean the sum of the applicable regional average direct care wage, as determined pursuant to subparagraph (i) of this paragraph, the applicable regional average employee-related component as determined pursuant to subparagraph (ii) of this paragraph, the applicable regional average program support component as determined pursuant to subparagraph (iii) of this paragraph, and the applicable regional general and administrative component computed in subparagraph (v) of this paragraph.

(vii) Provider average direct care wage, which shall mean the quotient of salaried direct care dollars divided by the salaried direct care hours of a provider.

(viii) Provider average employee-related component, which shall mean the sum of vacation leave accruals and fringe benefits of each provider, divided by an provider's salaried direct care dollars, such quotient to be multiplied by the provider average direct care wage as computed in subparagraph (vii) of this paragraph.

(ix) Provider average program support component, which shall mean the sum of transportation related-participant, staff travel, participant incidentals, expensed adaptive equipment, sub-contract raw materials, participant wages-non-contract, participant wages-contract, participant fringe benefits, staff development, supplies and materials-non-household, other-OTPS, lease/rental vehicle, depreciation-vehicle, interest-vehicle, other-equipment , other than to/from transportation allocation, salaried support dollars (excluding housekeeping and maintenance staff) and salaried program administration dollars of an provider. Such sum shall be divided by the salaried direct care dollars of such provider and such quotient shall be multiplied by the provider average direct care wage as computed in subparagraph (vii) of this paragraph.

(x) Provider average direct care hourly rate-excluding general and administrative, which shall mean the sum of the provider average direct care wage as determined pursuant to subparagraph (vii) of this paragraph, the provider average employee-related component as determined pursuant to subparagraph (viii) of this paragraph, and the provider average program support component as determined pursuant to subparagraph (ix) of this paragraph for each provider.

(xi) Provider average general and administrative component, which shall mean the sum of insurance-general and provider administration allocation for an provider, such sum to be divided by (the sum of total program/site costs and other than to/from transportation allocation less the sum of food, repairs and maintenance, utilities, expensed equipment, household supplies, telephone, lease/rental equipment, depreciation, insurance-property and casualty, total property-provider paid, housekeeping and maintenance staff, salaried clinical dollars, contracted clinical dollars and program administration property for a facility). The provider average direct care hourly rate-excluding general and administrative, as computed in subparagraph (x) of this paragraph, shall then be divided by (one minus the applicable regional average general and administrative quotient), from which the provider average direct care wage hourly rate-excluding general and administrative, as computed in subparagraph (x) of this paragraph, shall be subtracted.

(xii) Provider average direct care hourly rate, which shall mean the sum of the provider average direct care wage, as determined pursuant to subparagraph (vii) of this paragraph, the provider average employee-related component as determined pursuant to subparagraph (viii) of this paragraph, the provider average program support component as determined pursuant to subparagraph (ix) of this paragraph, and the provider general and administrative component as determined pursuant to subparagraph (xi) of this paragraph.

(xiii) Statewide average direct care hours per person, which shall mean the total base year salaried and contracted direct care hours for all providers divided by total

capacity for all providers, as such capacity is determined from the rate sheets for the base year and as pro-rated for partial year sites.

(xiv) Statewide average direct hours per provider, which shall mean the product of the statewide average direct care hours per person, as determined pursuant to subparagraph (xiii) of this paragraph, the applicable E-Score factor of an provider, the applicable provider acuity factor and the applicable provider rate sheet capacity for the base year, as pro-rated for partial year sites.

(xv) Statewide budget neutrality adjustment factor for hours, which shall mean the quotient of the total base year salaried and contracted direct care hours for all providers, divided by the total of statewide average direct hours for all providers, as determined pursuant to subparagraph (xiv) of this paragraph.

(xvi) Calculated direct care hours, which shall mean the product of the statewide average direct care hours per provider, as determined pursuant to subparagraph (xiv) of this paragraph, and the statewide budget neutrality adjustment factor for hours, as determined pursuant to subparagraph (xv) of this paragraph. Such product shall then be divided by the rate sheet capacity for the base year, pro-rated for partial year sites and such quotient multiplied by rate sheet capacity for the initial period.

(xvii) Regional average clinical hourly wage, which shall mean the quotient of base year salaried clinical dollars for each provider of a DOH region, aggregated for all such providers in such region, divided by base year salaried clinical hours for each provider of a DOH region, aggregated for all such providers in such region.

(xviii) Provider average clinical hourly wage, which shall mean the quotient of base year salaried clinical dollars of a provider divided by base year salaried clinical hours of such provider.

(xix) Provider salaried clinical hours, which shall mean the quotient of base year salaried clinical hours of an provider, divided by the rate sheet capacity for the base year, pro-rated for partial year sites, such quotient to be multiplied by the rate sheet capacity for the initial period for such provider.

(xx) Regional average contracted clinical hourly wage, which shall mean the quotient of base year contracted clinical dollars of a provider divided by the base year contracted clinical hours for each provider of a DOH region, aggregated for all such providers in such region.

(xxi) Provider contracted clinical hours, which shall mean the quotient of a provider's contracted clinical hours for the base year divided by rate sheet capacity for the base year, pro-rated for partial year sites, such quotient to be multiplied by rate sheet capacity for the initial period.

(xxii) Provider direct care hourly rate-adjusted for wage equalization factor, which shall mean the sum of the provider average direct care hourly rate, as determined pursuant to subparagraph (xii) of this paragraph multiplied by seventy-five hundredths and the applicable regional average direct care hourly rate, as determined pursuant to subparagraph (vi) of this paragraph multiplied by twenty-five hundredths and such sum divided by two.

(xxiii) Provider clinical hourly wage-adjusted for wage equalization factor, which shall mean the sum of the provider average clinical hourly wage, as determined

pursuant to subparagraph (xviii) of this paragraph, multiplied by seventy-five hundredths and the applicable regional average clinical hourly wage, as computed in subparagraph (xvii) of this paragraph multiplied by twenty-five hundredths and such sum divided by two.

(xxiv) Provider reimbursement for direct care hourly rate, which shall mean the product of the calculated direct care hours, as determined pursuant to subparagraph (xvi) of this paragraph, and the provider direct care hourly rate-adjusted for wage equalization factor, as computed in subparagraph (xxii) of this paragraph.

(xxv) Provider reimbursement for clinical hourly wage, which shall mean the product of the provider salaried clinical hours, as determined pursuant to subparagraph (xix) of this paragraph and the provider clinical hourly wage-adjusted for wage equalization factor, as determined pursuant to subparagraph (xxiii) of this paragraph.

(xxvi) Provider reimbursement for contracted clinical hourly wage, which shall mean the product of the provider contracted clinical hours, as determined pursuant to subparagraph (xxi) of this paragraph and the applicable regional average contracted clinical hourly wage, as determined pursuant to subparagraph (xx) of this paragraph.

(xxvii) Provider operating revenue, which shall mean the sum of the provider reimbursement from direct care hourly rate, as determined pursuant to subparagraph (xxiv) of this paragraph, the provider reimbursement from clinical hourly wage, as determined pursuant to subparagraph (xxv) of this paragraph, and the provider reimbursement from contracted clinical hourly wage, as determined pursuant to subparagraph (xxvi) of this paragraph.

(xxviii) Statewide budget neutrality adjustment factor for operating dollars, which shall mean the quotient of the operating revenue from all provider rate sheets in effect on June thirtieth, two thousand fourteen, divided by provider operating revenue for all providers, as computed in subparagraph (xxvii) of this paragraph.

(xxix) Total provider operating revenue- adjusted, which shall mean the product of the provider operating revenue, as determined pursuant to subparagraph (xxvii) of this paragraph, and the statewide budget neutrality adjustment factor for operating dollars, as determined pursuant to subparagraph (xxviii) of this paragraph.

The final monthly operating rate shall be determined by dividing the total provider operating revenue-adjusted, as determined pursuant to subparagraph (xxix) of this paragraph, by the applicable rate sheet capacity for the initial period and such quotient to be further divided by twelve.

(2) Alternative operating cost component. For providers that did not submit a cost report for residential habilitation provided in a supportive community residence for the base year, the final monthly operating rate shall be a regional monthly operating rate. This rate shall be the sum of:

(i) The product of the applicable regional average direct care hourly rate, as determined pursuant to subparagraph (vi) of paragraph (1) of this subdivision, and the applicable regional average direct care hours, which shall mean the quotient of base year salaried and contracted direct care hours for each provider of a DOH region, aggregated for all such providers in such region, divided by the rate sheet capacities for the base year, pro-rated for partial year sites for each provider of a DOH region, aggregated for all such providers in such region divided by twelve.

(ii) The product should then be added to the product of the applicable regional average clinical hourly wage, as determined pursuant to subparagraph (xvii) of paragraph (1) of this subdivision and the applicable regional average clinical hours, which shall mean the quotient of salaried and contracted clinical hours for the base year for each provider of a DOH region, aggregated for all such providers in such region, divided by the rate sheet capacities for the base year, pro-rated for partial year sites for each provider of a DOH region, aggregated for all such providers in such region divided by twelve.

Such sum shall be multiplied the statewide budget neutrality adjustment factor for operating dollars, as determined pursuant to subparagraph (xxviii) of paragraph (1) of this subdivision to determine the final regional monthly operating rate.

(3) Facility cost component. The facility cost component shall include allowable facility costs identified in the consolidated fiscal reports and shall be inclusive of the following components:

(i) Provider facility reimbursement, which shall mean the sum of food, repairs and maintenance, utilities, expensed equipment, household supplies, telephone, lease/rental equipment, depreciation, insurance-property and casualty, housekeeping and maintenance staff, and program administration property from the base year, divided by rate sheet capacity for the base year, pro-rated for partial year sites and such sum multiplied by rate sheet capacity for the initial period.

(ii) Statewide budget neutrality adjustment factor for facility reimbursement, which shall mean the quotient of total room and board revenue (excluding provider paid property) from all provider rate sheets in effect on June thirtieth, two thousand

fourteen, divided by total provider facility reimbursement, as computed in subparagraph (i) of this paragraph.

(iii) Total provider facility revenue-adjusted, which shall mean the product of the provider facility reimbursement, as determined pursuant to subparagraph (i) of this paragraph and the statewide budget neutrality adjustment factor for facility reimbursement, as determined pursuant to subparagraph (ii) of this paragraph.

The final monthly facility rate shall be determined by dividing the total provider facility revenue-adjusted, as determined pursuant to subparagraph (iii) of this paragraph, by twelve.

(4) Alternative facility cost component. For providers that did not submit a cost report for residential habilitation services provided in a supportive community residence for the base year, the final monthly facility rate shall be a regional monthly facility rate which shall mean the quotient of the sum of food, repairs and maintenance, utilities, expensed equipment, household supplies, telephone, lease/rental equipment, depreciation, insurance – property and casualty, housekeeping and maintenance staff, and program administration property for the base year divided by the rate sheet capacity for the base year, pro-rated for partial year sites for each provider of a DOH region, aggregated for all such providers in such region. Such quotient shall be multiplied by rate sheet capacity for the initial year. Such product shall be multiplied by the statewide budget neutrality adjustment factor for facility reimbursement, as determined pursuant to subparagraph (ii) of paragraph (3) of this subdivision and divided by twelve.

(5) Capital cost component. (i) General principles. Capital costs shall be included in the rate at the lower of the amount determined under 14 NYCRR Subpart 635-6 or the

thresholds determined pursuant to subparagraph (iv) of this paragraph. The Department may retroactively adjust the capital component.

(ii) Initial rate. The rate shall include the approved appraised costs of a lease or acquisition, and estimated costs for renovations, interest, soft costs and start-up expenses. Such costs shall be included in the rate as of the date of certification of such costs, continuing until such time as actual costs are submitted to the office for people with developmental disabilities. The amount included in the rate shall not exceed the regional threshold rates for such period. Estimated costs shall be submitted in lieu of actual costs for a period no greater than two years. If actual costs are not submitted to the office for people with developmental disabilities within two years from the date of certification of estimated costs, the amount of capital costs included in the rate shall be zero for each period in which actual costs are not submitted. The Department may retroactively adjust the capital component.

(iii) Cost verified rates. Actual costs shall be verified by the office for people with developmental disabilities and supporting documentation of such costs shall be submitted to the office for people with developmental disabilities, which shall transmit such information to the Department. A provider submitting such actual costs shall certify that the reimbursement requested reflects allowable capital costs and that such costs were actually expended by such provider. Under no circumstances shall the amount included in the rate under this subparagraph exceed the threshold rates established in subparagraph (iv) of this paragraph. Capital costs may be amortized over a maximum fifteen year period for acquisition of properties or the life of the lease for leased sites, but in no circumstance shall the amortization exceed the length

of the loan taken. Amortization shall begin upon certification by the provider of such costs. For community residences start-up costs may be amortized over a one-year period and for day habilitation sites start-up costs may be amortized over a five-year period beginning with certification. Limitations on reimbursement for such costs shall be the following:

(a) Allowable acquisition, rehabilitation and new construction costs shall be determined in accordance with 14 NYCRR Subpart 635-6. Acquisition costs are limited to the appraised value and acquisition and construction cannot exceed regionally based Hard Caps and thresholds; thresholds are based on number of individuals that reside in the residence (Schedule B). Residential Reserve for Replacement (RRR) funding is used for renovations/improvements in existing sites.

(b) Bids. Completion of the construction identified on the architect designed feasibility requires a minimum of three bids and selection must be the first responsible bidder.

(c) Change orders. Change orders are limited to fifteen percent of actual cost of rehabilitation or new construction costs. Change orders due to the error or omission of an architect are not reimbursable.

(d) Design costs- architectural fees. Design fee may not exceed five percent above the DASNY architectural fee schedule and is based on the lesser of the architect's estimated feasibility or actual bid plus approved change orders.

(e) Financing interest rates. Fixed rates are limited to prime plus four percent. Variable rates are limited to no more than five percent of the initial rate.

Mortgages which do not amortize over the nominal mortgage term are not allowable.

(f) Lease costs. Allowable lease costs shall be determined in accordance with 14 NYCRR Subpart 635-6.

(g) Loan closing costs. Reimbursement is limited to actual closing costs and cannot exceed more than twelve percent of the mortgage amount. Site survey or soil inspection costs and not included

(h) Other costs. Maximum of \$20,000 with defined threshold of other legal fees limited to five percent over the cost of bank attorney fees.

(i) Pre-operational utilities. Reimbursement is limited to three months of utilities for day and residential leased sites and not to exceed \$10,000.

(j) Purchase options. Limited to twelve months in length with a maximum of \$15,000 in cost.

(k) Short term interest. Reimbursement is limited up to twelve months (three months for site acquisition and nine months for construction/rehabilitation) of provable interest for a loan obtained prior to program certification.

(l) Soft costs. Allowable soft costs may include site survey, soil inspection, builder's risk insurance, property casualty insurance, performance bond, clerks of the works.

(iv) Thresholds. Thresholds shall be the maximum allowable reimbursement for capital costs. Thresholds for renovations are not inclusive of renovations specific to maintaining an existing site. These renovations shall be funded through the

Residential Reserve for Replacement (RRR). Thresholds shall be determined pursuant to the following schedules:

Residential rental sites

<i>Threshold for Residential Rental sites- leases less than 5-year term</i>				
Counties	certified capacity of 1	certified capacity of 2	certified capacity of 3	Each Increase in Certified Capacity by 1
Orange, Rockland, Putnam, Dutchess, Ulster	\$11,692	\$13,853	\$16,903	\$3,050
Nassau, Suffolk and Westchester Counties	\$15,251	\$18,809	\$22,495	\$3,686
New York City except Manhattan	\$21,351	\$24,909	\$28,468	\$3,558
Manhattan	\$28,341	\$32,153	\$35,585	\$3,431
All other Counties	\$9,023	\$10,548	\$12,200	\$1,652

<i>Heat Allowance For rentals which include Heat</i>	<i>+\$900</i>	<i>+\$1,200</i>	<i>+\$1,500</i>	<i>4 or more +\$1,500 +\$300 additional</i>
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<i>Threshold for leases greater than 5 years</i>	
New York City	\$13,217 per unit of certified capacity
Westchester, Nassau, Rockland and Suffolk Counties	\$10,548 per unit of certified capacity
Putnam, Orange, Dutchess and Ulster Counties	\$7,752 per unit of certified capacity
Upstate (all other counties)	\$5,465 per unit of certified capacity

Allowable renovation costs for new/relocating residential sites with leases less than 5- year term

<i>Renovation costs for residential leases less than 5 years</i>	
Counties	Threshold
New York City and the counties of Suffolk, Rockland Nassau,	Contract Costs for Renovation: The lesser of \$5,000 per person, or \$25,000 per unit,

Westchester, Putnam, Orange, Dutchess and Ulster	Contingency Allowance: where required by contract, an additional allowance for contingency funds to address cost overages with a limit of the lesser of actual cost overage or 10% of the contract cost.
All other Counties	Contract Costs for Renovation: The lesser of \$3,000 per person, or \$15,000 per unit
	Contingency Allowance: where required by contract, an additional allowance for contingency funds to address cost overages with a limit of the lesser of actual cost overage or 10% of the contract cost

Capital Thresholds for Residential Acquisitions- New or Relocation

(including Condominium and Cooperative Apartments).

County	Capital Threshold Cost per UNIT OF Certified Capacity  Average Needs Threshold	Capital Threshold Cost per UNIT OF Certified Capacity  High Needs threshold
Manhattan	\$ 212,021	\$228,161

Bronx, Kings, Queens, Richmond, Nassau and Westchester	\$ 145,645	\$159,182
Putnam, Rockland, Suffolk	\$ 123,835	\$135,424
Columbia, Dutchess, Orange, Sullivan, Ulster	\$ 109,010	\$117,605
Albany, Greene, Rensselaer, Saratoga, Schenectady, Warren	\$ 75,411	\$84,343
Upstate (all other)	\$ 69,397	\$77,622

Renovation costs in existing leased sites

County	Renovation Threshold - Existing Leased Sites Cost per unit of Certified Capacity
Manhattan	\$ 114,081
Bronx, Kings, Queens, Richmond, Nassau and Westchester	\$ 79,591
Putnam, Rockland, Suffolk	\$ 67,712
Columbia, Dutchess, Orange, Sullivan, Ulster	\$ 58,803
Albany, Greene, Rensselaer, Saratoga, Schenectady, Warren	\$ 42,172
Upstate (all other)	\$ 38,811

Capital Review Guidelines for Residential Start-Up Allowance

<i>Residential Start-up Allowance per bed</i>			
Counties	Supportive	Supervised	Relocations
New York City, Suffolk, Nassau, Westchester, Putnam, Rockland	\$5,100	\$5,800	\$1,000
Rest of the State	\$4,900	\$5,500	\$900

Pre-Operational Rent Allowance

<i>Pre-operational rent allowance</i>		
Program type	Supervised and Supportive Community Residences without Renovations	Supportive or Supervised with Renovations
Pre-operational rent allowance	1 month	Up to 3 months

DASNY Architect/Engineer Design Fee Schedule

<i>Design fees for New/Ground Up construction projects</i>	
Approved Construction Costs	Architect's Fee

To \$70,000		8.75% of cost
\$70,001 to \$100,000	\$6,125	Plus 8.00% of cost over \$70,000
\$100,001- \$150,000	\$8,525	Plus 7.50% of cost over \$100,000
\$150,001 to \$250,000	\$12,275	Plus 7.00% of cost over \$150,000
\$250,001 to \$500,000	\$19,275	Plus 6.50% of cost over \$250,000
\$500,001 to \$1,000,000	\$35,525	Plus 6.10% of cost over \$500,000
\$1,000,001 to 2,000,000	\$66,025	Plus 5.80% of cost over \$1,000,000
\$2,000,001 to \$3,500,000	\$124,025	Plus 5.40% of cost over \$2,000,000
\$3,500,001 to \$5,000,000	\$205,025	Plus 5.00% of cost over \$3,500,000
\$5,000,001 to \$7,500,000	\$280,025	Plus 4.50% of cost over \$5,000,000
\$7,500,001 to \$9,999,999	\$392,525	Plus 4.30% of cost over \$7,500,000

Design Fees

<i>Design fees for rehabilitation/acquisition projects</i>		
Approved Construction Costs	Architect's Fee	
\$0 to \$15,000	\$3,000	Subject to OPWDD approval
\$15,001 to \$50,000	\$3,000	Plus 17.50% of cost over \$15,000
\$50,001 to \$100,000	\$9,125	Plus 15.50% of cost over \$50,000
\$100,001 to \$150,000	\$16,875	Plus 12.50% of cost over \$100,000
\$150,001 to \$200,000	\$23,125	Plus 10.00% of cost over \$150,000
\$200,001 to \$250,000	\$28,125	Plus 8.0% of cost over \$200,000
\$250,001 to \$300,000	\$32,125	Plus 4.75% of cost over \$250,000
\$300,001 to \$350,000	\$34,500	Plus 10.80% of cost over \$300,000
\$350,001 to \$400,000	\$39,900	Plus 10.60% of cost over \$350,000

\$400,001 to \$450,000	\$45,200	Plus 10.40% of cost over \$400,000
\$450,001 to \$500,000	\$50,400	Plus 10.20% of cost over \$450,000
\$500,001 to \$550,000	\$55,500	Plus 10% of cost over \$500,000
\$550,001 to \$600,000	\$60,500	Plus 9.80% of cost over \$550,000
\$600,001 to \$650,000	\$65,400	Plus 9.60% of cost over \$600,000
\$650,001 to \$700,000	\$70,200	Plus 9.40% of cost over \$650,000
\$700,001 to \$750,000	\$74,900	Plus 9.20% of cost over \$700,000
\$750,001 to \$1,000,000	\$79,500	Plus 10.20% of cost over \$750,000
\$1,000,001 to \$1,500,000	\$105,000	Plus 9.90% of cost over \$1,000,000
\$1,500,001 to \$2,000,000	\$154,500	Plus 9.90% of cost over \$1,500,000
\$2,000,001 to \$2,500,000	\$204,000	Plus 9.20% of cost over \$2,000,000

\$2,500,001 to \$3,000,000	\$250,000	Plus 7.60% of cost over \$2,500,000
\$3,000,001 to \$3,500,000	\$288,000	Plus 7.50% of cost over \$3,000,000
\$3,500,001 to \$4,000,000	\$325,500	Plus 6.90% of cost over \$3,500,000
\$4,000,001 to \$4,500,000	\$360,000	Plus 6.30% of cost over \$4,000,000
\$4,500,001 to \$5,000,000	\$391,500	Plus 5.70% of cost over \$4,500,000
\$5,000,001 to \$5,500,000	\$420,000	Plus 5.10% of cost over \$5,000,000
\$5,500,001 to \$6,000,000	\$445,500	Plus 4.50% of cost over \$5,500,000
\$6,000,001 to \$7,000,000	\$468,000	Plus 5.70% of cost over \$6,000,000
\$7,000,001 to \$8,000,000	\$525,000	Plus 3.50% of cost over \$7,000,000
\$8,000,001 to \$9,000,000	\$566,000	Plus 2.50% of cost over \$8,000,000
\$9,000,001 to \$9,999,999	\$585,000	Plus 1.50% of cost over \$9,000,000

Soft costs

<i>Soft costs</i>
Site survey \$500 for existing site or \$5,000 (new construction)
Builders risk insurance \$2,000 for existing site, or \$4,000 (new construction)
Property casualty insurance \$2,000
Bank site inspection \$5,100 (new construction)
Performance Bond at 3% of the approved rehabilitation costs over \$99,999

(a) Capital Review Thresholds for Residential Leased Space – Apartments (Lease term is less than 5 years) For apartment leases of five years or less, the thresholds are applied against the annual rent costs excluding any ancillary costs identified in the lease that are required to be paid to the landlord for services such as lawn care or maintenance. The average annual rent cost is calculated by multiplying the average monthly rent for the entire period of the lease by twelve. The annual property amount included in the rate is the lesser of their actual rental costs or the thresholds, subject to the limitations in 14 NYCRR Subpart 635-6. Actual ancillary lease costs that are required to be paid to the landlord for services shall be included in the rate.

(b) Costs of residential acquisitions are included in the rate at the provider’s actual cost, or the thresholds described below. The threshold is based on the number of units of certified capacity and includes the costs of building, land and

rehabilitation costs (excluding contingency). The high needs threshold is limited to acquisitions involving rehabilitation of the property for populations needing specialized adaptations for physical or behavioral health needs as determined by the DDRO.

(c) For renovation costs in existing leased sites, allowable costs are limited to the provider's actual costs or the threshold values listed below. In addition, where required by contract, the provider is eligible for an additional allowance for contingency funds to address renovation cost overages with a limit of the lesser of actual cost overage or ten percent of the contract cost.

(d) Allowable soft costs may include site survey, soil inspection, builder's risk insurance, property casualty insurance, and performance bond and are limited to the thresholds described herein.

(6) Adjustments. Rates described in this subdivision shall be subject to a reimbursement offset. Such offset shall be determined as follows:

(i) The sum of the total provider facility revenue, as determined by subparagraph (iii) of paragraph (3) of this subdivision, and the capital reimbursement, as determined by paragraph (5) of this subdivision.

(ii) Supplemental security income, as determined by 14 NYCRR 671.7(a)(9)(xxi), and multiplied by three hundred sixty-five, or in the case of a leap year three hundred sixty-six, such product to be multiplied by a provider's initial period rate sheet capacity.

(iii) Supplemental nutrition assistance, as determined by 14 NYCRR 671.7(a)(10)(ii)(C), and multiplied by twelve, such product to be multiplied by a provider's initial period rate sheet capacity.

(iv) The sum of subparagraphs (ii) and (iii) of this paragraph shall be deducted from the amount determined pursuant to subparagraph (i) of this paragraph. If such amount is negative a provider's operating reimbursement, as calculated in paragraph (1) of this section, shall be reduced by such amount. If such amount is positive, a provider shall receive state supplemental dollars in that amount.

(e) Day habilitation – group and supplemental.

(1) Operating component. Allowable operating costs shall include costs identified in the consolidated fiscal reports and reimbursement for such costs shall be inclusive of the following components:

(i) Regional average direct care wage, which shall mean the quotient of base year salaried direct care dollars for each provider in a DOH region, aggregated for all such providers in such region, for all residential habilitation-supervised IRA, residential habilitation- supportive IRA, day habilitation services and ICF/DD services, divided by base year salaried direct care hours for each provider in a DOH region, aggregated for all such providers in such region, for all residential habilitation-supervised IRA, residential habilitation- supportive IRA, day habilitation services and ICF/DD services.

(ii) Regional average employee-related component, which shall mean the sum of vacation leave accruals and total fringe benefits for the base year for each provider of a DOH region, aggregated for all such providers in such region, such sum to be

divided by base year salaried direct care dollars for each provider of a DOH region, aggregated for all such providers in such region, and then multiplied by the applicable regional average direct care wage as determined by subparagraph (i) of this paragraph.

(iii) Regional average program support component, which shall mean the sum of transportation related-participant staff travel, participant incidentals, expensed adaptive equipment, sub-contract raw materials, participant wages-non-contract, participant wages-contract, participant fringe benefits, staff development, supplies and materials-non-household, other-OTPS, lease/rental vehicle, depreciation-vehicle, interest-vehicle, other-equipment, other than to/from transportation allocation, salaried support dollars (excluding housekeeping and maintenance staff) and salaried program administration dollars for the base year for each provider of a DOH region, aggregated by all such providers in such region. Such sum shall be divided by the total base year salaried direct dollars of all providers in a DOH region, and then multiplied by the applicable regional average direct care wage as determined pursuant to subparagraph (i) of this paragraph.

(iv) Regional average direct care hourly rate-excluding general and administrative, which shall mean the sum of the applicable regional average direct care wage as determined pursuant to subparagraph (i) of this paragraph, the applicable regional average employee-related component as determined pursuant to subparagraph (ii) of this paragraph, and applicable regional average program support component as determined pursuant to subparagraph (iii) of this paragraph.

(v) Regional average general and administrative component, which shall mean the sum of the insurance-general and provider administration allocation for the base year for each provider in a DOH region, aggregated for all such providers in such region, divided by (the sum of total program/site costs and other than to/from transportation allocation, less the sum of food, repairs and maintenance, utilities, expensed equipment, household supplies, telephone, lease/rental equipment, depreciation, total property-provider paid, housekeeping and maintenance staff, salaried clinical dollars, contracted clinical dollars and program administration property the base year for each provider of a DOH region, aggregated for all providers in such region). The regional average direct care hourly rate-exclusive of general and administrative costs, as determined pursuant to subparagraph (iv) of this paragraph, shall then be divided by (one minus the applicable regional average general and administrative quotient), from which the applicable regional average direct care wage hourly rate-excluding general and administrative, as computed in subparagraph (iv) of this paragraph shall be subtracted.

(vi) Regional average direct care hourly rate, which shall mean the sum of the applicable regional average direct care wage, as determined pursuant to subparagraph (i) of this paragraph, the applicable regional average employee-related component as determined pursuant to subparagraph (ii) of this paragraph, the applicable regional average program support component as determined pursuant to subparagraph (iii) of this paragraph, and the applicable regional general and administrative component computed in subparagraph (v) of this paragraph.

(vii) Provider average direct care wage, which shall mean the quotient of base year salaried direct care dollars divided by the base year salaried direct care hours of a provider.

(viii) Provider average employee-related component, which shall mean the sum of vacation leave accruals and fringe benefits for the base year for each provider, divided by base year salaried direct care dollars of an provider, such quotient to be multiplied by the provider average direct care wage as computed in subparagraph (vii) of this paragraph.

(ix) Provider average program support component, which shall mean the sum of transportation related-participant, staff travel, participant incidentals, expensed adaptive equipment, sub-contract raw materials, participant wages-non-contract, participant wages-contract, participant fringe benefits, staff development, supplies and materials-non-household, other-OTPS, lease/rental vehicle, depreciation-vehicle, interest-vehicle, other-equipment, other than to/from transportation allocation, salaried support dollars (excluding housekeeping and maintenance staff) and salaried program administration dollars for the base year for an provider. Such sum shall be divided by the base year salaried direct care dollars of such provider and such quotient shall be multiplied by the provider average direct care wage as computed in subparagraph (vii) of this paragraph.

(x) Provider average direct care hourly rate-excluding general and administrative, which shall mean the sum of the provider average direct care wage as determined pursuant to subparagraph (vii) of this paragraph, the provider average employee-related component as determined pursuant to subparagraph (viii) of this paragraph,

and the provider average program support component as determined pursuant to subparagraph (ix) of this paragraph for each provider.

(xi) Provider average general and administrative component, which shall mean the sum of insurance-general and provider administration allocation for the base year for an provider, such sum to be divided by (the sum of total program/site costs and other than to/from transportation allocation less the sum of food, repairs and maintenance, utilities, expensed equipment, household supplies, telephone, lease/rental equipment, depreciation, insurance – property and casualty, total property-provider paid, housekeeping and maintenance staff, salaried clinical dollars, contracted clinical dollars and program administration property for an provider) for the base year. The provider average direct care hourly rate-excluding general and administrative, as computed in subparagraph (x) of this paragraph, shall then be divided by (one minus the applicable regional average general and administrative quotient), from which the provider average direct care wage hourly rate-excluding general and administrative, as computed in subparagraph (x) of this paragraph, shall be subtracted.

(xii) Provider average direct care hourly rate, which shall mean the sum of the provider average direct care wage, as determined pursuant to subparagraph (vii) of this paragraph, the provider average employee-related component as determined pursuant to subparagraph (viii) of this paragraph, the provider average program support component as determined pursuant to subparagraph (ix) of this paragraph, and the provider general and administrative component as determined pursuant to subparagraph (xi) of this paragraph.

(xiii) Provider direct care hours, which shall mean the sum of base year salaried direct care hours and base year contracted direct care hours, such sum to be divided by the billed units for the base year. Such sum to be multiplied by rate sheet units for the initial period.

(xiv) Regional average clinical hourly wage, which shall mean the quotient of base year salaried clinical dollars for each provider of a DOH region, aggregated for all such providers in such region, divided by base year salaried clinical hours for each provider of a DOH region, aggregated for all such providers in such region.

(xv) Provider average clinical hourly wage, which shall mean the quotient of base year salaried clinical dollars of a provider divided by base year salaried clinical hours of such provider.

(xvi) Provider salaried clinical hours, which shall mean the quotient of base year salaried clinical hours of an provider, divided by the billed units for the base year, such quotient to be multiplied by the rate sheet units for the initial period for such provider.

(xvii) Regional average contracted clinical hourly wage, which shall mean the quotient of contracted clinical dollars divided by the base year contracted clinical hours for each provider of a DOH region, aggregated for all such providers in such region.

(xviii) Provider contracted clinical hours, which shall mean the quotient of a provider's contracted clinical hours for the base year divided by the billed units for the base year, such quotient to be multiplied by rate sheet units for the initial period.

(xix) Provider direct care hourly rate-adjusted for wage equalization factor, which shall mean the sum of the provider average direct care hourly rate, as determined pursuant to subparagraph (xii) of this paragraph multiplied by seventy-five hundredths and the applicable regional average direct care hourly rate, as determined pursuant to subparagraph (vi) of this paragraph multiplied by twenty-five hundredths.

(xx) Provider clinical hourly wage-adjusted for wage equalization factor, which shall mean the sum of the provider average clinical hourly wage, as determined pursuant to subparagraph (xv) of this paragraph, multiplied by seventy-five hundredths and the applicable regional average clinical hourly wage, as computed in subparagraph (xiv) of this paragraph multiplied by twenty-five hundredths.

(xxi) Provider reimbursement for direct care hourly rate, which shall mean the product of the calculated direct care hours, as determined pursuant to subparagraph (xiii) of this paragraph, and the provider direct care hourly rate-adjusted for wage equalization factor, as computed in subparagraph (xix) of this paragraph.

(xxii) Provider reimbursement for clinical hourly wage, which shall mean the product of the provider salaried clinical hours, as determined pursuant to subparagraph (xvi) of this paragraph and the provider clinical hourly wage-adjusted for wage equalization factor, as determined pursuant to subparagraph (xx) of this paragraph.

(xxiii) Provider reimbursement from contracted clinical hourly wage, which shall mean the product of the provider contracted clinical hours, as determined pursuant to subparagraph (xviii) of this paragraph and the applicable regional average contracted clinical hourly wage, as determined pursuant to subparagraph (xvii) of this paragraph.

(xxiv) Provider facility reimbursement, which shall mean the sum of food, repairs and maintenance, utilities, expensed equipment, household supplies, telephone, lease/rental equipment, depreciation, insurance-property and casualty, housekeeping and maintenance staff, and program administration property the base year for an provider and such sum to be divided by provider billed units for the base year. Such sum to be multiplied by rate sheet units for the initial period.

(xxv) Provider to/from transportation reimbursement, which shall mean the quotient of the to/from transportation allocation for the base year divided by the provider billed units for the base year. Such quotient to be multiplied by rate sheet units for the initial period.

(xxvi) Provider operating revenue, which shall mean the sum of provider reimbursement from direct care hourly rate, as determined pursuant to subparagraph (xxi) of this paragraph, the provider reimbursement from clinical hourly wage, as determined pursuant to subparagraph (xxii) of this paragraph, the provider reimbursement from contracted clinical hourly wage, as determined pursuant to subparagraph (xxiii) of this paragraph, the provider facility revenue, as determined pursuant to subparagraph (xxiv) of this paragraph, and provider to/from transportation reimbursement, as determined pursuant to subparagraph (xxv) of this paragraph.

(xxvii) Statewide budget neutrality adjustment factor for operating dollars, which shall mean the quotient of all provider rate sheets in effect on June thirtieth, two thousand fourteen, divided by provider operating revenue, as determined pursuant to subparagraph (xxvi) of this paragraph, for all providers.

(xxviii) Total provider operating revenue- adjusted, which shall mean the product of the provider operating revenue, as determined pursuant to subparagraph (xxvi) of this paragraph and the statewide budget neutrality adjustment factor for operating dollars, as determined pursuant to subparagraph (xxvii) of this paragraph.

The final daily operating rate shall be determined by dividing the total provider operating revenue-adjusted, as determined by subparagraph (xxviii) of this paragraph, by the applicable provider rate sheet units for the initial period.

(2) Alternative operating component. For providers that did not submit a cost report for day habilitation services for the base year, the final daily operating rate shall be a regional daily operating rate. This rate shall be the sum of:

(i) The product of the applicable regional average direct care hourly rate, as determined pursuant to subparagraph (vi) of paragraph (1) of this subdivision and the applicable regional average direct care hours, which shall mean the quotient of salaried and base year contracted direct care hours for each provider of a DOH region, aggregated for all such providers in such region, divided by the billed units for the base year for each provider of a DOH region, aggregated for all such providers in such region; and

(ii) the product of the applicable regional average clinical hourly wage, as determined pursuant to subparagraph (xiv) of paragraph (1) of this subdivision and the applicable regional average clinical hours, which shall mean the quotient of salaried and base year contracted clinical hours for each provider of a DOH region, aggregated for all such providers in such region, divided by the billed units for the base year for each provider of a DOH region, aggregated for all such providers in such region; and

(iii) the applicable regional average facility reimbursement, which shall mean the quotient of the sum of food, repairs and maintenance, utilities, expensed equipment, household supplies, telephone, lease/rental equipment, depreciation, insurance – property and casualty, housekeeping and maintenance staff, and program administration property for the base year divided by the billed units for the base year for each provider of a DOH region, aggregated for all such providers in such region; and

(iv) the applicable regional average to/from transportation reimbursement which shall mean the quotient of the to/from transportation allocation for the base year divided by the provider billed units for the base year for each provider of a DOH region, aggregated for all such providers in such region.

Such sum shall then be multiplied by the statewide budget neutrality adjustment factor for operating dollars, as determined pursuant to subparagraph (xxvii) of paragraph (1) of this subdivision.

(3) Capital component. (i) General principles. The rate shall include capital costs at the lower of the amount determined under 14 NYCRR Subpart 635-6 or thresholds as determined pursuant to subparagraph (iv) of this paragraph. The Department may retroactively adjust the capital component.

(ii) Initial rate. A provider shall be reimbursed for the lease or acquisition of property for approved appraised costs of such lease or acquisition with estimated costs for renovations, interest, soft costs and start-up expenses. Reimbursement for such estimated costs shall begin on the date of certification of such costs, continuing until such time as actual costs are submitted to the office for people with developmental

disabilities. Reimbursement shall not exceed the regional threshold rates for such period. Such estimated costs shall be submitted in lieu of actual costs for a period no greater than two years. If actual costs are not submitted to the office for people with developmental disabilities within two years from the date of certification of estimated costs, reimbursement for capital costs shall be zero for each period in which actual costs are not submitted. The Department may retroactively adjust the capital component.

(iii) Cost verified rates. Actual costs shall be verified by the Department and supporting documentation of such costs shall be submitted to the office for people with developmental disabilities, which shall transmit such information to the Department. A provider submitting such actual costs shall certify that the reimbursement requested reflects allowable capital costs and that such costs were actually expended by such provider. In no circumstances shall reimbursement under this subparagraph exceed the threshold rates established in subparagraph (iv) of this paragraph. Reimbursement may be amortized over a maximum fifteen year period for acquisition of properties or the life of the lease for leased sites, but in no circumstance shall the amortization exceed the length of the loan taken. Amortization shall begin upon certification. Start-up costs may be amortized over a one year period beginning with certification. Limitations on such costs to be included in the rate shall be the following:

(a) Acquisition and rehabilitation costs. Cost is limited to the regional threshold of cost per square foot that includes acquisition costs and rehabilitation.

(b) Bids. Completion of the construction identified on the architect designed feasibility requires a minimum of three bids and selection must be the first responsible bidder.

(c) Change orders. Change orders are limited to fifteen percent of actual cost of rehabilitation or new construction costs. Change orders due to the error or omission of an architect are not reimbursable.

(d) Design costs - architectural fees. Design fee may not exceed five percent above the DASNY architectural fee schedule and is based on the lesser of the architect's estimated feasibility or actual bid plus approved change orders.

(e) Equipment, supplies and miscellaneous. Based on the start-up allowance for residential programs, and based on the threshold for day leased site).

(f) Financing interest rates. Fixed rates are limited to prime plus four percent. Variable rates are limited to no more than five percent of the initial rate. Mortgages which do not amortize over the nominal mortgage term are not allowable.

(g) Lease costs. Reimbursement is limited to the fair market rent and cannot exceed regional thresholds for renovations and per square foot rental threshold. For renovations in existing sites reimbursement is limited to one-half of the costs of the regional thresholds (Schedule A). Day sites which are leased are limited to those in which the renovation is not included in the lease as a "build out". This type of lease shall be limited to appraisal of the property specific to such lease

(h) Other costs. Maximum of \$20,000 with defined threshold of other legal fees limited to five percent over the cost of bank attorney fees.

- (i) Pre-operational rent. Reimbursement for rental costs prior to program certification is limited to three months in a day or residential leased site.
  - (j) Pre-operational utilities. Reimbursement is limited to three months of utilities for day and residential leased sites and not to exceed \$10,000.
  - (k) Purchase options. Limited to twelve months in length with a maximum of \$15,000 in cost.
  - (l) Soft costs. Allowable soft costs may include site survey, soil inspection, builder's risk insurance, property casualty insurance, performance bond, clerks of the works.
  - (m) Loan closing costs. Reimbursement is limited to actual closing costs and cannot exceed more than twelve percent of the mortgage amount. Site survey or soil inspection costs and not included
  - (n) Short term interest. Reimbursement is limited up to twelve months (three months for site acquisition and nine months for construction/rehabilitation) of provable interest for a loan obtained prior to program certification.
- (iv) Thresholds. Thresholds for renovations are not inclusive of renovations specific to maintaining an existing site. These renovations shall be funded through the Residential Reserve for Replacement (RRR) Threshold rates shall be determined pursuant to the following schedules:

Capital Thresholds for Day Leased Space- New Space/Site.

<i>Threshold for Day Lease Space (Rentals)</i>	
County	Rental cost per square foot
Upstate (except where specified below)	\$13.34 per square foot
Albany, Rensselaer, Saratoga, Schenectady, Sullivan, Orange, Rockland, Ulster, Dutchess, Putnam, Monroe, Onondaga, and Erie	\$18.43 per square foot
Suffolk	\$22.88 per square foot
Nassau and Westchester	\$24.78 per square foot
New York City except Manhattan	\$27.96 per square foot
Manhattan	\$30.50 per square foot

Day Lease Space Renovation Thresholds

New/Relocations	NYC , Westchester and Nassau	\$8,100 in per unit of certified capacity
	All other counties	\$6,100 per unit of certified capacity
Expansion	NYC, Westchester and Nassau	\$8,100 per unit of increased capacity

	All Other Counties	\$6,100 per unit of increased capacity

Capital Thresholds for Day Program Acquisitions including Relocations

<i>Day Program Acquisition and Rehabilitation/New Construction Costs, Including relocations</i>	
Counties	Acquisition Thresholds
New York City	\$187 per square foot
Monroe, Ulster, Dutchess, Rockland, Westchester, Nassau, Orange, Suffolk, and Sullivan	\$161 per square foot
All other Counties	\$136 per square foot

Capital Thresholds for Day Program Renovation for existing leased or owned sites

<i>Day Program Renovations for Existing Sites</i>	
Counties	Acquisition Thresholds
New York City	\$ 93.50
Monroe, Ulster, Dutchess, Rockland, Westchester, Nassau, Orange, Suffolk and Sullivan	\$ 80.50
All other Counties	\$ 68.00

Capital Thresholds for Day Program Start-Up Costs

<i>Day Program Start-Up Allowance</i>	
Pre-Operational Rent	Up to 3 months (pre-operational)
Pre-Operational Utilities/Taxes	Up to 3 months, \$10,000 maximum
Pre- Operational Staffing	\$350 per individual trended
Pre- Operational Staffing FTEs	4 FTEs, 6 weeks for admin, 2 weeks other staff
Pre- Operational Staff Train dollars	Included in “Pre-Operational Staffing”
Pre- Operational Training FRE	Included in “Pre-Operational Staffing”
Pre- Operational Advertising	Included in “Pre-Operational Staffing”
Pre-Op Travel	Included in “Pre-Operational Staffing”
Pre- Operational Security Services	Included in “Miscellaneous”
Pre- Operational Furniture	Up to \$500 per person

Pre- Operational Equipment/Supply	Up to \$500 per person
Other Reasonable and Necessary Pre- Operational	Up to \$3,500 per site

DASNY Architect/Engineer Design Fee Schedule

<i>Design fees for New/Ground Up construction projects</i>		
Approved Construction Costs	Architect's Fee	
To \$70,000		8.75% of cost
\$70,001 to \$100,000	\$6,125	Plus 8.00% of cost over \$70,000
\$100,001- \$150,000	\$8,525	Plus 7.50% of cost over \$100,000
\$150,001 to \$250,000	\$12,275	Plus 7.00% of cost over \$150,000
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\$3,500,001 to \$5,000,000	\$205,025	Plus 5.00% of cost over \$3,500,000
\$5,000,001 to \$7,500,000	\$280,025	Plus 4.50% of cost over \$5,000,000
\$7,500,001 to \$9,999,999	\$392,525	Plus 4.30% of cost over \$7,500,000
\$10,000,000		To be negotiated

<i>Design fees for rehabilitation/acquisition projects</i>		
Approved Construction Costs	Architect's Fee	
\$0 to \$15,000	\$3,000	Subject to OPWDD approval
\$15,001 to \$50,000	\$3,000	Plus 17.50% of cost over \$15,000
\$50,001 to \$100,000	\$9,125	Plus 15.50% of cost over \$50,000

\$100,001 to \$150,000	\$16,875	Plus 12.50% of cost over \$100,000
\$150,001 to \$200,000	\$23,125	Plus 10.00% of cost over \$150,000
\$200,001 to \$250,000	\$28,125	Plus 8.0% of cost over \$200,000
\$250,001 to \$300,000	\$32,125	Plus 4.75% of cost over \$250,000
\$300,001 to \$350,000	\$34,500	Plus 10.80% of cost over \$300,000
\$350,001 to \$400,000	\$39,900	Plus 10.60% of cost over \$350,000
\$400,001 to \$450,000	\$45,200	Plus 10.40% of cost over \$400,000
\$450,001 to \$500,000	\$50,400	Plus 10.20% of cost over \$450,000
\$500,001 to \$550,000	\$55,500	Plus 10% of cost over \$500,000
\$550,001 to \$600,000	\$60,500	Plus 9.80% of cost over \$550,000
\$600,001 to \$650,000	\$65,400	Plus 9.60% of cost over \$600,000

\$650,001 to \$700,000	\$70,200	Plus 9.40% of cost over \$650,000
\$700,001 to \$750,000	\$74,900	Plus 9.20% of cost over \$700,000
\$750,001 to \$1,000,000	\$79,500	Plus 10.20% of cost over \$750,000
\$1,000,001 to \$1,500,000	\$105,000	Plus 9.90% of cost over \$1,000,000
\$1,500,001 to \$2,000,000	\$154,500	Plus 9.90% of cost over \$1,500,000
\$2,000,001 to \$2,500,000	\$204,000	Plus 9.20% of cost over \$2,000,000
\$2,500,001 to \$3,000,000	\$250,000	Plus 7.60% of cost over \$2,500,000
\$3,000,001 to \$3,500,000	\$288,000	Plus 7.50% of cost over \$3,000,000
\$3,500,001 to \$4,000,000	\$325,500	Plus 6.90% of cost over \$3,500,000
\$4,000,001 to \$4,500,000	\$360,000	Plus 6.30% of cost over \$4,000,000
\$4,500,001 to \$5,000,000	\$391,500	Plus 5.70% of cost over \$4,500,000

\$5,000,001 to \$5,500,000	\$420,000	Plus 5.10% of cost over \$5,000,000
\$5,500,001 to \$6,000,000	\$445,500	Plus 4.50% of cost over \$5,500,000
\$6,000,001 to \$7,000,000	\$468,000	Plus 5.70% of cost over \$6,000,000
\$7,000,001 to \$8,000,000	\$525,000	Plus 3.50% of cost over \$7,000,000
\$8,000,001 to \$9,000,000	\$566,000	Plus 2.50% of cost over \$8,000,000
\$9,000,001 to \$9,999,999	\$585,000	Plus 1.50% of cost over \$9,000,000
\$10,000,000	To be negotiated	

Soft costs

<i>Soft costs</i>
Site survey \$500 or \$5,000 (new construction)
Builders risk insurance \$2,000, or \$4,000 (new construction)
Property casualty insurance \$2,000
Bank site inspection \$5,100 (new construction)

Performance Bond at 3% of the approved rehab costs over \$99,999
Clerks of the works determined locally

(a) Capital Thresholds for Day Leased Space - New Space/Site. The threshold level is based on the cost per square foot and does not include heat, utilities or renovations. When heat and utility costs are included in the lease and are required to be paid to the landlord, the contract costs for heat and utilities shall be paid to the provider in addition to such thresholds.

(b) The portion of the day lease space renovation threshold for design fees is limited to the design fee thresholds set forth above. There shall be no reimbursement for renovation costs when the site of a program does not change or expand, but the program converts from one model of day program to another model of day program

86-10.4. Reporting requirements.

(a) Providers shall report costs and maintain financial and statistical records in accordance with 14 NYCRR Subpart 635-4.

(b) Generally Accepted Accounting Principles (GAAP). The completion of the financial and statistical report forms shall be in accordance with generally accepted accounting principles as applied to the provider unless the reporting instructions authorized specific variation in such principles. The State shall identify provider cost and providers shall submit cost data in accordance with generally accepted accounting principles (GAAP).

86-10.5. Trend Factor. For years in which the Department does not update the base year, subject to the approval of the Director of Budget, the Department may use a compounded trend factor to bring base year costs forward to the appropriate rate period. The trend factor shall be taken from applicable years from consumer and producer price indices, including, but not limited to the Medical Care Services Index; U.S. city average, by expenditure category and commodity and service group for the period April to April of each year.

86-10.6. Transition periods and reimbursement.

(a) Transition to new methodology. The reimbursement methodology described in this subpart will be phased-in over a three-year period, with a year for purposes of the transition period meaning a twelve month period from July first to the following June thirtieth, and with full implementation in the beginning of the fourth year. During this transition period, the base operating rate will transition to the target rate according to the phase-in schedule immediately below. The base operating rate will remain fixed and the target rate, as determined by the reimbursement methodology in this subpart, will be updated to reflect rebasing of cost data, trend factors and other appropriate adjustments.

<b>Transition Year</b>	<b>Phase-in Percentage</b>	
	<b>Base operating rate</b>	<b>New Methodology</b>
Year One (July 1, 2014 – June 30, 2015)	75%	25%

Year Two (July 1, 2015 – June 30, 2016)	50%	50%
Year Three (July 1, 2016 - June 30, 2017)	25%	75%
Year Four (July 1, 2017 – June 30, 2018)	0%	100%

(b) Transition from monthly to daily units of service. Reimbursement for residential habilitation provided in community residences shall be according to a daily unit of service. From the period beginning July first, two thousand fourteen through June thirtieth, two thousand fifteen, providers which receive reimbursement pursuant to subdivision (c) of section 86-10.3 of this Subpart shall determine and report to the Department retainer days, therapeutic leave days and vacant bed days.

(1) Retainer days shall mean days during which an individual is on medical leave from the community residence, or associated days where any other institutional or in-patient Medicaid payment is made for providing services to the individual. Retainer days shall be reimbursed at zero dollars.

(2) Therapeutic leave days shall mean days during which an individual is away from the community residence and is not receiving services from residential habilitation staff, and the absence is for the purpose of visiting with family or friends. Therapeutic leave days shall be reimbursed at zero dollars.

(3) Vacant bed days shall mean days for which the provider is unable to bill due to a resident moving from one residential site to another, or due to a resident passing away.

At the conclusion of the period ending June 30, 2015, the Department will reconcile the services recorded under the retainer and therapeutic leave days in order to determine the amount of reimbursement owed to the provider. Providers shall be paid for retainer days and therapeutic leave days at the daily operating rate as calculated pursuant to paragraph (1) of subdivision (c) of section 86-10.3 of this Subpart. Providers shall not be paid for more than fourteen retainer days for any one individual. Providers will be paid for vacant bed days at seventy five percent of the daily operating rate as calculated pursuant to paragraph (1) of subdivision (c) of section 86-10.3 of this Subpart up to a maximum of ninety days.

(c) At the conclusion of the period ending June 30, 2015, retainer days and therapeutic leave days shall be reconciled with the services recorded by the provider and reimbursed at the final daily rate, provided, however, that retainer days shall be limited to fourteen days per individual.

(d) For periods subsequent to June 30, 2015:

(1) The daily rate, as determined pursuant to paragraph (1) of subdivision (c) of section 86-10.3 of this Subpart will be adjusted to include an occupancy factor.

(2) Retainer days shall be reimbursed at the daily rate as determined pursuant to subparagraph (1) of this paragraph. Such reimbursement shall be limited to fourteen days per individual.

(3) Therapeutic leave days shall be reimbursed per individual at the daily rate as determined pursuant to subparagraph (1) of this paragraph.

86-10.7. Severability. If any provision of this Subpart or its application to any person or circumstance is held to be invalid, the remainder of this Subpart and the application of that provision to other persons or circumstances will not be affected.

## REGULATORY IMPACT STATEMENT

### Statutory Authority:

Social Services Law (SSL) section 363-a and Public Health Law (PHL) section 201(1)(v) provide that the Department is the single state agency responsible for supervising the administration of the State's medical assistance ("Medicaid") program and for adopting such regulations, not inconsistent with law, as may be necessary to implement the State's Medicaid program.

### Legislative Objective:

These proposed regulations further the legislative objectives embodied in section 363-a of the Social Services Law and section 201(1)(v) of the Public Health Law. The proposed regulations concern changes in the methodology for reimbursement of residential habilitation services delivered in Community Residences (CRs) and Individualized Residential Alternatives (IRAs), and for day habilitation services.

### Needs and Benefits:

The Office for People With Developmental Disabilities (OPWDD) and the Department of Health (DOH) are seeking to implement a new reimbursement methodology which complements existing OPWDD requirements concerning residential and day habilitation services, and satisfies commitments included in OPWDD's transformation agreement with the federal Centers for Medicare and Medicaid Services (CMS).

The methodology, which combines regional average cost components, provider specific cost experiences, and other factors, including the needs of individuals served, is expected to result in rates that are consistent with efficiency and economy, and that lead to quality outcomes for individuals receiving services. The purpose of the methodology change is to move from

budget to cost-based reimbursement, to provide a clear and transparent method of reimbursement, to move toward consistency in rates across the system, and to provide a more stable system of reimbursement.

Costs:

Costs to the Agency and to the State and its local governments:

The proposed regulations will be cost neutral to the state as the monies appropriated for such services will remain constant and only the distribution of such monies will be subject to change.

The new methodologies do not apply to the state as a provider of services.

There will be no savings or costs to local governments as a result of these regulations because pursuant to Social Services Law sections 365 and 368-a, either local governments incur no costs for these services or the State reimburses local governments for their share of the cost of Medicaid funded programs and services.

Costs to private regulated parties:

The proposed regulations will implement a new reimbursement methodology for residential habilitation delivered in CRs and IRAs and day habilitation. Application of the new methodology is expected to result in increased rates for some non-state operated providers and decreased rates for others. However, overall reimbursement to providers will not be changed.

Local Government Mandates:

There are no new requirements imposed by the rule on any county, city, town, village, school, fire or other special district.

#### Paperwork:

The proposed amendments will require additional paperwork to be completed by providers. The proposed regulations change the unit of service for residential habilitation in supervised CRs and supervised IRAs from a monthly to a daily unit of service. The monthly unit of service required documentation of service delivery on at least twenty-two days each month; the new methodology will require daily documentation. In addition, providers will need to bill for each day that services are delivered, rather than billing on a monthly basis. In addition, the regulations require that providers determine and report retainer days, therapeutic leave days, and vacant bed days.

#### Duplication:

The proposed regulations do not duplicate any existing State or federal requirements that are applicable to services for persons with developmental disabilities.

#### Alternatives:

OPWDD developed the methodology in collaboration with DOH and discussed the methodology with representatives of provider associations and with CMS. A variety of factors, including alternate transition plans, were considered; however, the proposed regulations represent the results of decisions made from those discussions and collaboration with DOH.

#### Federal standards:

The proposed amendments do not exceed any minimum standards of the federal government for the same or similar subject areas.

#### Compliance schedule:

OPWDD and DOH are planning for the regulations to be effective July 1, 2014. All necessary information, training, and guidance regarding the new service documentation

requirements and billing procedures will be provided to agencies in advance of the effective date of regulations. The planned provider training will explain all components, calculations, and provisions of these regulations.

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**REGULATORY FLEXIBILITY ANALYSIS**  
**FOR SMALL BUSINESS AND LOCAL GOVERNMENT**

**Effect of Rule:**

The proposed rule will shift resources across agencies, resulting in some agencies obtaining a higher reimbursement rate and others a lower reimbursement rate. The Department will determine actual costs of such agencies and to appropriately reflect such costs in agency reimbursement rates. The proposed rule primarily affects the operating cost component of agency reimbursement; however, there are changes to the capital cost component as well.

The new operating cost component will reflect actual costs of services to individuals receiving day and residential habilitation services. Such costs will be averaged according to region and across the State. The various averages will be adjusted and weighted for maximum accuracy. The methodology incorporated an acuity adjustment for residential habilitation services. The final operating rate will incorporate actual costs of an agency, the average regional costs of all agencies in such region and the average statewide costs for such services.

The capital cost component of the rate will be the lesser of actual costs, fair market value and threshold rates. Threshold rates will now be the maximum allowable reimbursement costs. The Department will retain the system of prior property approval and attendant system of estimated costs and cost verification processes. However, estimated costs will not exceed two years and the cost verification process shall be amended to place the onus of verification upon the provider agency. The Department recommends such changes as an incentive for such agencies to comply with the cost verification process, where such compliance has been difficult to obtain. A further consequence of the failure to submit actual cost data within the two years

prescribed by this rule will be the reduction of the capital cost component to zero until such time as the agency complies.

**Compliance Requirements:**

The proposed regulations change the unit of service for residential habilitation for supervised IRAs from a monthly to a daily unit of service, effective July 1, 2014. The monthly unit of service required documentation of service delivery on at least twenty-two days each month; the new methodology will require daily documentation. In addition, providers will need to bill for each day that services are delivered, rather than billing on a monthly basis. Providers must also determine and report retainer days and therapeutic leave days.

The proposed rule does not require any additional paperwork requirements for the capital cost component, but changes the consequences of non-compliance.

**Professional Services:**

No new professional services are required as a result of this amendment.

**Compliance Costs:**

The proposed rule imposes no new costs on regulated entities.

**Economic and Technological Feasibility:**

There are technical issues related to units of service that will be managed during the transition to the new methodology. Previously, providers of residential habilitation services used a monthly billing system that required twenty-two days of service delivery. Agencies will now provide the Department with data regarding therapeutic leave days, service days and retainer services provided to individuals. The proposed rule provides two transition periods. The first transitions the monthly unit of service to a daily unit of service, while the second transitions the old methodology to the new regional/cost based approach. The Department does not anticipate that regulated entities will require new professional services as a result of this new rule.

**Minimizing Adverse Impact:**

The transition to the new methodology may involve significant disruptions to certain providers. Rate rationalization will provide a clear, transparent method of reimbursement that will normalize rates across the industry and make for a more stable system of reimbursement across the services affected. The proposed regulations minimize adverse economic impact in several ways. First, there is a multi-year phase-in period for transition to the new methodology. For providers that will experience a decrease in reimbursement, this will help to smooth the effects of the reduction in revenue. In addition, the inclusion of several factors in the methodology, such as the acuity factor and the E-score factor, will enhance reimbursement for providers who serve individuals with greater needs and/or who require richer staffing than would otherwise be warranted.

**Small Business and Local Government Participation:**

The methodology was discussed with representatives of providers, including those members of New York State Association of Community and Residential Agencies (NYSACRA) who have fewer than 100 employees, at numerous meetings and conferences. The Department has conveyed its objective to promulgate these amendments to providers, at six meetings/conferences between August 2013 and January 2014. Further, the department is committed to the transparency of this methodology by posting the results by provider on its website.

## **RURAL AREA FLEXIBILITY ANALYSIS**

### **Effect on Rural Areas:**

Description of the types and estimation of the number of rural areas in which the rule will apply: OPWDD services are provided in every county in New York State. Forty three counties have a population of less than 200,000: Allegany, Cattaraugus, Cayuga, Chautauqua, Chemung, Chenango, Clinton, Columbia, Cortland, Delaware, Essex, Franklin, Fulton, Genesee, Greene, Hamilton, Herkimer, Jefferson, Lewis, Livingston, Madison, Montgomery, Ontario, Orleans, Oswego, Otsego, Putnam, Rensselaer, St. Lawrence, Schenectady, Schoharie, Schuyler, Seneca, Steuben, Sullivan, Tioga, Tompkins, Ulster, Warren, Washington, Wayne, Wyoming and Yates. Additionally, 10 counties with certain townships have a population density of 150 persons or less per square mile: Albany, Broome, Dutchess, Erie, Monroe, Niagara, Oneida, Onondaga, Orange and Saratoga.

The proposed amendments have been reviewed by the Department in light of their impact on rural areas. The proposed amendments establish standards for the provision and funding of residential and day habilitation service under the Home and Community Based Services (HCBS) waiver and make minor technical changes in existing regulations.

### **Reporting, Recordkeeping and Other Compliance Requirements and Professional Services:**

There are technical issues related to units of service that will be managed during the transition to the new methodology. Previously, providers of residential habilitation services used a monthly billing system that required twenty-two days of service delivery. Agencies will now provide the Department with data regarding therapeutic leave days, service days and retainer days provided to individuals. The proposed rule provides two transition periods, the first

transitions the monthly unit of service to a daily unit of service while the second transitions the old methodology to the new regional/cost based approach. The Department does not anticipate that regulated entities will require new professional services as a result of this new rule.

**Costs:**

The proposed rule imposes no new costs on regulated entities.

**Minimizing Adverse Impact:**

The transition from rates to rates set according to a standardized methodology may involve significant disruptions to certain providers. Rate rationalization will provide a clear, transparent method of reimbursement that will normalize rates across the industry and make for a more stable system of reimbursement across the services affected.

The proposed regulations minimize adverse economic impact in several ways. First, there is a multi-year phase-in period for transition to the new methodology. For providers that will experience a decrease in reimbursement, this will help to smooth the effects of the reduction in revenue. In addition, the inclusion of several factors in the methodology, such as the acuity factor and the E-score factor, will enhance reimbursement for providers who serve individuals with greater needs and/or who require richer staffing than would otherwise be warranted. OPWDD has also been working with providers to develop strategies to assist providers in achieving efficiencies in service provision. This will help providers accommodate a reduction in revenue without compromising the quality of services provided.

**Rural Area Participation:**

The Department has conveyed its objective to promulgate these amendments to providers, at six meetings/conferences between August 2013 and January 2014. The methodology was discussed with representatives of providers, including providers in rural areas,

such as NYSARC, the NYS Association of Community and Residential Agencies, NYS Catholic Conference and CP Association of NYS, some who have fewer than 100 employees, at numerous meetings and conferences. Further, the department is committed to the transparency of this methodology by posting the results by provider on its website.

## **JOB IMPACT STATEMENT**

A job impact statement is not being submitted for these proposed amendments because the Department determined that they will not cause a loss of more than 100 full time annual jobs State wide. The proposed regulations will implement a new reimbursement methodology for residential habilitation delivered in CRs and IRAs and day habilitation. Application of the new methodology is expected to result in increased rates for some non-state operated providers and decreased rates for others. However, overall reimbursement to providers will not be changed.

Some providers will experience a decrease in reimbursement as a result of these amendments. The Department expects that most providers in this situation will be able to accommodate the reduction in revenue by making programs more efficient without compromising the quality of services. However, some providers may effectuate a modest reduction in employment opportunities as a result of the decrease in revenue. At the same time, other providers that experience an increase in reimbursement may commensurately increase employment opportunities. Therefore, the Department expects that there will be no overall effect on jobs and employment opportunities as a result of these amendments.

## Assessment of Public Comment

1. COMMENT: 86-10.3(c)(1)(xxviii) State Wide Budget Neutrality Adjustment - In addition to describing the calculation of the Budget Neutrality Adjustment, the actual value of the adjustment should be published as part of the regulation in order for providers to be able to calculate its rate from reading the regulations. Also, the Budget Neutrality Adjustment is permanently fixed because it is calculated using the sum of all provider rate sheets “in effect on June thirtieth, two thousand fourteen.” This language should be modified to indicate that this value will be revised annually to include the value of services expansion and other funding increases added after June 30, 2014.

RESPONSE: The Department has decided that no change to the regulation is necessary at this time in response to the comment. However, the comment will be taken under advisement for consideration when subsequent amendments are made to the regulation.

2. COMMENT: 86-10.2(h) (1) (2) (3) (4) DOH Regions - The use of DOH regions to align providers is predicated on the anticipated move to managed care. However, since the predominance of funding for people with developmental disabilities is in fact related to OPWDD funded services and not health or other long term care services we question not using regions that are driven by OPWDD services.

RESPONSE: Although DOH regions are slightly different from OPWDD regions, the Department of Health feels that the regions are closely aligned and are appropriate for use

in the methodology. The regions were chosen to align with long term managed care regions currently being used by The Department.

3. COMMENT: 86-10.2(n) Initial Period - The “initial period” is defined as “July first, two thousand fourteen through December thirty-first, two thousand fourteen for providers reporting on a calendar year basis or July first, two thousand fourteen through June thirtieth, two thousand fifteen for providers reporting on a fiscal year basis”. However, in 641-1-6 (Transition Period and reimbursement), there is no reference to the “initial period” but rather to the “base operating rate” which as defined in 641-1.2(d) has a different meaning.

RESPONSE: The “initial period” will be July one, two thousand fourteen through June thirty, two thousand fifteen and refers to the first year of operation under the new methodology, while the “base operating rate” refers to the reimbursement amount calculated by dividing the annual reimbursement by applicable annual units of service in effect on June thirtieth, two thousand fourteen. The Department has decided that no change to the regulation is necessary at this time in response to the comment. However, the comment will be taken under advisement for consideration when subsequent amendments are made to the regulation.

4. COMMENT: 86-10.3(c)(1)(i-vi), 86-10.3(d)(1)(i-vi) & 86-10.3(e)(1)(i-vi) Regional Averages - The regulations refer to various “regional averages” for various components of the operating rate and the method for calculating such “regional averages” and the

resulting values should be published as part of the regulations in order for providers to be able to calculate its rate from reading the regulation.

RESPONSE: The regional averages will be posted on the Department's website and therefore will be accessible to providers.

5. COMMENT: 86-10.3(c)(1)(xiv) Statewide Average Direct Hours Per Provider - We previously raised serious concerns about IRA methodology and the health, safety and community inclusion implications of using statewide averages, E-Scores and acuity based upon the developmental disabilities profile (DDP) which has not been validated. The instrument also lacks inter-rater reliability. The proposed methodology will result in approximately 120 providers receiving revenue reductions for direct support hours that they actually provided while 127 providers will receive increased funding for direct support staffing hours without any prior documentation that additional direct support hours are required. See attached letters (A and B) to CMS which illuminate these concerns.

The use of DDP scores to adjust hours was not included in the ICF or day habilitation methodologies because of insufficient statistical validity. We believe that the statistical validity to use DDP score to adjust hours in ICFs and day habilitation programs should have confirmed that the DDP has no place in the new rate setting methodology.

In our view, the appropriate solution is to not discriminate against people who live in IRA's by amending the regulation to allow all IRA providers to be funded for the actual direct support hours that they actually provided in the same manner as is proposed for

ICFs/DD and day habilitation programs. The solution is to await implementation of the new CAS assessment tool next year and ensure not-discriminatory treatment of all individuals receiving OPWDD supported services.

RESPONSE: The Department is confident in the results of a regression analysis utilizing DDP for the Supervised and Supportive IRA, which yielded strong regression models with r-squared values between 30 and 40%. The findings for Day Hab and ICF yielded r-squared values below an acceptable level, and therefore were not used. Risk assessment tools currently used in acute care payment methodologies on average have lower r-squared values ranging between 15 percent and 30 percent.

6. COMMENT: 86-10.3(c)(3)(i-iii) & 86-10.3(d)(3)(i-iii) Facility Cost Component - We strongly object to the methodology being utilized to calculate residential facility costs. We believe that the calculation is not consistent with the federal Social Security Administration regulations and expectations on the use of Supplemental Security Income (SSI). Our objection centers on the proposed methodology related to the calculation of the provider's room and board costs.

The proposed rate methodology proposes to take a provider's actual board costs and apply a budget neutrality factor that will in effect reduce each provider's board costs; then add in the approved room costs to generate adjusted total room and board costs. From this adjusted figure Supplemental Security Income (SSI) and the Supplemental Nutrition Assistance Program (SNAP) funding is subtracted to generate a net (reduced) room and board value. In a number of instances, the value of the combination of the SSI

and SNAP benefits will exceed this net (reduced) room and board value which will falsely result in “excess” SSI/SNAP benefits which can then be used to reduce a provider’s rate funded under Medicaid. Meanwhile, the individuals who reside in IRA settings are not able to have their SSI/SNAP benefits fully utilized to first cover their actual room and board costs.

In doing the calculation in this manner it will result in the unintentional misuse of the SSI and the SNAP benefits of the people with developmental disabilities who live in these settings. Both of these federal programs are designed for very specific purposes under federal law. According to Social Security’s website, SSI provides cash to help aged, blind, and disabled people, who have little or no income, meet basic needs for food, clothing and shelter. Also, according to the NYS Office of Temporary Disability and Assistance, SNAP benefits can help low-income working people, seniors, the disabled and others feed themselves and their families.

By determining that some portion of the SSI will not be used to cover the full room and board costs for a person, in other words only pays those costs in part, it could have an adverse impact and result in the person’s SSI benefit reduced by up to one third.

It is also clear in federal regulation that it is the responsibility of the representative payee to know the person’s needs and to use the SSI benefits in the person’s best interest to meet their maintenance needs. Federal regulation does not permit a State to “in essence” make this decision either on behalf of the person or their representative payee. It is only when the State is the representative payee can it make such a decision.

Although CMS insists that Medicaid does not pay for room and board costs and that SSI and earned and unearned income should pay for room and board, the proposed rate

methodology for facility costs property could take a portion of a person's SSI, even though all of their room and board costs have not been covered, and use it reduce the cost of a Medicaid funded waiver residential habilitation service.

We understand the potential need for DOH to include a budget neutrality calculation but it should occur at the very end of the calculation when the State can decide how much of the true (actual) excess room and board costs over SSI/SNAP benefits it wants to supplement providers.

RESPONSE: The Department has decided that no change to the regulation is necessary at this time in response to the comment. However, the comment will be taken under advisement for consideration when subsequent amendments are made to the regulation.

7. COMMENT: 86-10.3(c)(5)(i-iv), 86-10.3(d)(5)(i-iv) & 86-10.3(e)(5)(i-iv) Capital Component - The capital thresholds included in the proposed regulations are more than 6 years old (adopted April 1, 2008) and minimally should be made current. This issue is especially problematic for the downstate regions of the State where affordable housing continues to be a significant problem. There needs to be a provision for amendments to the cap and threshold values for capital acquisitions, new construction and leases to be updated on at least a periodic basis based upon an appropriate housing index;

The State and the nonprofit providers have made significant investments in real property to support thousands of individuals yet there is no provision to exceed the threshold values:

- especially as homes are reviewed by OPWDD against fire safety guidelines that could require providers to make significant capital investments to meet code;

- for developing new homes that can satisfactorily meet the needs of individuals with significant challenging behaviors and/or medical issues; and
- in order to meet money follows the person goals which require 4 persons or less to live together.

The inclusion of language that “DOH may retroactively adjust the capital component” in (i) General Principles is problematic for providers whose capital cost has already been approved by OPWDD in that the draft regulation appear to permit DOH to reduce capital reimbursement approved under proposes to limit reimbursement at the lower of the amount Subpart 745-6 if it exceeds reimbursement under the new proposed regulations. The language in the proposed regulation needs to be amended as follows (“(i) General principles. Capital costs shall be included in the rate at the lower of the amount determined pursuant to Subpart 635-6 of this Title or thresholds as determined pursuant to subparagraph (iv) of this paragraph. *However, capital costs approved by OPWDD prior to July 1, 2014 through the formal prior property approval process shall only be subject to Subpart 635-6 of this Title.* DOH may retroactively adjust the capital component *to reflect capital costs approved pursuant to Subpart 635-6 or pursuant to this paragraph.*

The language in “(ii) Initial rate” needs to be amended to make clear that the new regulations on capital costs only apply to new residential and day programs and that the new proposed capital cost rules do not apply to capital costs approved by OPWDD prior to July 1, 2014 and such capital costs shall only be subject to Subpart 635-6.

The short term interest time limit (“k”) should be increased from 12 months to 18 months without limitation between acquisition or renovation phases given the delays in receiving

prior property approvals as well the delays in the ability to obtain building permits from local municipalities.

RESPONSE: The Department has decided that no change to the regulation is necessary at this time in response to the comment. However, the comment will be taken under advisement for consideration when subsequent amendments are made to the regulation.

8. COMMENTS: 86-10.5 Trend Factor - The regulation states that “for years in which DOH does not update the base year, subject to the approval of the Director of the Budget, DOH may use a compounded trend factor to bring base year costs forward to the appropriate rate period”. However, the regulation fails to describe the use of a trend factor when the base year is being updated.

RESPONSE: The Department’s language as stated is correct. Trend factors will not be applied in years in which the methodology is rebased.

9. COMMENTS: 86-10.6(b)(1-3) Therapeutic Leave Days - The regulations indicate that Therapeutic Leave Days shall be reimbursed at zero dollars to start and reimbursed after a period of time. This will have major cash flow implications on providers and was recognized by both DOH and OPWDD after the regulation was proposed. There was misunderstanding by DOH that an edit in E-MedNY was needed before reimbursing providers which is not the case. It is our understanding that OPWDD/DOH plans to correct this through an emergency regulation, to be filed by June 30, 2014, which will

indicate that the provider will be reimbursed for therapeutic leave days at its residential habilitation rate starting July 1, 2014.

Finally, since reimbursement for therapeutic leave days will commence July 1, 2014, this section needs to be amended to exclude reference to therapeutic leave days.

RESPONSE: The Department has made system changes in order to allow providers to be paid for therapeutic leave days as they are reported. With respect to the remainder of the comment, the Department has decided that no change to the regulations is necessary at this time in response to the comment. However, the comment will be taken under advisement for consideration when subsequent amendments are made to the regulation.

10. COMMENTS: 86-10.6 (b) (3) Vacant Bed Days. The last sentence in this section needs to be amended as follows: “Providers will be paid for vacant bed days at seventy five percent of the daily operating rate as calculated pursuant to paragraph (1) of subdivision (c) of section 641-1.3 of this Subpart up to a maximum of *ninety consecutive vacancy days per vacancy*”.

We also recommend that the following two items be added to the proposed regulations:

- The regulations should provide for at least a 90 day correction period for errors made in the computation of the rate.
- Template funding/rates is clearly not addressed in the Waiver regulations. We recommend that the funding of template rates under Balancing Incentive Program (BIP) funds be specifically included in the rate setting methodology.

RESPONSE: The vacant bed language is correct as written. The maximum allowable vacant bed days for the initial period will be limited to a maximum of ninety days per bed.

- OPWDD regulations 14 NYCRR 686.13(h) already allow for a 90-day review period for any rates promulgated. This regulation when promulgated will not supersede the previous approved regulation.
- Template funded individuals are not included in the new methodology as yet. These individuals will continue to receive their current level of funding until 10/1/15 at which time consideration will be given to the needs of these individuals.