

Rate Rationalization – Prevocational Services (Site-Based and Community-Based), Respite (Hourly and Free-standing), Supported Employment and Residential Habilitation (Family Care)

Effective date: 4/13/16

SUMMARY OF EXPRESS TERMS

This regulation establishes a new reimbursement methodology for Prevocational (Site-based and Community-based), Respite (Hourly and Free-standing), Supported Employment Services, and Residential Habilitation (Family Care) programs, which will be effective July 1, 2015.

For Prevocational (Site-based) and Respite (Hourly and Free-standing) programs, the methodology will include the following elements:

- 1) The use of a base period Consolidated Fiscal Report (CFR) for the period of January 1, 2013 – December 31, 2013 for calendar year filers or the period of July 1, 2012 –June 30, 2013 for fiscal year filers.
- 2) The assignment of geographic location, based on CFR information and consistent with Department of Health (DOH) 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, except that the initial reimbursement will remain in the rate for only two years from the date of site certification unless actual costs are verified with the Department of Health.

4) Wage Equalization factors.

5) A budget neutrality factor.

6) A two year phase-in period for transition to the methodology.

For Prevocational (Community-based) Services, Supported Employment Services and Residential Habilitation (Family Care) programs, the methodology will include the following elements:

- 1) The use of a base period Consolidated Fiscal Report (CFR) for the period of January 1, 2013 – December 31, 2013 for calendar year filers or the period of July 1, 2012 –June 30, 2013 for fiscal year filers to calculate a fee reimbursement schedule.
- 2) The assignment of geographic location, based on CFR information.
 - For Residential Habilitation (Family Care), the geographic location will be consistent with DOH regions.

- For Prevocational (Community-based) Services and Supported Employment Services, the geographic location will be consistent with Office for People With Developmental Disabilities (OPWDD) regions.

Pursuant to the authority vested in the Commissioner of Health by section 201 of the Public Health Law, Title 10 of the Official Compilation of Codes, Rules and Regulations of the State of New York is amended, to be effective upon publication of a Notice of Adoption in the New York State Register to read as follows:

86-13. Rates for Non-State Providers of Prevocational Services (Site-based) and Respite (Hourly and Free-standing), and fees for Prevocational Services (Community-based), Residential Habilitation (Family Care) and Supported Employment.

86-13.1 – Applicability - On and after July first, two thousand fifteen, rates of reimbursement for Prevocational Services (Site based) and Respite (Hourly and Free-standing) and fees for Prevocational Services (Community-based), Residential Habilitation (Family Care) and Supported Employment, other than those provided by the Office for People With Developmental Disabilities, shall be determined in accordance with this Subpart.

86-13.2. 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 prevocational and respite services, operating costs that are allowable under 14 NYCRR Section 635-10.4.

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

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

(e) Department of Health (DOH) Regions. Regions as defined by DOH, 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: Five boroughs of New York City, Nassau, Suffolk, 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 paragraphs (1), (2) or (3) of this subdivision.
- (f) Financing expenses. Interest expense and fees charged for financing of costs related to the purchase/acquisition, alteration, construction, rehabilitation and/or renovation of real property.
- (g) Free-standing respite. Respite services provided in a free-standing respite facility under the home and community based services waiver operated by OPWDD and pursuant to 14 NYCRR Subpart 635-10.
- (h) Hourly respite. Respite services provided outside of a free-standing respite center under the home and community based services waiver operated by OPWDD and pursuant to 14 NYCRR Subpart 635-10.
- (i) Individual. Person receiving a service authorized by OPWDD.
- (j) Initial period. July first, two thousand fifteen through June thirtieth, two thousand sixteen.
- (k) Lease/rental and ancillary costs. A provider's annual rental payments for real property and ancillary outlays associated with the property such as utilities and maintenance.

(l) Office for People With Developmental Disabilities (OPWDD) Regions. OPWDD regions are as follows:

(1) Region 1: Bronx, Kings, New York, Queens and Richmond counties.

(2) Region 2: Nassau, Putnam, Rockland, Suffolk, and Westchester counties.

(3) Region 3: All other counties in New York State.

(m) Operating costs. Provider costs related to the provision of prevocational services (site-based) and respite services (hourly and free-standing) identified in such provider's cost reports.

(n) Prevocational services. Prevocational services provided under the home and community based services waiver operated by OPWDD and pursuant to 14 NYCRR Subpart 635-10 are defined as follows:

(1) Site based prevocational services are habilitation services that assist individuals to develop employment readiness skills and that are provided in non-residential facilities certified by OPWDD. The services consist of learning and work experiences that are not job-task specific but contribute to an individual's ability to attain paid employment in the community.

(2) Community prevocational services are habilitation services that assist the individual to develop employment readiness skills and that are provided in the most integrated setting appropriate to the needs of the individual receiving such services. The services consist of learning and work experiences, including volunteer work, that are not job-task specific but contribute to an individual's ability to attain paid employment in the community.

(o) Provider. An individual, corporation, partnership, or other organization to which OPWDD has issued an operating certificate or approval to operate a prevocational (site-based), prevocational (community-based), hourly respite, free-standing respite, residential habilitation (family care) or supported employment program, and for which DOH has issued a Medicaid provider agreement.

(p) Rate sheet units. The number of units for which OPWDD authorizes a provider to deliver services in a specific program.

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

(r) Residential habilitation (family care). Residential habilitation (family care) services that are (1) provided under the home and community based services waiver operated by OPWDD, (2) provided pursuant to 14 NYCRR Subpart 635-10, and (3) provided by a family care home issued an operating certificate by OPWDD.

- (s) Start-up costs. Those costs associated with the opening of a new program. Start-up costs include pre-operational rent, utilities, staffing, staff training, advertising for staff, travel, security services, furniture, equipment and supplies.

- (t) Supported employment services. Supported employment services provided under the home and community based services waiver operated by OPWDD and pursuant to 14 NYCRR Subpart 635-10.

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

- (v) Units of service. The unit of measure for the following waiver services shall be:
 - (1) Prevocational (Site-Based) – daily.

 - (2) Prevocational (Community-Based) – hourly.

 - (3) Respite (Hourly and Free-standing) – hourly.

 - (4) Supported Employment – hourly.

(5) Residential habilitation (family care) – daily.

86-13.3. Rates for prevocational services (site-based), respite (hourly and free-standing), prevocational services (community-based), supported employment, and residential habilitation (family care).

- (a) There shall be one provider-wide rate for each provider of prevocational services (site-based), except that rates for prevocational services provided to individuals identified as specialized populations by OPWDD shall be determined under section 86-13.8 of 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 paragraphs. Such base year may be updated periodically, as determined by DOH.
- (c) Prevocational (site-based).

(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 (including production staff) for each provider in a DOH region, aggregated for all such providers in such region, divided by base year salaried direct care hours (including production staff) for each provider in a DOH region, aggregated for all such providers in such region.
- (ii) Regional average employee-related component, which shall mean the quotient of the sum of vacation leave accruals and total fringe benefits for the base year for each provider in a DOH region, aggregated for all such providers in such region, divided by base year salaried direct care dollars (including production staff) for each provider in a DOH region, aggregated for all such providers in such region, and such quotient shall be 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 quotient of 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 in a DOH region, aggregated by all such providers in such region, divided by the total base year salaried direct care dollars (including production staff) of all providers in a DOH region, and such quotient shall be 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 costs, 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 the 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 quotient of the sum of the insurance-general and agency 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 equipment, total property-provider paid, housekeeping and maintenance staff, salaried clinical dollars, and contracted clinical dollars 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-excluding 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 hourly rate-excluding general and administrative costs, 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 as 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 (including production staff) divided by the base year salaried direct care hours (including production staff) of a provider.

- (viii) Provider average employee-related component, which shall mean the quotient of the sum of vacation leave accruals and fringe benefits for the base year for each provider, divided by base year salaried direct care dollars (including production staff) of a provider, and such quotient shall 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 quotient of 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, divided by the base year salaried direct care dollars (including production staff) 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 costs, 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 quotient of the sum of insurance-general and agency administration allocation for the base year for a provider, 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 equipment, insurance – property and casualty, total property-provider paid, housekeeping and maintenance staff, salaried clinical dollars, and contracted clinical dollars for a provider) for the base year. The provider average direct care hourly rate-excluding general and administrative costs, as computed in subparagraph (x) of this paragraph, shall then be divided by (one minus the applicable provider average general and administrative quotient), from which the provider average direct care hourly rate-excluding general and administrative costs, 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 average general and administrative component as determined pursuant to subparagraph (xi) of this paragraph.

- (xiii) Provider direct care hours, which shall mean the quotient of the sum of base year salaried direct care hours (including production staff) and base year contracted direct care hours, divided by the billed units for the base year, and such quotient shall 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 in a DOH region, aggregated for all such providers in such region, divided by base year salaried clinical hours for each provider in 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, and such quotient shall 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 for each provider in a DOH region, aggregated for all such providers in such region, divided by the base year contracted clinical hours for each provider in 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, and such quotient shall 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 provider 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 quotient of the sum of food, repairs and maintenance, utilities, expensed equipment, household

supplies, telephone, lease/rental equipment, depreciation equipment, insurance – property and casualty, housekeeping and maintenance staff, and program administration property the base year for a provider, divided by provider billed units for the base year, and such quotient shall 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, and such quotient shall be multiplied by rate sheet units for the initial period.

(xxvi) Provider operating revenue, which shall mean the sum of provider reimbursement for direct care hourly rate, as determined pursuant to subparagraph (xxi) of this paragraph, the provider reimbursement for 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 reimbursement 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 the operating revenue from all provider rate sheets in effect

on June thirtieth, two thousand fifteen, 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 or submitted a cost report that was incomplete for prevocational 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 base year salaried and contracted direct care hours (including

production workers) for each provider in a DOH region, aggregated for all such providers in such region, divided by the billed units for the base year for each provider in 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 base year salaried and contracted clinical hours for each provider in a DOH region, aggregated for all such providers in such region, divided by the billed units for the base year for each provider in 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 in 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 in 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) For Capital Assets Approved on or after July first, two thousand fifteen.

OPWDD regulations under 14 NYCRR Subpart 635-6 establish standards and criteria for calculating provider reimbursement for the acquisition and lease of real property assets which require approval by the office for people with developmental disabilities. The regulations also address associated depreciation and related financing expenses. The rate will include costs for actual straight line depreciation, interest expense, financing expenses, and lease cost.

In no case will the total capital reimbursement associated with the capital asset exceed the total acquisition, renovation and financing cost associated with a capital asset. The asset life for building acquisitions shall be twenty-five years.

(ii) For Capital Assets Approved Prior to July first, two thousand fifteen. The State will identify each asset by provider, and provide a schedule of these assets

identifying: total actual cost, reimbursable cost determined by the prior approval, total financing cost, allowable depreciation and allowable interest for the remaining useful life as determined by the prior approval, and the allowable reimbursement for each year of the remaining useful lives.

In no case will the total reimbursable depreciation or principal amortization and total interest associated with the capital asset exceed the total acquisition, renovation and financing cost associated with a capital asset.

- (iii) Notification to Providers. 14 NYCRR Subpart 635-6 contains the criteria and standards associated with capital costs and reimbursement. Each provider will receive a schedule of approved reimbursable costs that is being used to establish the real property capital component of the provider's reimbursement rate.

- (iv) Rate for capital assets approved on or after July first, two thousand fifteen. The rate shall include the approved appraised costs of an acquisition or fair market value of a lease, and estimated costs for renovations, interest, soft costs and start-up expenses. Such costs shall be included in the rate as of the date when prevocational services are first provided at the site, continuing until such time as actual costs are submitted to the State. 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 State within two years from the date when prevocational services were first provided at the site, 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.

- (v) Cost verified rates for capital assets approved on or after July first, two thousand fifteen. The provider shall submit to the State supporting documentation of actual costs. Actual costs shall be verified by the State reviewing the supporting documentation of such costs. 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 amount authorized in the approval process. Capital costs shall be depreciated over a twenty-five year period for acquisition of properties or the life of the lease for leased sites. Capital improvements shall be depreciated over the life of the asset. The amortization of interest shall not exceed the life of the loan taken. Amortization or depreciation shall begin upon certification by the provider of such costs. Start-up costs may be amortized over a one year period beginning with site opening. If actual costs are not submitted to the State within two years from the date when prevocational services were first provided at the site, the amount of capital costs included in the rate shall be zero for each period in which actual costs are not submitted.

- (vi) Capital reimbursement schedule. Beginning with the cost reporting period ending December thirty-first, two thousand fourteen, each provider shall submit to OPWDD, as part of the annual cost report, a capital reimbursement schedule.

This schedule will specifically identify the differences, by capital reimbursement item, between the amounts reported on the certified cost report, and the reimbursable items, including depreciation, interest and lease cost from the schedule of approved reimbursable capital costs.

The provider's independent auditor will apply procedures to verify the accuracy and completeness of the capital reimbursement schedule.

The Department will retroactively adjust capital reimbursement based on the actual cost verification process as described in subparagraph (v) of this paragraph.

(d) Respite (hourly and free-standing).

- (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, divided by base year salaried direct care hours for each provider in a DOH region, aggregated for all such providers in such region.

- (ii) Regional average employee-related component, which shall mean the quotient of the sum of vacation leave accruals and total fringe benefits for the base year for each provider in a DOH region, aggregated for all such providers in such region, divided by base year salaried direct care dollars for each provider in a DOH region, aggregated for all such providers in such region, and such quotient shall be 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 quotient of 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 in a DOH region, aggregated by all such providers in such region, divided by the total base year salaried direct care dollars of all providers in a DOH region, and such quotient shall be 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 costs, 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 the 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 quotient of the sum of the insurance-general and agency 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 equipment, total property-provider paid, housekeeping and maintenance staff, salaried clinical dollars, and contracted clinical dollars 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-excluding 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 hourly rate-excluding general and

administrative costs, 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 as 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 quotient of 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, and such quotient shall 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 quotient of 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, 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 costs, 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 quotient of the sum of insurance-general and agency administration allocation for the base year for a provider, 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 equipment, insurance – property and casualty, total property-provider paid, housekeeping and maintenance staff, salaried clinical dollars, and contracted clinical dollars for a provider) for the base year. The provider average direct care hourly rate-excluding general and administrative costs, as computed in subparagraph (x) of this paragraph, shall then be divided by (one minus the applicable provider average general and administrative quotient), from which the provider average direct care hourly rate-excluding general and administrative costs, 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 average general and administrative component as determined pursuant to subparagraph (xi) of this paragraph.

- (xiii) Provider direct care hours, which shall mean the quotient of the sum of base year salaried direct care hours and base year contracted direct care hours,

divided by the billed units for the base year, and such quotient shall 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 in a DOH region, aggregated for all such providers in such region, divided by base year salaried clinical hours for each provider in 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, and such quotient shall 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 for each provider in a DOH region, aggregated for all such providers in such region, divided by the base year contracted clinical hours for each provider in 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, and such quotient shall 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 provider 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 quotient of the sum of food, repairs and maintenance, utilities, expensed equipment, household supplies, telephone, lease/rental equipment, depreciation equipment, insurance – property and casualty, housekeeping and maintenance staff, and program administration property the base year for a provider, divided by provider billed units for the base year, and such quotient shall be multiplied by rate sheet units for the initial period.

(xxv) Provider operating revenue, which shall mean the sum of provider reimbursement for direct care hourly rate as determined pursuant to subparagraph (xxi) of this paragraph, the provider reimbursement for 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 the operating revenue from all provider rate sheets in effect on June thirtieth, two thousand fifteen, 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 units for the initial period.

(2) Alternative operating component. For providers that did not submit a cost report or submitted a cost report that was incomplete for free-standing or hourly respite 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 base year salaried and contracted direct care hours for each provider in a DOH region, aggregated for all such providers in such region, divided by the billed units for the base year for each provider in 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 base year salaried and contracted clinical hours for each provider in a DOH region, aggregated for all such providers in such region, divided by the billed units for the base year for each provider in 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 in 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 (xxvi) of paragraph (1) of this subdivision.

(3) Capital component.

(i) For free-standing respite sites.

A. The rate shall be determined by dividing the approved annual costs by 12. Capital costs shall be determined in accordance with 14 NYCRR Subpart 635-6.

B. The capital rate shall be paid monthly.

Note: The provisions of this paragraph do not apply to capital approved by OPWDD prior to July first, two thousand fifteen.

- (ii) Initial rate for capital assets approved on or after July first, two thousand fifteen.

The rate shall include the approved appraised costs of an acquisition or fair market value of a lease, 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 the site, continuing until such time as actual costs are submitted to the State. 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 State within two years from the date of site certification, 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 for capital assets approved on or after July first, two thousand fifteen. The provider shall submit to the State supporting documentation of actual costs. Actual costs shall be verified by the State reviewing the supporting documentation of such costs. 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 amount authorized in the approval process. Capital costs shall be depreciated over a twenty-five year period for acquisition of properties or the life of the lease for leased sites. Capital improvements shall be depreciated over the life of the asset. The amortization of interest shall not

exceed the life of the loan taken. Amortization or depreciation shall begin upon certification by the provider of such costs. Start-up costs may be amortized over a one year period beginning with site certification. If actual costs are not submitted to the State within two years from the date of site certification, the amount of capital costs included in the rate shall be zero for each period in which actual costs are not submitted.

(e) Prevocational (community-based).

(1) Fee schedule. Effective July first, two thousand fifteen, prevocational (community-based) services will be reimbursed according to the fee schedule below:

| Prevocational (community-based) | | | | |
|---------------------------------|-----------------|---------------------------|----------------------|-----------------------|
| OPWDD Region | Unit of Service | Individual (serving 1) | Group (serving 2) | Group (serving 3+) |
| 1 | Hourly | \$41.57 | \$25.98 | \$20.78 |
| 2 | Hourly | \$43.92 | \$27.45 | \$21.96 |
| 3 | Hourly | \$42.90 | \$26.81 | \$21.45 |

(f) Supported employment.

(1) Fee schedule. Effective July first, two thousand fifteen, supported employment will be reimbursed according to the fee schedule below:

| Supported employment (Intensive Phase) | | | |
|--|-----------------|-------------------------|--------------------------|
| OPWDD Region | Unit of Service | Intensive-1 (serving 1) | Intensive-2 (serving 2+) |
| 1 | Hourly | \$67.88 | \$27.15 |
| 2 | Hourly | \$62.19 | \$24.88 |
| 3 | Hourly | \$54.98 | \$21.99 |

| Supported employment (Extended Phase) | | | |
|---------------------------------------|-----------------|------------------------|-------------------------|
| OPWDD Region | Unit of Service | Extended-1 (serving 1) | Extended-2 (serving 2+) |
| 1 | Hourly | \$67.88 | \$27.15 |
| 2 | Hourly | \$62.19 | \$24.88 |
| 3 | Hourly | \$54.98 | \$21.99 |

(g) Residential habilitation (family care).

(1) Fee schedule. Effective July first, two thousand fifteen, residential habilitation (family care) will be reimbursed according to the fee schedule below:

| Residential habilitation (family care) – Base Fee | | |
|---|-----------------|-----|
| DOH Region | Unit of Service | Fee |
| | | |

| | | |
|---|-------|---------|
| 1 | Daily | \$42.06 |
| 2 | Daily | \$43.61 |
| 3 | Daily | \$35.58 |
| 4 | Daily | \$41.53 |

| Residential habilitation (family care) – Difficulty of Care (DOC) Add-on | | | | | | | |
|--|-----------------|--------------|--------------|--------------|--------------|--------------|--------------|
| | Unit of Service | ISPM level 1 | ISPM level 2 | ISPM level 3 | ISPM level 4 | ISPM level 5 | ISPM level 6 |
| Family Care | Daily | \$5.56 | \$10.87 | \$11.12 | \$16.43 | \$32.26 | \$37.57 |

86-13.4. 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).

86-13.5. 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.

86-13.6. Transition periods and reimbursement.

(a) Transition to new methodology. The reimbursement methodology described in this subpart for prevocational services (site-based) and respite (hourly and free-standing) will be phased-in over a two 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 third 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.

| Transition | Phase-in Percentage | |
|---|----------------------------|--------------------|
| | Base operating rate | Target rate |
| Year One (July 1, 2015 – June 30, 2016) | 50% | 50% |
| Year Two (July 1, 2016 - June 30, 2017) | 25% | 75% |
| Year Three (July 1, 2017 – June 30, 2018) | 0% | 100% |

86-13.7. Rate corrections for prevocational services (site-based) and respite (hourly and free-standing) rates.

(a) Arithmetic or calculation errors will be adjusted accordingly in instances that would result in a change of \$5,000 or more in a provider’s annual reimbursement for prevocational services.

(b) In order to request a rate correction in accordance with subdivision (a) of this section, the provider must send DOH its request by certified mail, return receipt requested, within ninety days of the provider receiving the rate computation or with ninety days of the first day of the rate period in question, whichever is later.

86-13.8. Specialized template populations. Notwithstanding any other provisions of this Subpart, rates for individuals identified by OPWDD as qualifying for specialized template populations funding shall be as follows. As used in this section, “Downstate” shall mean the counties of New York, Kings, Bronx, Queens, Richmond, Nassau, Suffolk, Westchester, Rockland, Orange Sullivan, Putnam and Dutchess, and “Upstate” shall mean all other counties in New York State.

(a) For individuals initially identified as qualifying for specialized template populations funding between November first, two thousand eleven and March thirty-first, two thousand fourteen:

| Prevocational – Specialized Level of Care | |
|---|---|
| Region | Gross Annual Funding Allocation Per Individual – Operating Only |
| Downstate | |

| | |
|---------|----------|
| | \$41,730 |
| Upstate | \$37,562 |

| Prevocational– Highly Complex Level of Care | |
|---|---|
| Region | Gross Annual Funding Allocation Per Individual – Operating Only |
| Downstate | \$46,433 |
| Upstate | \$43,063 |

(b) For individuals initially identified as qualifying for specialized template populations funding after March thirty-first, two thousand fourteen:

| Prevocational – Highly Complex Level of Care | |
|--|---|
| Region | Gross Annual Funding Allocation Per Individual – Operating Only |
| Downstate | |

| | |
|---------|----------|
| | \$46,433 |
| Upstate | \$43,063 |

(c) January first, two thousand fifteen increase. The fees for specialized template populations funding will be revised to incorporate funding for compensation increases to direct support professional employees. Such fee increases will be effective January first, two thousand fifteen. The compensation increase funding will be included in the provider's fee issued for January first, two thousand fifteen or in a subsequent fee with the inclusion of funding in the amount necessary to achieve the same funding impact as if the fee had been issued on January first, two thousand fifteen. The compensation increase funding will be inclusive of associated fringe benefits.

(d) April first, two thousand fifteen increase. In addition to compensation funding effective January first, two thousand fifteen, the fees for specialized template population funding will be revised to incorporate funding for a compensation increase to direct support professional and clinical employees to be effective April first, two thousand fifteen. The April first, two thousand fifteen direct support compensation funding will be compounded on the amount which was calculated for the January first, two thousand fifteen compensation increase and will be an augmentation to the January first, two thousand fifteen increase.

(e) Calculations.

- (1) The portion of the fee that is identified as direct care and support will be increased by 2% and multiplied by the fee sheet fringe benefit percentage to calculate the additional direct support compensation increases for January first, two thousand fifteen and April first, two thousand fifteen.

- (2) The portion of the fee that is identified as clinical will be increased by 2% and multiplied by the fee sheet fringe benefit percentage to calculate the additional clinical compensation increase for April first, two thousand fifteen.

86-13.9. 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 prevocational services (site-based and community-based), respite services (hourly and free-standing), supported employment services, and residential habilitation services delivered in family care homes.

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 prevocational, respite, supported employment and residential habilitation services that are provided in family care homes, and satisfies commitments included in OPWDD's transformation agreement with the federal Centers for Medicare and Medicaid Services (CMS).

The cost-based methodology for prevocational (site-based) and respite (hourly and free-standing) services combines regional average cost components and provider specific cost

experiences. The fee methodology for prevocational (community-based), supported employment and residential habilitation (family care) will create standardized fees for these services. The purpose of the methodology change is to move from budget-based reimbursement to a system based on costs; 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 new methodologies do not apply to the state as a provider of services.

Even if the methodologies in the proposed regulations lead to an increase in Medicaid expenditures in a particular county, these amendments will not have any fiscal impact on local governments, as the contribution of local governments to Medicaid has been capped. Chapter 58 of the Laws of 2005 places a cap on the local share of Medicaid costs and local governments are already paying for Medicaid at the capped level.

Costs to Private Regulated Parties:

The proposed regulations will implement new reimbursement methodologies for prevocational services (site-based and community-based), respite services (hourly and free-standing), supported employment services, and residential habilitation services delivered in family care homes. Application of the new methodology is expected to result in increased rates for some non-state operated providers and decreased rates for others.

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 require providers of prevocational services (site-based) to submit a capital assets schedule to OPWDD as part of the annual cost report; to identify the differences, by asset, between the amount on the cost report and the amount prior approved by OPWDD; and to have an independent auditor apply procedures to verify the accuracy and completeness of the capital assets schedule.

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 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, 2015. All necessary information and guidance regarding implementation of the new methodologies will be provided to agencies in advance of the effective date of regulations.

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REGULATORY FLEXIBILITY ANALYSIS
FOR SMALL BUSINESS AND LOCAL GOVERNMENT

Effect of Rule:

The Department has determined, through a review of the certified cost reports, that most prevocational services (site-based and community-based), respite services (free-standing and hourly), supported employment services (SEMP), and residential habilitation services that are delivered in family care homes, are provided by agencies that employ more than 100 people overall. However, some smaller agencies that employ fewer than 100 employees overall would be classified as small businesses. Currently, there are 94 providers of prevocational services; 295 providers of respite services; 165 providers of SEMPs; and 32 providers of residential habilitation services delivered in family care homes. OPWDD is unable to estimate the portion of these providers that may be considered to be small businesses.

The proposed regulations concern changes in the methodologies for reimbursement of prevocational services (site-based and community-based), respite services (free-standing and hourly), supported employment services (SEMP), and residential habilitation services delivered in family care homes.

The proposed regulations will shift resources across provider agencies; this will result in some agencies obtaining a higher reimbursement rate and others a lower reimbursement rate.

The proposed regulations primarily affect the operating cost component of agency reimbursement. The new operating cost component will reflect actual costs of services to individuals receiving prevocational (site-based) and respite (hourly and free-standing) services. Such costs will be averaged according to region and the averages will be adjusted and weighted for maximum accuracy. The final operating rate will incorporate actual costs of an agency and

the average regional costs of all agencies in such region. For prevocational services (community-based), supported employment and residential habilitation (family care), the fee schedule will reflect the average regional costs of all agencies in the identified regions.

The capital cost component of the rate for prevocational services (site-based) and respite (free-standing) will be the lesser of approved or actual costs. The Department and OPWDD will retain the system of prior property approval and the attendant system of estimated costs and cost verification processes. A 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 will require additional paperwork to be completed by providers. The proposed rule requires providers of prevocational services (site-based) to submit a capital assets schedule to OPWDD as part of the annual cost report, to identify the differences, by asset, between the amount on the cost report and the amount prior approved by OPWDD, and to have an independent auditor apply procedures to verify the accuracy and completeness of the capital assets schedule.

Professional Services:

Additional professional services will be required as a result of these regulations. The amendments require providers of prevocational services (site-based) to verify the accuracy and completeness of the capital assets schedule. However, the regulations will not add to the professional service needs of local governments.

Compliance Costs:

The proposed regulations will require additional paperwork to be completed by providers and may result in minor compliance costs as a result. The proposed rule requires providers of

prevocational services (site-based) to submit a capital assets schedule to OPWDD as part of the annual cost report, to identify the differences, by asset, between the amount on the cost report and the amount prior approved by OPWDD, and to have an independent auditor apply procedures to verify the accuracy and completeness of the capital assets schedule. The Department does not expect costs to vary for providers that are small businesses or for local governments of different types and sizes.

Economic and Technological Feasibility:

The proposed amendments do not impose on regulated parties the use of any technological processes.

Minimizing Adverse Impact:

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 providing a multi-year phase-in period for transition to the new methodology for prevocational (site-based) and respite (hourly and free-standing) services. For providers that will experience a decrease in reimbursement, this will help to smooth the effects of the reduction in revenue.

The Department has also reviewed and considered the approaches for minimizing adverse economic impact as suggested in section 202-b(1) of the State Administrative Procedure Act. The Department has determined that the revision to reimbursement proposed in this amendment is the most optimal approach to instituting the necessary change in rate methodology while minimizing any adverse impact on providers.

Small Business and Local Government Participation:

The rate-setting methodologies in the proposed regulations were discussed with representatives of providers, including the New York State Association of Community and Residential Agencies (NYSACRA), which represents some providers who have fewer than 100 employees. The Department and OPWDD also discussed plans to promulgate these regulations to providers during four meetings between October and December 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. In addition, certain townships in 10 other counties 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 regulations have been reviewed in light of their impact on rural area provider agencies. The proposed regulations concern changes in the methodologies for reimbursement of prevocational services (site-based and community-based), respite services (free-standing and hourly), supported employment services (SEMP) and residential habilitation services that are delivered in family care homes.

The proposed regulations will shift resources across provider agencies, including rural area provider agencies. This will result in some agencies obtaining a higher reimbursement rate and others a lower reimbursement rate.

The proposed regulations primarily affect the operating cost component of agency reimbursement. The new operating cost component will reflect actual costs of services to

individuals receiving prevocational (site-based) and respite (hourly and free-standing) services. Such costs will be averaged according to region and the averages will be adjusted and weighted for maximum accuracy. The final operating rate will incorporate actual costs of an agency and the average regional costs of all agencies in such region. For prevocational services (community-based), supported employment and residential habilitation (family care), the fee schedule will reflect the average regional costs of all agencies in the identified regions.

The capital cost component of the rate for prevocational services (site-based) and respite (free-standing) will be the lesser of approved or actual costs. The Department and OPWDD will retain the system of prior property approval and the attendant system of estimated costs and cost verification processes. A 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.

Reporting, Recordkeeping and Other Compliance Requirements and Professional Services:

There will be additional reporting, recordkeeping and professional services imposed by these regulations. The proposed rule requires providers of prevocational services (site-based) to submit a capital assets schedule to OPWDD as part of the annual cost report, to identify the differences, by asset, between the amount on the cost report and the amount prior approved by OPWDD, and to have an independent auditor apply procedures to verify the accuracy and completeness of the capital assets schedule. However, the regulations will not add to the professional service needs of local governments.

Costs:

The proposed regulations will require additional paperwork to be completed by providers and may result in minor compliance costs as a result. The proposed rule requires providers of

prevocational services (site-based) to submit a capital assets schedule to OPWDD as part of the annual cost report, to identify the differences, by asset, between the amount on the cost report and the amount prior approved by OPWDD, and to have an independent auditor apply procedures to verify the accuracy and completeness of the capital assets schedule.

Minimizing Adverse Impact:

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 providing a multi-year phase-in period for transition to the new methodology for prevocational (site-based) and respite (hourly and free-standing) services. For providers that will experience a decrease in reimbursement, this will help to smooth the effects of the reduction in revenue.

The Department has also reviewed and considered the approaches for minimizing adverse economic impact as suggested in section 202-b(1) of the State Administrative Procedure Act. The Department has determined that the revision to reimbursement proposed in this amendment is the most optimal approach to instituting the necessary change in rate methodology while minimizing any adverse impact on providers.

Rural Area Participation:

The rate-setting methodologies in the proposed regulations were discussed with representatives of providers, including the New York State Association of Community and Residential Agencies (NYSACRA), which represents some rural area providers. The Department and OPWDD also discussed plans to promulgate these regulations to providers during four meetings between October and December 2014. 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 prevocational services (site-based and community-based), respite services (hourly and free-standing), supported employment and residential habilitation (family care). Application of the new methodology is expected to result in increased rates for some non-state operated providers and decreased rates for others.

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

The Department of Health (DOH) received one set of comments during the public comment period from the Cerebral Palsy Associations of New York State.

Comment:

DOH recognized the fact that the 7/1/15 pre-vocational service fees for specialized template populations, as calculated and presented in the proposed regulation, need to be revised to incorporate compensation funding increases for direct support professionals that were effective 1/1/15 and 4/1/15 for clinical employees.

To be consistent, DOH must also recognize the need for similar revisions to the proposed 7/1/15 community pre-vocational and Supported Employment (SEMP) fees since these proposed fees also did not include either of these compensation funding increases when they were developed.

Response:

DOH will not change the regulation at this time. However, the comment will be taken under advisement for consideration when subsequent amendments are made to the regulation.

Comment:

We are asking that DOH recognize and make an appropriate adjustment in the calculation of the SEMP and pre-vocational service fees as well as in Agency respite rates to recognize the cost associated with a NYC law (called the Earned Sick Time Act) that went into effect on 4/1/14. Many of the new key provisions of the Act will have direct fiscal impact on our

OPWDD funded providers that operate in New York City – resulting in increased expenses not previously incurred. Some of the key provisions of the Act are attached to the letter.

Obviously, of major concern is that now NYC providers will be required to provide sick leave to basically ALL part-time employees, substitute direct support professionals, as well as per diem professionals, and clinical staff. This is a NEW cost that is now mandated by this NYC law, so an adjustment will need to be made by DOH at least until such time as the 7/1/14-6/30/15 cost period or after is used to establish fees/rates. This also impacts other OPWDD service rates (IRA residential and day habilitation and ICF services) that are being revised effective 7/1/15.

Response:

DOH will not change the regulation as this time. However, the comment will be taken under advisement for consideration when subsequent amendments are made to the regulation.

Comment:

The DOH regulations need to be clear that the SEMP fees do not include the cost related to the generic round trip transportation of an individual with developmental disabilities between their home and their job.

Response:

DOH will not change the regulation as this time. However, the comment will be taken under advisement for consideration when subsequent amendments are made to the regulation.

Comment:

Community pre-vocation is a new OPWDD service with no prior programmatic or cost experience. The regional fees developed by DOH were developed based upon the existing community habilitation program and fees with an adjustment for noncertified site cost. The new

fee schedule for Community Pre-vocational services is very much lower than those for Supported Employment in both the intensive and extended phases. People involved in pre-vocational services have been enrolled in that program because they need more supports in order to be ready to work. The supports that they will need will be more intensive and more structured due to their higher needs levels. Therefore, it is not likely that the proposed fees will be sufficient. Once sufficient program and cost experience is obtained, DOH will need to modify the fee schedule accordingly.

Response:

DOH will not change the regulation at this time. However, the comment will be taken under advisement for consideration when subsequent amendments are made to the regulation.