



**Amendments to Rate-Setting Methodology:
Rates for Residential Habilitation Delivered in IRAs & CRs and for
Day Habilitation Services**

Amendment of 14 NYCRR Subpart 641-1

Effective November 1, 2014

- **14 NYCRR Subpart 641-1 is hereby repealed and a new Subpart 641-1 is added as follows:**

Part 641. Rate Setting for Non-State Providers

Subpart 641-1. Rates for Non-State Providers of Residential Habilitation in Community Residences, Including Individualized Residential Alternatives (IRAs), and for Non-State Providers of Day Habilitation.

641-1.1. Applicability. On and after November 1, 2014, rates of reimbursement for residential habilitation services provided in community residences, including IRAs, and for day habilitation services, other than those provided by OPWDD, shall be determined in accordance with this Subpart.

641-1.2. Definitions. As used in this Subpart, the following terms shall have the following meanings:

(a) Allowable capital costs. Capital costs that are allowable under Subpart 635-6 of this Title.

(b) Allowable operating costs. In the case of residential habilitation services, operating costs that are allowable under paragraph 635-10.4 (b)(1) and subdivision 686.13(b) of this Title; in the case of day habilitation services, operating costs that are allowable under paragraph 635-10.4(b)(2) of this Title.

(c) Acuity factor. Factor developed through a regression analysis utilizing components of Developmental Disabilities Profile (DDP) scores, average residential bed size, Willowbrook class indicators, and historical utilization data to predict direct care hours needed to serve individuals.

(d) Base year. The consolidated fiscal report period from which the initial period rate will be calculated. Such period shall be January 1, 2011 through December 31, 2011 for providers

Note: All new material

**Final Regulations: Amendments to Rate-Setting Methodology:
Rates for Residential Habilitation Delivered in IRAs & CRs and for
Day Habilitation Services**

Effective: November 1, 2014

reporting on a calendar year basis and July 1, 2010 through June 30, 2011 for providers reporting on a fiscal year basis.

(e) Base operating rate. Reimbursement amount calculated by dividing annual reimbursement by applicable annual units of service, both in effect on June 30, 2014.

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

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

(h) Department of Health (DOH) Regions. Regions as defined by the New York State Department of Health (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: 5 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.

(i) Developmental Disabilities Profile (DDP-2). The document titled *Developmental Disabilities Profile (DDP-2)*, dated 7/10, and issued by OPWDD. This document, the *Developmental Disabilities Profile (DDP-2) Users' Guide*, and another document titled *Scoring the DDP* are available during business hours and by appointment at the following locations:

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

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

Note: All new material

**Final Regulations: Amendments to Rate-Setting Methodology:
Rates for Residential Habilitation Delivered in IRAs & CRs and for
Day Habilitation Services**

Effective: November 1, 2014

(j) Evacuation Score (E-Score). The score for a supervised community residence that is certified under Chapters 32 or 33 of the Residential Board and Care Occupancies of the NFPA 101 *Life Safety Code* (2000 edition) that is provided to DOH by OPWDD once a year. The E-score is described in the NFPA 101A, *Guide on Alternative Approaches to Life Safety*, 2001 edition. The *Life Safety Code* and *Guide on Alternative Approaches to Life Safety* are available from the National Fire Protection Association, One Batterymarch Park, Quincy, MA 02169-7471; or is available during business hours and by appointment at the following locations:

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

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

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

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

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

(n) Initial period. July 1, 2014 through June 30, 2015.

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

(p) Occupancy factor. Beginning July 1, 2015 such factor will be an adjustment made prospectively at the beginning of the applicable rate year, based upon the previous years' experience. Such adjustment shall be provider specific and shall be the lower of the provider's actual vacancy or five percent.

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

Note: All new material

**Final Regulations: Amendments to Rate-Setting Methodology:
Rates for Residential Habilitation Delivered in IRAs & CRs and for
Day Habilitation Services**

Effective: November 1, 2014

(r) Provider. An individual, corporation, partnership, or other organization to which OPWDD has issued an operating certificate to operate a community residence, and for which DOH has issued a Medicaid provider agreement, or an individual, corporation, partnership, or other organization to which OPWDD has issued an operating certificate or approval to operate a day habilitation program, and for which DOH has issued a Medicaid provider agreement.

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

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

(u) Residential habilitation. Residential habilitation services provided in a community residence, under the home and community based services waiver operated by OPWDD and pursuant to Subpart 635-10 and Part 671 of this Title.

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

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

(x) State supplement. Amount paid to a provider to cover Room and Board costs in excess of SSI and Supplemental Nutrition Assistance Program (SNAP) payments.

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

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

(1) Residential habilitation provided in a supervised community residence - daily

(2) Residential habilitation provided in a supportive community residence - monthly

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**Final Regulations: Amendments to Rate-Setting Methodology:
Rates for Residential Habilitation Delivered in IRAs & CRs and for
Day Habilitation Services**

Effective: November 1, 2014

(3) Day habilitation - daily

641-1.3. Rates for residential habilitation services and for day habilitation services.

(a) There shall be one provider-wide rate for each provider of residential habilitation service and one provider-wide rate for each provider of day habilitation services, except that rates for residential habilitation or day habilitation services provided to individuals identified as specialized populations by OPWDD shall be determined under section 641-1.8 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 subdivisions. Such base year may be updated periodically, as determined by DOH.

(c) Components of rates for residential habilitation provided in supervised community residences.

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

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

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

Note: All new material

**Final Regulations: Amendments to Rate-Setting Methodology:
Rates for Residential Habilitation Delivered in IRAs & CRs and for
Day Habilitation Services**

Effective: November 1, 2014

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 in a DOH region, aggregated by all such providers in such region. Such sum shall be divided by the total base year salaried direct care 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 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-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.

Note: All new material

**Final Regulations: Amendments to Rate-Setting Methodology:
Rates for Residential Habilitation Delivered in IRAs & CRs and for
Day Habilitation Services**

Effective: November 1, 2014

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

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

(viii) Provider average employee-related component, which shall mean the sum of vacation leave accruals and fringe benefits 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 agency administration allocation for the base year for

Note: All new material

**Final Regulations: Amendments to Rate-Setting Methodology:
Rates for Residential Habilitation Delivered in IRAs & CRs and for
Day Habilitation Services**

Effective: November 1, 2014

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

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

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

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

(xvi) Calculated direct care hours, which shall mean the product of the statewide average direct care hours per provider, as determined pursuant to subparagraph (xiv) of this paragraph, and the statewide budget neutrality adjustment factor for hours, as determined pursuant to subparagraph (xv) of this paragraph. Such product

Note: All new material

**Final Regulations: Amendments to Rate-Setting Methodology:
Rates for Residential Habilitation Delivered in IRAs & CRs and for
Day Habilitation Services**

Effective: November 1, 2014

shall then be divided by the rate sheet capacity for the base year, pro-rated for partial year sites and such quotient multiplied by rate sheet capacity for the initial period.

(xvii) Regional average clinical hourly wage, which shall mean the quotient of base year salaried clinical dollars for each provider 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.

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

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

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

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

(xxii) Provider direct care hourly rate- adjusted for wage equalization factor, which shall mean the sum of the provider average direct care hourly rate, as determined pursuant to subparagraph (xii) of this paragraph multiplied by .75 and the applicable regional average direct care hourly rate, as determined pursuant to subparagraph (vi) of this paragraph multiplied by .25.

(xxiii) Provider clinical hourly wage – adjusted for wage equalization factor, which shall mean the sum of the provider average clinical hourly wage, as determined pursuant to subparagraph (xviii) of this paragraph, multiplied by .75 and the applicable regional average clinical hourly wage, as computed in subparagraph (xvii) of this paragraph multiplied by .25.

Note: All new material

**Final Regulations: Amendments to Rate-Setting Methodology:
Rates for Residential Habilitation Delivered in IRAs & CRs and for
Day Habilitation Services**

Effective: November 1, 2014

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

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

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

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

(xxviii) Statewide budget neutrality adjustment factor for operating dollars, which shall mean the quotient of the operating revenue from all provider rate sheets in effect on June 30, 2014, divided by provider operating revenue for all providers, as computed in subparagraph (xxvii) of this paragraph.

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

The final daily operating rate shall be determined by dividing the total provider operating revenue- adjusted, as determined pursuant to subparagraph (xxix) of this paragraph, by the applicable rate sheet capacity for the initial period and such quotient to be further divided by 365, or 366 in the case of a leap year.

(2) Alternative operating cost component. For providers that did not submit a cost report or submitted a cost report that was incomplete for residential habilitation services for the

Note: All new material

**Final Regulations: Amendments to Rate-Setting Methodology:
Rates for Residential Habilitation Delivered in IRAs & CRs and for
Day Habilitation Services**

Effective: November 1, 2014

base year, the final daily operating rate shall be a regional daily operating rate. This rate shall be the sum of:

(i) The product of the applicable regional average direct care hourly rate, as determined pursuant to subparagraph (vi) of paragraph (1) of this subdivision, and the applicable regional average direct care hours, which shall mean the quotient of salaried and contracted direct care hours for the base year for each provider in a DOH region, aggregated for all such providers in such region, divided by the rate sheet capacities for the base year, pro-rated for partial year sites for each provider in a DOH region, aggregated for all such providers in such region divided by 365, or 366 in the case of a leap year.

(ii) The product shall then be added to the product of the applicable regional average clinical hourly wage, as determined pursuant to subparagraph (xvii) of paragraph (1) of this subdivision and the applicable regional average clinical hours, which shall mean the quotient of salaried and contracted clinical hours for the base year for each provider in a DOH region, aggregated for all such providers in such region, divided by the rate sheet capacities for the base year, pro-rated for partial year sites for each provider in a DOH region, aggregated for all such providers in such region divided by 365, or 366, in the case of a leap year.

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

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

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

(ii) The final monthly State supplement shall be calculated in accordance with paragraph (6) of this subdivision, divided by twelve.

Note: All new material

**Final Regulations: Amendments to Rate-Setting Methodology:
Rates for Residential Habilitation Delivered in IRAs & CRs and for
Day Habilitation Services**

Effective: November 1, 2014

(4) Alternative facility cost component. For providers that did not submit a cost report or submitted a cost report that was incomplete for residential habilitation services provided in a supervised community residence for the base year, the final monthly facility rate shall be a regional monthly facility rate which shall mean the quotient of the sum of food, repairs and maintenance, utilities, expensed equipment, household supplies, telephone, lease/rental equipment, depreciation, insurance – property and casualty, housekeeping and maintenance staff, and program administration property for the base year divided by the rate sheet capacity for the base year, pro-rated for partial year sites for each provider in a DOH region, aggregated for all such providers in such region. Such quotient shall be multiplied by rate sheet capacity for the initial period. The final monthly State Supplement shall be calculated in accordance with paragraph (6) of this subdivision, divided by twelve.

(5) Capital component.

(i) Capital costs shall be determined pursuant to Subpart 635-6 of this Title.

Note: The provisions of this paragraph (5) do not apply to capital approved by OPWDD prior to July 1, 2014.

(ii) Initial rate. 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. DOH may retroactively adjust the capital component.

(iii) Cost verified rates. 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. Capital costs approved on or after November 1, 2014 shall be amortized over a 25 year period for acquisition of properties or the life of the lease for leased sites. 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 beginning with site certification.

Note: All new material

**Final Regulations: Amendments to Rate-Setting Methodology:
Rates for Residential Habilitation Delivered in IRAs & CRs and for
Day Habilitation Services**

Effective: November 1, 2014

(iv) Renovations of existing provider owned residential programs shall be funded through the Residential Reserve for Replacement (RRR).

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

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

(ii) Supplemental security income, as determined by subparagraph 671.7(b)(9)(xxi) of this Title, annualized and multiplied by a provider's initial period rate sheet capacity.

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

(iv) The sum of subparagraphs (ii) and (iii) of this paragraph shall be deducted from the amount determined pursuant to subparagraph (i) of this paragraph. If such amount is negative, the State supplement will be equal to zero. If such amount is positive, a provider shall receive the State supplement amount multiplied by the statewide budget neutrality factor for State supplement as calculated below.

(v) Statewide budget neutrality factor for State supplement, which shall mean the sum of the State supplement from all provider rate sheets in effect on June 30, 2014, less \$6 million consistent with the savings plan developed by the workgroup established pursuant to Chapter 53 of the Laws of 2013, divided by the sum of the State supplement for all providers, as calculated pursuant to subparagraph (iv) of this paragraph.

If the sum of the State supplement from all provider rate sheets in effect on June 30, 2014 is lower than the sum of the State supplement for all providers as calculated pursuant to subparagraph (iv) of this paragraph then the Statewide budget neutrality factor shall be applied. If such sum is greater, then no Statewide budget neutrality factor for State supplement shall be applied

(7) Adjustment for July 1, 2014 through October 31, 2014. DOH shall calculate the amount of reimbursement each provider would have received for July 1 through October 31, 2014 services under the methodology described in the November 1, 2014 amendments to this

Note: All new material

**Final Regulations: Amendments to Rate-Setting Methodology:
Rates for Residential Habilitation Delivered in IRAs & CRs and for
Day Habilitation Services**

Effective: November 1, 2014

Subpart. DOH or OPWDD shall pay each provider the difference between such reimbursement and the amount the provider was entitled to receive under this Subpart in effect from July 1 to October 31, 2014.

(d) Components of rates for residential habilitation provided in supportive community residences.

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

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

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

Note: All new material

**Final Regulations: Amendments to Rate-Setting Methodology:
Rates for Residential Habilitation Delivered in IRAs & CRs and for
Day Habilitation Services**

Effective: November 1, 2014

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 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 such providers in such region). The regional average direct care hourly rate-exclusive of general and administrative costs, as determined pursuant to subparagraph (iv) of this paragraph, shall then be divided by (one minus the applicable regional average general and administrative quotient), from which the applicable regional average direct care wage hourly rate-excluding general and administrative, as computed in subparagraph (iv) of this paragraph shall be subtracted.

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

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

(viii) Provider average employee-related component, which shall mean the sum of vacation leave accruals and fringe benefits of each provider, divided by a provider's

Note: All new material

**Final Regulations: Amendments to Rate-Setting Methodology:
Rates for Residential Habilitation Delivered in IRAs & CRs and for
Day Habilitation Services**

Effective: November 1, 2014

salaries direct care dollars, such quotient to be multiplied by the provider average direct care wage as computed in subparagraph (vii) of this paragraph.

(ix) Provider average program support component, which shall mean the sum of transportation related-participant, staff travel, participant incidentals, expensed adaptive equipment, sub-contract raw materials, participant wages-non-contract, participant wages-contract, participant fringe benefits, staff development, supplies and materials-non-household, other-OTPS, lease/rental vehicle, depreciation-vehicle, interest-vehicle, other-equipment, other than to/from transportation allocation, salaries support dollars (excluding housekeeping and maintenance staff) and salaries program administration dollars of a provider. Such sum shall be divided by the salaries 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 agency administration allocation 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 equipment, insurance – property and casualty, total property-provider paid, housekeeping and maintenance staff, salaries clinical dollars and contracted clinical dollars for the base year for a provider). The provider average direct care hourly rate-excluding general and administrative, as computed in subparagraph (x) of this paragraph, shall then be divided by (one minus the applicable provider 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

Note: All new material

**Final Regulations: Amendments to Rate-Setting Methodology:
Rates for Residential Habilitation Delivered in IRAs & CRs and for
Day Habilitation Services**

Effective: November 1, 2014

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

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

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

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

(xvii) Regional average clinical hourly wage, which shall mean the quotient of base year salaried clinical dollars for each provider 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.

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

(xix) Provider salaried clinical hours, which shall mean the quotient of base year salaried clinical hours of a provider, divided by the rate sheet capacity for the base

Note: All new material

**Final Regulations: Amendments to Rate-Setting Methodology:
Rates for Residential Habilitation Delivered in IRAs & CRs and for
Day Habilitation Services**

Effective: November 1, 2014

year, pro-rated for partial year sites, such quotient to be multiplied by the rate sheet capacity for the initial period for such provider.

(xx) Regional average contracted clinical hourly wage, which shall mean the quotient of base year contracted clinical dollars of each provider in a DOH region, aggregated of 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.

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

(xxii) Provider direct care hourly rate- adjusted for wage equalization factor, which shall mean the sum of the provider average direct care hourly rate, as determined pursuant to subparagraph (xii) of this paragraph multiplied by .75 and the applicable regional average direct care hourly rate, as determined pursuant to subparagraph (vi) of this paragraph multiplied by .25.

(xxiii) Provider clinical hourly wage – adjusted for wage equalization factor, which shall mean the sum of the provider average clinical hourly wage, as determined pursuant to subparagraph (xviii) of this paragraph, multiplied by .75 and the applicable regional average clinical hourly wage, as computed in subparagraph (xvii) of this paragraph multiplied by .25.

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

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

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

Note: All new material

**Final Regulations: Amendments to Rate-Setting Methodology:
Rates for Residential Habilitation Delivered in IRAs & CRs and for
Day Habilitation Services**

Effective: November 1, 2014

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

(xxviii) Statewide budget neutrality adjustment factor for operating dollars, which shall mean the quotient of the operating revenue from all provider rate sheets in effect on June 30, 2014, divided by provider operating revenue for all providers, as computed in subparagraph (xxvii) of this paragraph.

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

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

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

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

(ii) The product shall then be added to the product of the applicable regional average clinical hourly wage, as determined pursuant to subparagraph (xvii) of paragraph (1) of this subdivision and the applicable regional average clinical hours, which shall mean the quotient of salaried and contracted clinical hours for the base year for

Note: All new material

**Final Regulations: Amendments to Rate-Setting Methodology:
Rates for Residential Habilitation Delivered in IRAs & CRs and for
Day Habilitation Services**

Effective: November 1, 2014

each provider in a DOH region, aggregated for all such providers in such region, divided by the rate sheet capacities for the base year, pro-rated for partial year sites for each provider in a DOH region, aggregated for all such providers in such region divided by twelve.

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

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

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

(ii) The final monthly State Supplement shall be calculated in accordance with paragraph (6) of this subdivision, divided by the applicable rate sheet capacity for the initial period and such quotient to be further divided by twelve.

(4) Alternative facility cost component. For providers that did not submit a cost report or submitted a cost report that was incomplete for residential habilitation services provided in a supportive community residence for the base year, the final monthly facility rate shall be a regional monthly facility rate which shall mean the quotient of the sum of food, repairs and maintenance, utilities, expensed equipment, household supplies, telephone, lease/rental equipment, depreciation, insurance – property and casualty, housekeeping and maintenance staff, and program administration property for the base year divided by the rate sheet capacity for the base year, pro-rated for partial year sites for each provider in a DOH region, aggregated for all such providers in such region. Such quotient shall be multiplied by rate sheet capacity for the initial year. The final monthly State supplement shall be calculated in accordance with paragraph (6) of this subdivision, divided by the applicable rate sheet capacity for the initial period, and such quotient to be further divided by twelve.

(5) Capital cost component.

Note: All new material

**Final Regulations: Amendments to Rate-Setting Methodology:
Rates for Residential Habilitation Delivered in IRAs & CRs and for
Day Habilitation Services**

Effective: November 1, 2014

(i) Capital costs shall be determined under Subpart 635-6 of this Title

Note: The provisions of this paragraph (5) do not apply to capital approved by OPWDD prior to July 1, 2014.

(ii) Initial rate. 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. DOH may retroactively adjust the capital component.

(iii) Cost verified rates. 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. Capital costs approved on or after November 1, 2014 shall be amortized over a 25 year period for acquisition of properties or the life of the lease for leased sites. 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 beginning with site certification.

(iv) Renovations of existing provider owned residential programs shall be funded through the Residential Reserve for Replacement (RRR).

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

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

(ii) Supplemental security income, as determined by subparagraph 671.7(b)(9)(xxi) of this Title, annualized and multiplied by a provider's initial period rate sheet capacity.

Note: All new material

**Final Regulations: Amendments to Rate-Setting Methodology:
Rates for Residential Habilitation Delivered in IRAs & CRs and for
Day Habilitation Services**

Effective: November 1, 2014

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

(iv) The sum of subparagraphs (ii) and (iii) of this paragraph shall be deducted from the amount determined pursuant to subparagraph (i) of this paragraph. If such amount is negative, the State supplement will be equal to zero. If such amount is positive, a provider shall receive the State supplement amount multiplied by the Statewide budget neutrality factor for State supplement as calculated below.

Statewide budget neutrality factor for State supplement, which shall mean the sum of the State supplement from all provider rate sheets in effect on June 30, 2014, divided by the sum of the State supplement for all providers, as calculated pursuant to subparagraph (iv) of this paragraph.

If the sum of the State supplement from all provider rate sheets in effect on June 30, 2014 is lower than the sum of the State supplement for all providers as calculated pursuant to subparagraph (iv) of this paragraph then the Statewide budget neutrality factor shall be applied. If such sum is greater, then no Statewide budget neutrality factor for State supplement shall be applied

(7) Adjustment for July 1, 2014 through October 31, 2014. DOH shall calculate the amount of reimbursement each provider would have received for July 1 through October 31, 2014 services under the methodology described in the November 1, 2014 amendments to this Subpart. DOH or OPWDD shall pay each provider the difference between such reimbursement and the amount the provider was entitled to receive under this Subpart in effect from July 1 to October 31, 2014.

(e) Day habilitation – group and supplemental.

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

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

Note: All new material

**Final Regulations: Amendments to Rate-Setting Methodology:
Rates for Residential Habilitation Delivered in IRAs & CRs and for
Day Habilitation Services**

Effective: November 1, 2014

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 in 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 in 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 in a DOH region, aggregated by all such providers in such region. Such sum shall be divided by the total base year salaried direct care 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 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 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

Note: All new material

**Final Regulations: Amendments to Rate-Setting Methodology:
Rates for Residential Habilitation Delivered in IRAs & CRs and for
Day Habilitation Services**

Effective: November 1, 2014

provider in a DOH region, aggregated for all providers in such region). The regional average direct care hourly rate-exclusive of general and administrative costs, as determined pursuant to subparagraph (iv) of this paragraph, shall then be divided by (one minus the applicable regional average general and administrative quotient), from which the applicable regional average direct care wage hourly rate-excluding general and administrative, as computed in subparagraph (iv) of this paragraph shall be subtracted.

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

Note: All new material

**Final Regulations: Amendments to Rate-Setting Methodology:
Rates for Residential Habilitation Delivered in IRAs & CRs and for
Day Habilitation Services**

Effective: November 1, 2014

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 agency 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 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, 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 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 average general and administrative component as determined pursuant to subparagraph (xi) of this paragraph.

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

(xiv) Regional average clinical hourly wage, which shall mean the quotient of base year salaried clinical dollars for each provider 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.

Note: All new material

**Final Regulations: Amendments to Rate-Setting Methodology:
Rates for Residential Habilitation Delivered in IRAs & CRs and for
Day Habilitation Services**

Effective: November 1, 2014

(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 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, 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 .75 and the applicable regional average direct care hourly rate, as determined pursuant to subparagraph (vi) of this paragraph multiplied by .25.

(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 .75 and the applicable regional average clinical hourly wage, as computed in subparagraph (xiv) of this paragraph multiplied by .25.

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

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

(xxiii) Provider reimbursement from contracted clinical hourly wage, which shall mean the product of the provider contracted clinical hours, as determined pursuant

Note: All new material

**Final Regulations: Amendments to Rate-Setting Methodology:
Rates for Residential Habilitation Delivered in IRAs & CRs and for
Day Habilitation Services**

Effective: November 1, 2014

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 equipment, insurance – property and casualty, housekeeping and maintenance staff, and program administration property for 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 to/from transportation reimbursement, which shall mean the quotient of the to/from transportation allocation for the base year divided by the provider billed units for the base year. Such quotient to be multiplied by rate sheet units for the initial period.

(xxvi) Provider operating revenue, which shall mean the sum of provider reimbursement from direct care hourly rate, as determined pursuant to subparagraph (xxi) of this paragraph, the provider reimbursement from clinical hourly wage, as determined pursuant to subparagraph (xxii) of this paragraph, the provider reimbursement from contracted clinical hourly wage, as determined pursuant to subparagraph (xxiii) of this paragraph, the provider facility 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 all provider rate sheets in effect on June 30, 2014, 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.

Note: All new material

**Final Regulations: Amendments to Rate-Setting Methodology:
Rates for Residential Habilitation Delivered in IRAs & CRs and for
Day Habilitation Services**

Effective: November 1, 2014

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

(i) The product of the applicable regional average direct care hourly rate, as determined pursuant to subparagraph (vi) of paragraph (1) of this subdivision and the applicable regional average direct care hours, which shall mean the quotient of salaried and base year contracted direct care hours for each provider 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 salaried and base year 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.

Note: All new material

**Final Regulations: Amendments to Rate-Setting Methodology:
Rates for Residential Habilitation Delivered in IRAs & CRs and for
Day Habilitation Services**

Effective: November 1, 2014

- (i) For Capital Assets Approved on or after July 1, 2014. OPWDD regulations at Subpart 635-6 of this Title establish standards and criteria for calculating provider reimbursement for the acquisition and lease of real property assets which require approval by OPWDD. 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 25 years.

- (ii) For Capital Assets Approved Prior to July 1, 2014. 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. Subpart 635-6 of this Title 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) Initial rate for capital assets approved on or after July 1, 2014. 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. DOH may retroactively adjust the capital component.

Note: All new material

**Final Regulations: Amendments to Rate-Setting Methodology:
Rates for Residential Habilitation Delivered in IRAs & CRs and for
Day Habilitation Services**

Effective: November 1, 2014

- (v) Cost verified rates for capital assets approved on or after July 1, 2014. 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 25 year period for acquisition of properties or amortized over 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.
- (vi) Capital reimbursement reconciliation schedule. Beginning with the cost reporting period ending December 31, 2014, each provider shall submit to OPWDD, as part of the annual cost report, a capital reimbursement reconciliation 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 reconciliation schedule.

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

641-1.4. Reporting requirements.

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

Note: All new material

**Final Regulations: Amendments to Rate-Setting Methodology:
Rates for Residential Habilitation Delivered in IRAs & CRs and for
Day Habilitation Services**

Effective: November 1, 2014

(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).

641-1.5. Trend Factor. 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. 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.

641-1.6. Transition periods and reimbursement.

(a) Transition to new methodology. The reimbursement methodology described in this subpart will be phased-in over a three-year period, with a year for purposes of the transition period meaning a twelve month period from July 1st to the following June 30th, and with full implementation in the beginning of the fourth year. During this transition period, the base operating rate will transition to the target rate as determined by the reimbursement methodology described in this subpart, 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 Year	Phase-in Percentage	
	Base operating rate	Target Rate
Year One (July 1, 2014 – June 30, 2015)	75%	25%
Year Two (July 1, 2015 – June 30, 2016)	50%	50%
Year Three (July 1, 2016 - June 30, 2017)	25%	75%
Year Four (July 1, 2017 – June 30, 2018)	0%	100%

(b) Transition from monthly to daily units of service. Reimbursement for residential habilitation provided in supervised community residences shall be according to a daily unit

Note: All new material

**Final Regulations: Amendments to Rate-Setting Methodology:
Rates for Residential Habilitation Delivered in IRAs & CRs and for
Day Habilitation Services**

Effective: November 1, 2014

of service. From the period beginning July 1, 2014 through June 30, 2015, providers that receive reimbursement of residential habilitation in supervised community residences pursuant to this Subpart shall determine and report to DOH retainer days, therapeutic leave days and vacant bed days.

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

(i) Retainer days shall be reimbursed at zero dollars.

(ii) At the mid-point and again at the conclusion of the period ending June 30, 2015, DOH will reconcile the services recorded under the retainer days in order to determine the amount of reimbursement owed to the provider. Providers shall be paid for retainer days at the level described in subdivision (a) of this section.

(iii) Providers shall not be paid for more than fourteen retainer days per annual period for any one individual.

(2) Therapeutic leave days shall mean days during which an individual is away from the community residence and is not receiving services from residential habilitation staff, and the absence is for the purpose of visiting with family or friends, or a vacation. Therapeutic leave days shall be reimbursed at the level described in subdivision (a) of this section.

(3) Vacant bed days shall mean days for which the provider is unable to bill due to a resident moving from one residential site to another, or due to a resident passing away. At the conclusion of the period ending June 30, 2015, providers will be paid for vacant bed days at seventy five percent of the level described in subdivision (a) of this section up to a maximum of ninety days per bed.

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

(1) The daily rate, as determined pursuant to this Subpart, excluding section 641-1.8 will be adjusted to include an occupancy factor.

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

Note: All new material

**Final Regulations: Amendments to Rate-Setting Methodology:
Rates for Residential Habilitation Delivered in IRAs & CRs and for
Day Habilitation Services**

Effective: November 1, 2014

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

641-1.7. Rate corrections

- (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 either residential habilitation services provided in community residences or day habilitation services.
- (b) In order to request a rate correction in accordance with subdivision (a) of this section, the provider must send to Department of Health its request by certified mail, return receipt requested, within 90 days of the provider receiving the rate computation or within 90 days of the first day of the rate period in question, whichever is later.

641-1.8. Specialized template populations. Notwithstanding any other provision 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" means the counties of New York, Kings, Bronx, Queens, Richmond, Nassau, Suffolk, Westchester, Rockland, Orange, Sullivan, Putnam and Dutchess, and "Upstate" means all other counties in New York State.

- (a) For individuals initially identified as qualifying for specialized template populations funding between November 1, 2011 and March 31, 2014

Residential – Specialized Level of Care	
Region	Gross Annual Funding Allocation Per Individual (Operating only)
Downstate	\$166,400
Upstate	\$150,500

Residential – Highly Complex Level of Care	
Region	Gross Annual Funding Allocation Per Individual (Operating only)
Downstate	\$189,500
Upstate	\$171,500

Note: All new material

**Final Regulations: Amendments to Rate-Setting Methodology:
Rates for Residential Habilitation Delivered in IRAs & CRs and for
Day Habilitation Services**
Effective: November 1, 2014

Residential – Auspice Change	
Region	Gross Annual Funding Allocation Per Individual (Operating only)
Downstate	\$136,500
Upstate	\$123,500

Day Hab – Specialized Level of Care	
Region	Gross Annual Funding Allocation Per Individual (Operating only)
Downstate	\$41,730
Upstate	\$37,562

Day Hab – 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 31, 2014

Residential – Highly Complex Level of Care	
Region	Gross Annual Funding Allocation Per Individual (Operating only)
Downstate	\$189,500
Upstate	\$171,500

Note: All new material

**Final Regulations: Amendments to Rate-Setting Methodology:
Rates for Residential Habilitation Delivered in IRAs & CRs and for
Day Habilitation Services**
Effective: November 1, 2014

Residential – Auspice Change	
Region	Gross Annual Funding Allocation Per Individual (Operating Only)
Downstate	\$136,500
Upstate	\$123,500

Day Hab – Highly Complex Level of Care	
Region	Gross Annual Funding Allocation Per Individual (Operating only)
Downstate	\$46,433
Upstate	\$43,063

Note: All new material
35