

Rate Rationalization – Intermediate Care Facilities for Persons with Developmental Disabilities (ICF/DDs)

Effective date: 7/1/14

SUMMARY OF EXPRESS TERMS

This regulation establishes a new reimbursement methodology for Intermediate Care Facilities for People with Developmental Disabilities (ICFs/DD) scheduled to be effective July 1, 2014.

The methodology for this program 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, day services 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 day services component is based on the existing units of service from the provider rate sheet in effect on June 30, 2014 and the July 1, 2014 rate for the service. 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.

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 86-11 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:

86-11.1. Applicability. On and after July first, two thousand fourteen, rates of reimbursement for intermediate care facilities for persons with developmental disabilities (ICF/DD) services, other than those provided by the Office for People with Developmental Disabilities, shall be determined in accordance with this Subpart.

86-11.2. Definitions. As used in this Subpart, the following terms shall have the following meanings:

(a) Allowable costs. Costs that are allowable under 14 NYCRR Subpart 635-6 or 14 NYCRR section 681.14(f).

(b) 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.

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

(d) Budget neutrality adjustment. Factor applied to adjust the proposed amount so that it is equivalent to the base amount of dollars.

(e) 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.

(f) Facility. The site or physical building where ICF/DD services are provided.

(g) 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.

(h) Individual. Person receiving ICF/DD services.

(i) ICF/DD. An intermediate care facility for persons with developmental disabilities, as such term is used in 14 NYCRR Part 681.

(j) 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.

(k) 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.

(l) 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 an ICF/DD, and for which the NYS Department of Health has issued a Medicaid provider agreement.

(m) Rate sheet capacity. The certified capacity of the ICF/DDs operated by a provider.

(n) Reimbursable cost. The final allowable costs of the rate year after all audit and/or adjustments are made.

(o) Target rate. The final rate in effect at the end of the transition period for each provider.

86-11.3. Rates for providers of ICF/DD services.

(a) There shall be one provider-wide rate for each provider, except that rates for ICF/DD 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, and capital cost components as identified in applicable subdivisions. Such base year may be updated periodically, as determined by the Department.

(c) Operating component

(1) The operating component shall be based on allowable 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 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 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 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 a 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 a 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 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 quotient 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 a 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 from 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 from 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 a 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 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, and the provider facility reimbursement, as determined pursuant to subparagraph (xxiv) of this paragraph.

(xxvi) 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 (xxv) of this paragraph, for all providers.

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

The final daily operating rate shall be determined by dividing the total provider operating revenue- adjusted, as determined by subparagraph (xxvii) of this paragraph, by the applicable provider rate sheet capacity for the initial period and such quotient to be further divided by three hundred sixty-five.

(2) Alternative operating component. For providers that did not provide services during 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 rate sheet capacities, pro-rated for partial year sites 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 rate sheet capacities, pro-rated for

partial year sites 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 revenue, 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 capacities, pro-rated for partial year sites for the base year for each provider of a DOH region, aggregated for all such providers in such region; and

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) Day program services component. There shall be a day program services component for individuals who participate in in-house day programming and day services, which shall equal the sum of the in-house day programming amount from the provider rate sheet in effect on June thirtieth, two thousand and fourteen, and the product of the units of service for the day services providers as was used in the calculation of the rate in effect on June thirtieth, two thousand and fourteen and the day service provider's rate in effect on July first, two thousand and fourteen.

(4) Capital 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. 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 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:

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>

<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
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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 office for people with developmental disabilities.

(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.

86-11.4. Assessment. Providers under this section shall be subject to the assessment described in section 43.04 of the Mental Hygiene Law.

86-11.5. 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.

86-11.6. 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.

86-11.7. 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 rate will transition to the target rate as determined by the reimbursement methodology described in this subpart, according to the phase-in schedule outlined below. The base 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/or other appropriate adjustments.

Transition Year	Phase-in Percentage	
	Base operating rate	New Methodology
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%

86-11.8. 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 sections 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 Intermediate Care Facilities for Persons with Developmental Disabilities (ICFs/DD).

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 ICFs/DD, 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 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 ICFs/DD. 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 are not expected to increase paperwork to be completed by providers.

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 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 in ICFs/DD. Such costs will be averaged according to region and across the State. The various averages will be adjusted and weighted for maximum accuracy. 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: 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 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:

The proposed rule provides a transition period from 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 this 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 by utilizing 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.

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. 43 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 ICFs/DD and make minor technical changes in existing regulations.

Reporting, Recordkeeping and Other Compliance Requirements and Professional Services:

There are no additional reporting, recordkeeping and other compliance requirements and professional services imposed by these amendments.

The proposed rule provides a transition period from 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 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 by utilizing 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.

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 ICFs/DD. 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: 86-11.3(c)(1)(xxvi) 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: 86-11.2(e) (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: 86-11.2(i) 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: 86-11.3(c)(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: 86-11.3(c)(4)(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.

6. COMMENTS: 86-11.6 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 Departments language as stated is correct. Trend factors will not be applied in years in which the methodology is rebased.

7. COMMENTS: The regulations should provide for at least a 90-day correction period for errors made in the computation of the rate.

RESPONSE: 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.