

Application for a §1915(c) Home and Community-Based Services Waiver

PURPOSE OF THE HCBS WAIVER PROGRAM

The Medicaid Home and Community-Based Services (HCBS) waiver program is authorized in § 1915(c) of the Social Security Act. The program permits a state to furnish an array of home and community-based services that assist Medicaid beneficiaries to live in the community and avoid institutionalization. The State has broad discretion to design its waiver program to address the needs of the waiver target population. Waiver services complement and/or supplement the services that are available to participants through the Medicaid State plan and other federal, state and local public programs as well as the supports that families and communities provide.

The Centers for Medicare & Medicaid Services (CMS) recognizes that the design and operational features of a waiver program will vary depending on the specific needs of the target population, the resources available to the state, service delivery system structure, state goals and objectives, and other factors. A State has the latitude to design a waiver program that is cost-effective and employs a variety of service delivery approaches, including participant direction of services.

Request for an Amendment to a §1915(c) Home and Community-Based Services Waiver

1. Request Information

A. The **State of New York** requests approval for an amendment to the following Medicaid home and community-based services waiver approved under authority of § 1915(c) of the Social Security Act.

B. Program Title:

NYS OPWDD Comprehensive Renewal Waiver

C. Waiver Number: NY.0238

Original Base Waiver Number: NY.0238.

D. Amendment Number: NY.0238.R06.14

E. Proposed Effective Date: (mm/dd/yy)

10/01/23

Approved Effective Date: 10/01/23

Approved Effective Date of Waiver being Amended: 10/01/19

2. Purpose(s) of Amendment

Purpose(s) of the Amendment. Describe the purpose(s) of the amendment:

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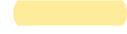




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300s), totaled by DOH Region, by Salaried Clinical hours (CFR4, Title Code 300s), totaled by DOH Region.

- (o) Provider Average Clinical Hourly Wage = From the CFR for the base year, divide Salaried Clinical dollars (CFR4, Title Code 300s), totaled by provider, by Salaried Clinical hours (CFR4, Title Code 300s), totaled by provider.
- (p) Provider Salaried Clinical Hours = From the CFR for the base year, divide Salaried Clinical hours (CFR4, Title 300s), totaled by provider, by provider billed units for the base year. Multiply by Rate Period authorized units for the Initial Period.
- (q) Regional Average Contracted Clinical Hourly Wage = From the CFR for the base year, divide Contracted Clinical dollars (CFR4A, Title Code 300s) totaled by DOH Region by Contracted Clinical hours (CFR4A, Title Code 300s), totaled by DOH Region.
- (r) Provider Contracted Clinical Hours = From the CFR for the base year, divide Contracted Clinical hours (CFR4A, Title 300s), totaled by provider, by provider billed units for the base year. Multiply by Rate Period authorized units for the Initial Period.
- (s) Provider Direct Care Hourly Rate- Adjusted for Wage Equalization = Multiply applicable Provider Average Direct Care Hourly Rate, as computed in subparagraph (l) of this paragraph, by .75. Multiply applicable Regional Average Direct Care Hourly Rate, as computed in subparagraph (f) of this paragraph, by .25. Add results together.
- (t) Provider Clinical Hourly Wage – Adjusted for Wage Equalization = Multiply applicable Provider Average Clinical Hourly Wage, as computed in subparagraph (o) of this paragraph, by .75. Multiply applicable Regional Average Clinical Hourly Wage, as computed in subparagraph (n) of this paragraph, by .25. Add results together.
- (u) Provider Reimbursement from Direct Care Hourly Rate = Multiply applicable Provider Direct Care Hours, as computed in subparagraph (m) of this paragraph, by applicable Provider Direct Care Hourly Rate-Adjusted for Wage Equalization, as computed in subparagraph (s) of this paragraph.
- (v) Provider Reimbursement from Clinical Hourly Wage = Multiply applicable Provider Salaried Clinical Hours, as computed in subparagraph (p) of this paragraph, by applicable Provider Clinical Hourly Wage-Adjusted for Wage Equalization, as computed in subparagraph (t) of this paragraph.
- (w) Provider Reimbursement from Contracted Clinical Hourly Wage = Multiply applicable Provider Contracted Clinical Hours, as computed in subparagraph (r) of this paragraph, by applicable

Regional Average Contracted Clinical Hourly Wage, as computed in subparagraph (q) of this paragraph.

- (x) Provider Facility Reimbursement – From the CFR for the base year, add Food (CFR line 21), Repairs and Maintenance (CFR1 line 22), Utilities (CFR1 line 23), Expensed Equipment (CFR1 line 28), Household Supplies (CFR1 line 37), Telephone (CFR1 line 38), Lease/Rental Equipment (CFR1 line 43), Depreciation Equipment (CFR1 line 45), Insurance – Property and Casualty (CFR1 line 55), Housekeeping and Maintenance Staff (CFR4 Title 102), and Program Administration Property (OPWDD4 line 24), totaled by provider. Divide by the provider billed units for the base year. Multiply by Rate Period authorized units for the Initial Period.
- (y) To/From Transportation will be updated on 7/01/2024. After 7/01/2024 to/from transportation will be updated annually by utilizing the most current available CFR. Divide To/From Transportation Allocation (CFR1 line 68b) by applicable provider billed units. Multiply by rate period authorized units.
- (z) Provider Operating Revenue = Add applicable Provider Reimbursement from Direct Care Hourly Rate, as computed in subparagraph (u) of this paragraph, applicable Provider Reimbursement from Clinical Hourly Wage, as computed in subparagraph (v) of this paragraph, applicable Provider Reimbursement from Contracted Clinical Hourly Wage, as computed in subparagraph (w) of this paragraph, applicable Provider Facility Reimbursement, as computed in subparagraph (x) of this paragraph, and Provider To/From Transportation Reimbursement, as computed in subparagraph (y) of this paragraph.
- (aa) Statewide Budget Neutrality Adjustment Factor for Operating Dollars = Divide Operating Revenue from all provider Rate.

Sheets in effect 06/30/15, by Provider Operating Revenue for all providers, as computed in subparagraph (z) of this paragraph.
- (bb) Total Provider Operating Revenue- Adjusted = Multiply applicable Provider Operating Revenue, as computed in subparagraph (z) of this paragraph, by Statewide Budget Neutrality Adjustment Factor for Operating Dollars, as computed in subparagraph (aa) of this paragraph.
- (cc) Total Capital Reimbursement = Capital reimbursement shall be computed as described in subparagraph (ii) of this paragraph.
- (dd) Target Daily Rate = Add applicable Total Provider Operating Revenue-Adjusted, as computed in subparagraph (bb) of this paragraph and Total Capital Reimbursement, as computed in

subparagraph (cc) of this paragraph. Divide sum by applicable provider Rate Period authorized units for the Initial Period.

- ii. Total Capital Reimbursement = Capital reimbursement shall be computed as follows:
 - (a) For Capital Assets Approved by OPWDD on Prior Property Approvals Prior to July 1, 2014. OPWDD regulations under 14 NYCRR Subpart 635-6 establish standards and criteria that describes the Capital acquisition and lease of real property assets which require approval by OPWDD.
 1. Reimbursement rates will include actual straight-line depreciation, amortization, Interest expense, financing expenses, and lease costs.
 2. OPWDD will never approve lease or acquisition costs in excess of the lower of fair market value (as determined by an independent appraisal) or the provider's actual cost. However, OPWDD may limit the approved costs to a lower amount based on a review of the reasonableness of the transaction and price and a comparison of costs to those of similar facilities with the same characteristics. For example, if a provider purchases or leases a property in an area in which real estate costs are considerably higher than those in the surrounding areas, and an equally suitable property in the surrounding area was available to the provider for purchase or lease at a lower cost, OPWDD may limit the allowable costs to those of properties in the surrounding area.
 3. In no case will the total capital reimbursement associated with the capital asset exceed the total acquisition or renovation cost associated with a capital asset.
 4. The State will identify each asset by provider and provide a schedule of these assets identifying: total actual cost, reimbursable cost and useful life, determined by the prior property 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.
 5. Notification to Providers. Each provider will receive supporting documentation detailing all real property to be included in the capital component of the provider's reimbursement rate.
 - (b) Capital rate for capital assets approved by OPWDD on Prior Property Approvals on or after July 1, 2014. OPWDD regulations under 14 NYCRR Subpart 635-6 establish standards and criteria that describes the Capital acquisition and lease of real property assets which require approval by OPWDD.

1. Reimbursement rates will include actual straight-line depreciation, Interest expense, financing expenses, and lease cost established using generally accepted accounting principles, comply with CMS Publication – 15 (Medicare cost and cost allocation principles) and establish useful lives using the American Hospital Association (AHA) Estimated Useful Lives of Depreciable Hospital Assets Revised 2008 Edition.
2. OPWDD will never approve lease or acquisition costs in excess of the lower of fair market value (as determined by an independent appraisal) or the provider's actual cost. However, OPWDD may limit the approved costs to a lower amount based on a review of the reasonableness of the transaction and price and a comparison of costs to those of similar facilities with the same characteristics. For example, if a provider purchases or leases a property in an area in which real estate costs are considerably higher than those in the surrounding areas, and an equally suitable property in the surrounding area was available to the provider for purchase or lease at a lower cost, OPWDD may limit the allowable costs to those of properties in the surrounding area.
3. 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.
4. The State will identify each asset by provider and provide a schedule of these assets identifying: total actual cost, reimbursable cost and useful life, determined by the prior property 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.
5. Notification to Providers. Each provider will receive supporting documentation detailing all real property to be included in the capital component of the provider's reimbursement rate.
6. The rate shall include applicable annual interest, depreciation and/or amortization of the approved appraised costs of an acquisition for a useful life consistent with AHA guidelines, 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, 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, the amount of capital costs included in the rate shall be zero for

each period in which actual costs are not submitted. DOH will retroactively adjust the capital component; and will return FFP to CMS on the next quarterly expenditure report (CMS-64) following the two-year period. Once the final cost reconciliation has been received by the Department of Health, the rate will be retroactively adjusted to include reconciled costs.

7. 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 amortized according to AHA guidelines for the acquisition of properties or the life of the lease for leased sites. Capital improvements shall be depreciated over the life of the asset, or the revised useful life of the asset as a result of the capital improvements, whichever is greater. 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 shall be amortized over a one-year period beginning with certification of the site. 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 will retroactively adjust capital reimbursement based on the actual cost verification process as described in subparagraph II of this paragraph.

(c) CFR reporting for Capital assets:

1. Expenses relating to Equipment are reported in two sections of CFR-1. Expensed equipment is included under the Other Than Personal Services (OTPS) section of CFR-1 and is included in the operating portion of the rate reimbursement (Lines 27 & 28). Depreciable equipment expenses are included under the Equipment section of CFR-1 and all items in this section are included in the operating portion of the rate reimbursement (Lines 42-47).
2. Capital expenses related to real property are included under the Property section of the CFR-1 (Lines 49-62). With the exception of Insurance-Property or Casualty, which is reported on CFR-1, Line 55, Lines 49-62 are not included in the rates. Alternatively, providers are reimbursed for Capital in accordance with the capital schedule (as identified in 1. iv

and 2. iv of this paragraph) and the Insurance-Property or Casualty reported on CFR-1, Line 55.

3. All expenses reported on CFR-1 are to be reported in accordance with Appendix X – Adjustments to Reported Costs, dated January 1, 2014, which details expenses that are considered to be non-allowable. CFR instructions for reporting depreciation and amortization are included in Appendix O of the January 1, 2014 CFR Manual, which can be found at:

http://www.oms.nysed.gov/rsu/Manuals_Forms/Manuals/CFRManual/home.html

4. Capital 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 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 costs. The provider's independent auditor will apply procedures to verify the accuracy and completeness of the capital schedule.
5. For cost reporting periods beginning July 1, 2015 and thereafter, NS providers are required to file an annual CFR to the State by June 1st for providers reporting on the January 1st through December 31st period or December 1st for providers reporting on the July 1st through June 30th period. If the completed CFR is not submitted by either June 1st for providers reporting on the January 1st through December 31st period or December 1st for providers reporting on the July 1st through June 30th period, a 2 percent penalty on the provider's OPWDD Medicaid reimbursement will be imposed effective on the due date of the CFR. However, OPWDD will not impose such a penalty if it determines that there were unforeseeable circumstances beyond the provider's control (such as a natural disaster, or other circumstance as determined by the OPWDD commissioner) that prevented the provider from filing the cost report by the due date.

- iii. Alternative Operating Cost Component – For providers that did not submit a cost report for Pre Vocational Site Based services for the base year, the target daily operating rate shall be a regional daily operating rate, calculated as follows:

- (a) Reimbursement from Regional Direct Care Hourly Rate = from the base year, divide the Salaried and Contracted Direct Care Hours (CFR4 and CFR4-A, Title 200s), totaled by DOH region, by

billed units for the base year (pro-rated for partial year sites), totaled by DOH region. Multiply by the applicable Regional Average Direct Care Hourly Rate, as computed in subparagraph (f) of paragraph i, and by Rate Period authorized units for the Initial Period.

- (b) Reimbursement from Regional Clinical Hourly Wage = from the base year, divide the Salaried and Contracted Clinical Hours (CFR4 and CFR4-A, Title 300s), totaled by DOH region, by billed units for the base year (pro-rated for partial year sites), totaled by DOH region. Multiply by the applicable Regional Average Clinical Hourly Wage, as computed in subparagraph (n) of paragraph i, and by Rate Period authorized units for the Initial Period.
- (c) Provider Operating Revenue = Add applicable Reimbursement from Regional Direct Care Hourly Rate, as computed in subparagraph (a) of this paragraph, and applicable Reimbursement from Regional Clinical Hourly Wage, as computed in subparagraph (b) of this paragraph.
- (d) Total Provider Operating Revenue – Adjusted = Multiply applicable Provider Operating Revenue, as computed in subparagraph (c) of this paragraph, by Statewide Budget Neutrality Adjustment Factor for Operating Dollars, as computed in subparagraph (bb) of paragraph i.
- (e) Total Capital Reimbursement = Capital reimbursement shall be computed as described in subparagraph (cc) of paragraph i.
- (f) Target Regional Daily Rate = Add applicable Total Provider Operating Revenue-Adjusted, as computed in subparagraph (d) of this paragraph and Total Capital Reimbursement, as computed in subparagraph (e) of this paragraph. Divide sum by applicable provider Rate Period authorized units for the Initial Period This rate will be in effect until such time that the provider has submitted a cost report for a base year which will be used in the calculation of a subsequent rate period.

The rates are available here:

https://www.health.ny.gov/health_care/medicaid/rates/mental_hygiene/index.htm. These rates may be adjusted to incorporate funding to reflect cost-of Living (COLA), compensation increases, or any other adjustments authorized pursuant to NYS law.

For cost reporting periods beginning July 1, 2015 and thereafter, NS providers are required to file an annual CFR to the State by June 1st for providers reporting on the January 1st through December 31st period or December 1st for providers reporting on the July 1st through June 30th period. If the completed CFR is not submitted by either June 1st for providers reporting on the January 1st through December 31st period or December 1st for

providers reporting on the July 1st through June 30th period, a 2 percent penalty on the provider's OPWDD Medicaid reimbursement will be imposed effective on the due date of the CFR. However, OPWDD will not impose such a penalty if it determines that there were unforeseeable circumstances beyond the provider's control (such as a natural disaster, or other circumstance as determined by the OPWDD commissioner) that prevented the provider from filing the cost report by the due date.

h. Subsequent Rate Periods for Pre Vocational Services:

- i. The Department will follow a rate cycle utilizing the base period CFR.

i. **Changes in Ownership and Control** - The following will be effective beginning August 1, 2017.

Where a non-state governmental provider or voluntary provider ceases some or all of its operations due to:

- i. a limitation, suspension, revocation, or surrender of that provider's operating certificate;
- ii. bankruptcy or other financial or operational distress; or
- iii. dissolution of the provider under State Law;

and there may arise or arises an emergency situation of a loss of services to individuals, OPWDD will transfer all of the affected provider's services to another voluntary provider at a temporarily enhanced reimbursement rate as described below.

In those emergency situations, the voluntary provider assuming the transferred services will be reimbursed at a rate which is the higher of the two providers' rates, as those rates are calculated in accordance with NY.0238 (hereafter "higher of rate"). The higher of rate will be in effect until a full year's cost of providing services to the individual(s) impacted by the transfer of services is reflected in the assuming provider's base year CFR.

In situations where a non-state governmental provider or voluntary provider ceases some or all of its operations due to circumstances other than those specified in subparagraphs (i), (ii) or (iii) of this paragraph, or there is no emergency situation of a loss of services to individuals, any provider assuming the operation of those services will not be eligible for a temporarily enhanced reimbursement rate. The assuming provider will use their rate as calculated for all of the individuals they are taking over services for.

- j. The following services will be reimbursed based on the fee schedules found using the link below as of **10/1/2023**. These fees reflect the

adjustments as described in Section VII. The fees are calculated utilizing various factors, including but not limited to, provider costs, historical utilization, DDP-2 scores, regional averages and review of nationally accepted methodologies and fees. Fee schedules are posted on the Department of Health's webpage at:

https://www.health.ny.gov/health_care/medicaid/rates/mental_hygiene/index.htm. These fees may be adjusted to incorporate funding to reflect cost-of living adjustment (COLA)s, compensation increases, or any other adjustments authorized pursuant to NYS law.

- i. Community Habilitation
 - ii. Intensive Behavioral Services
 - iii. Family Education and Training
 - iv. Supported Employment Services (SEMP)
 - v. Pathway to Employment
 - vi. Prevocational (Community Based)
 - vii. Residential Habilitation (Family Care)
 - viii. Respite
 - ix. Higher Needs Funding
 - x. Home Enabling Supports (Product and Monthly Fees)
- (a) The Respite fee schedule will be used to compute a 24-hour per day reimbursement for no more than 42 days in a 180-day period per beneficiary. For days in excess of the 42 days, the maximum amount for any 24-hour period, per individual beneficiary, that may be paid under this waiver is limited to the Regional Rate – Daily using the link above.
- (b) Higher Needs Funding - Effective July 1, 2017 the State will set a Higher Needs rate for Services delivered to individuals with Developmental Disabilities, who are not currently being served in one of the following services or individuals who are currently being served but have experienced a significant change in their status as described below. Eligibility for the Higher Needs rate will be based upon an evaluation of the person's needs for additional direct care and/or clinical support hours that are eligible for funding as part of a Residential or Day Habilitation rate.

This method applies to individuals who are approved for one or more of the following services on and after July 1, 2017:

- Residential Habilitation – Supervised IRA
- Residential Habilitation – Supportive IRA
- Day Habilitation

1. "Significant change" is a decline in a person's status that has occurred within the previous six months and:
 - (i) Will not normally resolve itself without intervention by staff and i.e. it is not "self-remitting;"
 - (ii) Impacts more than one area of the person's health and/or behavioral status;
 - (iii) Requires professional review and/or revision of the care plan; and

- (iv) Results in the newly identified staffing need for enhanced or increased oversight supervision.
2. OPWDD will conduct a clinical determination of the level of direct care and/or clinical support needs of an individual at the time he or she requests one of the above-referenced services. The clinical determination will be conducted for the purpose of establishing the level of direct care and/or clinical supports necessary to provide the individual with the appropriate level of services to ensure his or her health, safety and welfare. This will be done on a service-specific basis.
 3. The level of direct care and/or clinical supports determined in subparagraph 2 of this paragraph will be evaluated against a set of threshold levels established by OPWDD.
 4. If the direct care and/or clinical supports determined in subparagraph 2 of this paragraph meet the threshold levels established by OPWDD then a Higher Needs rate will be set. The Higher Needs rate will be provider-specific and will be based upon the inclusion of direct support and/or clinical hours as described below. These hours will be added to the agency's approved direct care and/or clinical hours as described in Section IV. Once added to current reimbursable hours, an agency specific fee will be calculated.
 5. The need for an Higher Needs rate will be subject to review on a six-month basis until such time as the support hours can be integrated into the provider's existing Residential or Day Habilitation Rate or until the cost of providing service(s) to this individual for a full year is reflected in the service provider's base year CFR applicable to the requested service and are included in the rebase of the methodology, at which time the Higher Needs funding for the individual will sunset.
 6. Based on the clinical determination conducted by OPWDD, an individual will receive additional hours of direct care and/or clinical supports as delineated in the following tables:

HIGHER NEEDS FUNDING – RESIDENTIAL Effective 7/1/17 – 3/31/18	
Tier	Additional Hours Per Individual
1	1000
2	2000
3	See Fee Tables

HIGHER NEEDS FUNDING - DAY HABILITATION Effective 7/1/17 – 3/31/18	
Tier	Additional Hours Per Unit
1	0.95
2	1.89
3	See Fee Tables

Effective 4/1/18, based on the clinical determination conducted by OPWDD, an individual will receive additional hours of direct care and/or clinical supports as delineated in the following tables. Additional hours will not exceed those shown in these tables.

HIGHER NEEDS FUNDING – RESIDENTIAL Effective 4/1/18	
Tier	Additional Hours Per Individual
1	1000
2	2000
3	Greater than 2000

HIGHER NEEDS FUNDING - DAY HABILITATION Effective 7/1/17	
Tier	Additional Hours Per Unit
1	0.95
2	1.89
3	Greater than 1.89

8. Effective 7/1/17, the Special Populations Funding will be replaced by Higher Needs Funding. Individuals approved for Special Populations funding prior to 7/1/17 will be grandfathered into the Higher Needs Tier equivalent to the funding level for which he or she was approved as shown in the Higher Needs Funding tables found using the following link:

https://www.health.ny.gov/health_care/medicaid/rates/mental_hygiene/index.htm

Daily reimbursement will not exceed these fees. Individuals approved for Higher Needs funding on or after 7/1/17 will receive a daily fee not to exceed these fees.

9. Effective 4/1/18, there will not be a limit on the daily fee for individuals that meet the criteria set forth in Subsection (b) of this Section.
10. Intermediate Care Facility for the Developmentally Disabled (ICF/IID) Conversions - Effective July first, two thousand seventeen, the State will establish higher needs funding for services delivered to individuals with Developmental Disabilities who are transitioning from

an Intermediate Care Facility for the Developmentally Disabled (ICF/IID) to one of the following services:

- Residential Habilitation – Supervised IRA
- Residential Habilitation – Supportive IRA

- (i) The higher needs funding will be based upon a review of the average direct care and/or clinical support hours provided in the entire ICF/IID program from which the individual is transitioning.
- (ii) The average salaried direct care, contracted direct care, salaried clinical and contracted clinical hours identified in subparagraph (i) of this paragraph will be compared to the Calculated Direct Care Hours, Provider Salaried Clinical Hours and/or Provider Contracted Clinical Hours per individual that the agency currently receives in accordance with the respective methodology described in NY Waiver – NY.0238.
- (iii) If the average direct care and/or clinical support hours identified in subparagraph (i) of this paragraph are higher than the Calculated Direct Care Hours, Provider Salaried Clinical Hours and/or Provider Contracted Clinical Hours per individual currently being served by the proposed service provider based on the reimbursement methodology as described in NY .0238, then a higher needs funding per individual will be set. The only difference between the higher needs funding and the provider's rate calculated in accordance with the methodology described in NY.0238 is the additional needed direct care and/or clinical support hours. The higher needs funding rate will replace direct care and/or clinical support hours in the rate established in accordance with NY.0238 with the hours identified in accordance with subparagraph (i) of this paragraph.
- (iv) There will be no change to the other cost components associated with delivering the requested service(s); the only change will be the number of direct care and/or clinical support hours available to appropriately support the individual(s) in one or more of the community service options described above.

V. Self-Direction Services

a. Fiscal Intermediary Services

Effective 8/1/2017, Fiscal Intermediary Services will be reimbursed based on the level of service provided as described in Appendix C of this HCBS Agreement. The fees are available here

https://www.health.ny.gov/health_care/medicaid/rates/mental_hygiene/index.htm

These fees may be adjusted to incorporate funding to reflect cost-of-living adjustment (COLA)s,

compensation increases, or any other adjustments authorized pursuant to NYS law.

The current Personal Resource Account (PRA) value table can be located at the following:

https://www.health.ny.gov/health_care/medicaid/rates/mental_hygiene/index.htm

b. Individual Directed Goods and Services (IDGS)

The claiming limits and allowable goods and services that can be purchased using IDGS are described in ADM #2015-05R Service Documentation for Individual Directed Goods and Services (IDGS) or subsequent revisions available here: [Regulations & Guidance | Office for People With Developmental Disabilities \(ny.gov\)](#)

The pricing parameters for IDGS for most items are based upon the historic and customary budgeted amounts within self-directed budgets in place in 2012, unless otherwise noted in the "pricing parameters" column of the IDGS Chart.

c. Live-in Caregiver

Access to Live-in Caregiver (LIC) services is restricted to people who self-direct their services with budget authority and do not live-in certified residences. Further, the person's Life Plan must list the Live-in Caregiver service and describe the Live-in Caregiver's role. The Fiscal Intermediary agency pays allowable Live-in Caregiver expenses as follows:

- Payment of the total calculated monthly amount may be made directly to the service recipient each month;
- Payment of rent and utilities is made to the landlord or utility company;
- Payment may not be made directly to the Live-In Caregiver; and
- Payment for food is based on food costs incurred by the individual that can be reasonably attributed to the LIC.

The payment is based on the proportion of these costs that can be attributed to the Live-in Caregiver. For example, if the person and Live-in Caregiver are the only two people living in an apartment, then a maximum of 50% of the above costs would be attributed to the Caregiver. The total service cost for Live-in Caregiver in and of itself does not include any administrative charges by a provider.

The Live-In Caregiver (LIC) service cost methodology was developed based on a regional approach and is reflective of the Personal Resource Allocation (PRA) rate setting regions. A maximum threshold has been established for each region, amounts up to the regional maximum for LIC services may be budgeted. Regional thresholds include funding for rent, food, and utilities. The rental component is based on the 2012 payment standards used by

New York State-OPWDD to support non-HCBS Waiver services Housing Subsidies. In addition to the base rental component, thresholds include add-ons for food and utilities. Each region includes a \$5,000 add on to support food costs. Additionally, the regional maximums include a utility subsidy of \$3,500 for the New York City and Long Island/Hudson Valley regions, and a \$3,000 utility subsidy for the rest of the state. The LIC service is only available to individuals in Self-Direction. The regional thresholds are a maximum budgeted amount, actual costs may be lower than the maximum threshold but cannot exceed the ceiling.

d. Support Brokerage

Support Brokerage is reimbursed by the Fiscal Intermediary provider at an hourly rate of payment. The Support Brokerage fee is based on the Department of Labor hourly wage data for Social and Human Service Assistants, with adjustments for: fringe benefits, administrative costs, other than personal service, and non-face-to-face service time. These adjustments are based upon the methodology used to develop the Community Habilitation fee. The Support Brokerage fees are available here: https://www.health.ny.gov/health_care/medicaid/rates/mental_hygiene. These fees may be adjusted to incorporate funding to reflect cost-of living adjustment (COLA)s, compensation increases, or any other adjustments authorized pursuant to NYS law.

e. "Self-Hired" Staffing for Community Habilitation, Supported Employment and Respite Services

Individuals who select and hire staff using a Fiscal Intermediary may pay the staff delivering the self-directed services an hourly rate that does not exceed the levels on the fees schedules found using the link below: https://www.health.ny.gov/health_care/medicaid/rates/mental_hygiene/index.htm

Effective 7/1/17, individuals who select and hire Respite staff using a Fiscal Intermediary may pay the Respite staff delivering the self-directed services an hourly rate that does not exceed the calculated fee for In-Home Respite, as specified in the appropriate fee schedule for the service as identified at the following link: https://www.health.ny.gov/health_care/medicaid/rates/mental_hygiene/index.htm.

VI. Services paid using a Contract/Cost Amount

a. Environmental Modifications (Home Accessibility)

NYS is the provider of record for Environmental Modifications for billing purposes. The work is done by a contractor who is selected through a standard bid process, following the rules established by the Office of the State Comptroller. The Environmental Modification is only billed to Medicaid once the contract work is verified as complete. The amount billed is equal to the contract value. Environmental

Modifications are limited to individual or family owned or controlled homes.

Effective with claims submitted to eMedNY on or after **October 1, 2023** the maximum expenditure for Environmental Modifications for the benefit of an individual Medicaid beneficiary may not exceed \$60,000 in any consecutive five year period.

b. Assistive Technology-Adaptive Devices

NYS is the provider of record for Assistive Technology for billing purposes. The service/device is selected through a standard bid process, following the rules established by the Office of the State Comptroller. Assistive Technology is only billed to Medicaid once the work is verified as completed or the device is delivered. The amount billed is equal to the contract or vendor value.

For Assistive Technology Services that qualify as Home Enabling Supports – Pay Charges, an OPWDD provider will be the provider of record for billing Medicaid. These claims are subject to oversight as described in Appendix I.

Effective with claims submitted to eMedNY on or after **October 1, 2023** the maximum expenditure for adaptive technology services for the benefit of an individual Medicaid beneficiary may not exceed **\$25,000** in any consecutive two years period.

c. Vehicle Modifications

NYS, **or a not-for-profit provider**, is the provider of record for Vehicle Modifications for billing purposes. The work is done by a contractor who is selected through a standard bid process, following the rules established by the Office of the State Comptroller. The Vehicle Modification is only billed to Medicaid once the contract work is verified as complete. The amount billed is equal to the contract value.

The maximum expenditure for Vehicle Modifications **will be limited to a maximum expenditure of \$35,000, \$65,000 for complex modifications, once in a five (5) year period.** Contracts for vehicle modifications are limited to the primary vehicle of the recipient.

VII. Services paid via Fiscal Intermediary

a. Community Transition Services

This service is a one-time reimbursement. The one-time payment will be no more than \$5,000 per person. This service may not be used to pay for furnishing living arrangements that are owned or leased by a waiver provider where the provision of these items and services are inherent to the service they are already providing.

VIII. Adjustments

- a. Increases to Compensation, these increases will be displayed as a separate line and calculated as stated below.

- i. **Applicability.** On or after January 1, 2015, rates of reimbursement for providers that operate eligible programs as defined in this section will be revised to incorporate funding for compensation increases to their direct support professional employees. Such rate increases will be effective January 1, 2015. The compensation increase funding will be included in the provider's rate issued for January 1, 2015 and in a subsequent rate with the inclusion of funding in the amount necessary to achieve the same funding impact as if the rate had been issued on January 1, 2015. The compensation increase funding will be inclusive of associated fringe benefits. The inclusion of this provision will be included until the use of the January 1, 2015 through December 31, 2015 CFR (Upstate) and the July 1, 2014 through June 30, 2015 CFR (Downstate) as a base at which time the adjustment will be included in the CFR and no longer necessary. The July 1, 2014 through June 30, 2015 Downstate CFR data will be adjusted to annualize the six-month increase.
- ii. **Definitions.** As used in this section, the following terms shall have the following meanings:
 - (a) Direct support professionals are those defined as Direct Care and Support per Consolidated Fiscal Report (CFR) Appendix R and reported on the CFR under the Position Title code identifiers of 100 or 200. Contracted staff salary information will not be utilized.
 - (b) Clinical staff are those defined as Clinical per CFR Appendix R and reported on the CFR under the Position Title code identifier of 300. Contracted staff salary information will not be utilized.
 - (c) Eligible rate-based programs shall mean supervised community residences (including supervised IRAs), supportive community residences (including supportive IRAs), or group day habilitation programs.

January 1, 2015 Increase. Rates for eligible rate-based programs will be revised to incorporate funding for compensation increases to direct support professional employees. Such rate increases will be effective January 1, 2015. The compensation increase funding will be included in the provider's rate issued for January 1, 2015, and in a subsequent rate with the inclusion of funding in the amount necessary to achieve the same funding impact as if the rate had been issued on January 1, 2015. The compensation increase funding will be inclusive of associated fringe benefits.

- (a) **April 1, 2015 Increase.** In addition to the compensation funding effective January 1, 2015, providers that operate supervised IRAs, including supervised community residences, supportive IRAs, including supportive community residences, and group day habilitation will receive a compensation increase targeted to direct support professional and clinical employees to be effective April 1, 2015. The compensation increase funding will be inclusive of associated fringe benefits. The April 1, 2015 direct support professional's compensation funding will be the same, on an annualized basis, as that which was calculated for the January 1, 2015 compensation increase and will be an augmentation to the January 1, 2015 increase.

- (b) Calculations. The basis for the calculation of provider and regional direct care, support and clinical salary averages and associated fringe benefit percentages will be the data in providers' CFRs for July 1, 2010 through June 30, 2011 for providers reporting on a fiscal year basis or January 1, 2011 through December 31, 2011 for providers reporting on a calendar year basis.
1. The January 1, 2015 and April 1, 2015 Direct Support Professionals compensation increase funding formula will be as follows:
 - A) The annual impact of a two percent increase to 2010-11 or 2011 salaried direct care dollars, salaried support dollars and associated fringe benefits will be calculated.
 - B) The annual impact of the two percent increase for salaried direct care dollars, salaried support dollars and associated fringe will be added to the appropriate operating components in the rate methodology. This will result in a recalculation of provider and regional average direct care wages, provider and regional average employee-related components, provider and regional average program support components, and provider and regional average direct care hourly rates.
 - C) The provider direct care hourly rate – adjusted for wage equalization factor will be recalculated to utilize the provider average direct care hourly rate and regional average direct care hourly rate, as calculated in subparagraph 2) of this paragraph.
 - D) An identification will be made of the dollar difference between the provider direct care hourly rate – adjusted for wage equalization factor, which is in the rate in effect on December 31, 2014, and the provider direct care hourly rate – adjusted for wage equalization factor, as calculated in subparagraph 3) of this paragraph.
 - E) The rate difference identified in subparagraph 4) of this paragraph will be multiplied by the calculated direct care hours in the rate in effect on December 31, 2014 to calculate the additional funding generated by the direct care compensation adjustment.
 - F) The rate add-on for the compensation increase shall be determined by dividing the additional funding, as calculated in subparagraph 5) of this paragraph by the rate sheet units in effect on January 1, 2015.
 2. The April 1, 2015 Clinical compensation increase funding formula will be as follows:
 - A) The annual impact of a two percent increase to 2010-11 or 2011 salaried clinical dollars and associated fringe benefits will be calculated.

- B) The annual impact of the two percent increase for salaried clinical dollars and associated fringe will be added to the appropriate operating components in the rate methodology. This will result in a recalculation of provider and regional average employee-related components, provider and regional average clinical hourly wages.
 - C) The provider clinical hourly wage – adjusted for wage equalization factor will be recalculated to utilize the provider average clinical hourly wage and regional average clinical hourly wage, as calculated in subparagraph 2) of this paragraph.
 - D) An identification will be made of the dollar difference between the provider clinical hourly wage – adjusted for wage equalization factor, which is in the rate in effect on December 31, 2014, and the provider clinical hourly wage – adjusted for wage equalization factor, as calculated in subparagraph 3) of this paragraph.
 - E) The rate difference identified in subparagraph 4) of this paragraph will be multiplied by the provider salaried clinical hours in the rate in effect on December 31, 2014 to calculate the additional funding generated by the clinical compensation adjustment.
 - F) The rate add-on for the compensation increase shall be determined by dividing the additional funding, as calculated in subparagraph 5) of this paragraph by the rate sheet units in effect on January 1, 2015.
- iv. When costs for this adjustment appear in the CFR and are included in the rebase of the methodology, the add-on will sunset.
- b. Other adjustments to reimbursement. Adjustments will be displayed as a separate line and calculated as stated below.
- i. Applicability. Rates of reimbursement for providers that operate eligible programs as defined in this section will be revised for services and included in the provider's rate for the period as specified. Funding will continue to be included in subsequent rate periods in the amount necessary to achieve the same funding impact. The inclusion of this provision will be included until the use of the CFR for January 1, 2017 through December 31, 2017, (Upstate) and July 1, 2016 through June 30, 2017, (Downstate) as a base, at which time the adjustment will be included in the CFR and no longer necessary.
 - ii. January 1, 2016 Increase. Rates for supervised community residences (including supervised IRAs) that submitted billing outside of the rate for clinic nutrition and psychology services during the period of July 1, 2014 through March 31, 2015 will be revised to incorporate the funding for these services. In addition, rates for supportive community residences

(including supportive IRAs) that submitted billing outside of the rate for personal care, home health aide and Supplemental Group Day Habilitation services during the period of June 1, 2014 through May 31, 2015 will be revised to incorporate funding for these services. The amount of the funding to be added will be equal to the annualized dollars for the billing periods identified above. The effective date of the adjustments is October 1, 2015, although the funding will be added to the rate as of January 1, 2016.

- iii. July 1, 2016 Decrease. Rates for supervised community residences (including supervised IRAs) and group day habilitation programs with clinical hours of direct, hands-on physical therapy, occupational therapy, speech/language pathology, social work and psychology services provided during the period of January 1, 2013 through December 31, 2013 (Upstate) and July 1, 2012 through June 30, 2013 (Downstate) will be revised to remove the funding for these services. The amount of funding to be removed for each provider from each program will be equal to the sum of the direct, hands-on clinical hours identified by the provider multiplied by the Provider Clinical Hourly Wage – Adjusted for Wage Equalization for the program. The amount of funding to be removed will be documented and attested to by the provider.
- iv. Cost of Living Adjustment (COLA). Beginning April 1, 2016, rates of reimbursement for supervised community residences (including supervised IRAs), supportive community residences (including **supportive IRAs**), group day habilitation programs, prevocational services (site-based), and respite (hourly and free-standing), and fees for prevocational services (community-based), residential habilitation (family care), supported employment, community habilitation, special populations funding, intensive behavioral services, **support brokerage, fiscal intermediary, and pathway to employment** will be revised to **reflect cost-of-living adjustments (COLAs), compensation increases, or any other adjustments authorized pursuant to New York State law.**
- v. Minimum Wage. Beginning January 1, 2017, rates of reimbursement for providers that operate supervised community residences (including supervised IRAs), supportive community residences (including IRAs), group day habilitation programs, prevocational services (site-based), and respite (hourly and free-standing) will be adjusted to address cost increases resulting from the implementation of Chapter 54 of the Laws of 2016 for New York State, amending section 652 of Labor Law. The minimum wage adjustment will be developed and implemented as follows:
 - (a) The minimum wage adjustment for 2017 and 2018 will be developed based on provider-attested survey data, or the cost report data, if the survey was not submitted by the provider. In subsequent years, the minimum wage adjustment will be based on the 2018 survey data, or cost report data, if the survey was not submitted by the provider. Once the costs are included in a CFR utilized in a base year, such reimbursement will be excluded from the rate calculation.

- (b) The minimum wage adjustment will be incorporated into rates by adding the calculated amounts to the reimbursement. The midpoint of the wage bands, as reported in the provider surveys, will be compared to the minimum wage requirements specified in statute. The minimum wage adjustment amounts will be calculated by multiplying the difference between the midpoint of the applicable wage bands and the specified wage level, by the total number of hours reported within the wage bands. The minimum wage adjustment amounts will be totaled for each provider and the provider-specific mandated fringe percentage amount, as calculated from the cost report data, will be added.
- c. Increases to Compensation - These increases will be displayed as a separate line and calculated as stated below.
 - i. Applicability. On or after January 1, 2018, rates of reimbursement for providers that operate eligible programs as defined in this section will be revised to incorporate funding for compensation increases to their direct support professional employees. Such rate increases will be effective January 1, 2018. The compensation increase funding will be included in the provider's rate issued for January 1, 2018 and in a subsequent rate with the inclusion of funding in the amount necessary to achieve the same funding impact as if the rate had been issued on January 1, 2018. The compensation increase funding will be inclusive of associated fringe benefits.
 - ii. Definitions. As described in subparagraph VII.a.ii of this section.
 - iii. January 1, 2018 Increase. Rates for eligible rate based programs will be revised to incorporate funding for compensation increases to direct support professional employees. Such rate increases will be effective January 1, 2018. The compensation increase funding will be included in the provider's rate issued for January 1, 2018, and in a subsequent rate with the inclusion of funding in the amount necessary to achieve the same funding impact as if the rate had been issued on January 1, 2018. The compensation increase funding will be inclusive of associated fringe benefits. The inclusion of this provision will be included until the use of the January 1, 2018 through December 31, 2018 CFR (Upstate) and the July 1, 2017 through June 30, 2018 CFR (Downstate) as a base at which time the adjustment will be included in the CFR and no longer necessary. The July 1, 2017 through June 30, 2018 Downstate CFR data will be adjusted to annualize the six-month increase.
- (a) April 1, 2018 Increase. In addition to the compensation funding effective January 1, 2018, providers that operate supervised IRAs, including supervised community residences, supportive IRAs, including supportive community residences, and group day habilitation will receive a compensation increase targeted to direct support professional and clinical employees to be effective April 1, 2018. The compensation increase funding will be inclusive of associated fringe benefits. The April 1, 2018 direct support professionals' compensation funding will be the same, on an

annualized basis, as that which was calculated for the January 1, 2018 compensation increase and will be an augmentation to the January 1, 2018 increase.

- (b) Calculations. The basis for the calculation of provider and regional direct care, support and clinical salary averages and associated fringe benefit percentages will be the data in providers' CFRs for July 1, 2014 through June 30, 2015 for providers reporting on a fiscal year basis or January 1, 2015 through December 31, 2015 for providers reporting on a calendar year basis.
1. The January 1, 2018 and April 1, 2018 Direct Support Professionals compensation increase funding formula will be as follows:
 - A) The annual impact of a three and a quarter percent increase to 2014-15 or 2015 salaried direct care dollars, salaried support dollars and associated fringe benefits will be calculated.
 - B) The annual impact of the three and a quarter percent increase for salaried direct care dollars, salaried support dollars and associated fringe will be added to the appropriate operating components in the rate methodology. This will result in a recalculation of provider and regional average direct care wages, provider and regional average employee-related components, provider and regional average program support components, and provider and regional average direct care hourly rates.
 - C) The provider direct care hourly rate – adjusted for wage equalization factor will be recalculated to utilize the provider average direct care hourly rate and regional average direct care hourly rate, as calculated in subparagraph 2) of this paragraph.
 - D) An identification will be made of the dollar difference between the provider direct care hourly rate – adjusted for wage equalization factor, which is in the rate in effect on December 31, 2017, and the provider direct care hourly rate – adjusted for wage equalization factor, as calculated in subparagraph 3) of this paragraph.
 - E) The rate difference identified in subparagraph 4) of this paragraph will be multiplied by the calculated direct care hours in the rate in effect on December 31, 2017 to calculate the additional funding generated by the direct care compensation adjustment.
 - F) The rate add-on for the compensation increase shall be determined by dividing the additional funding, as

calculated in subparagraph 5) of this paragraph by the rate sheet units in effect on January 1, 2018.

2. The April 1, 2018 Clinical compensation increase funding formula will be as follows:
 - A) The annual impact of a three and a quarter percent increase to 2014-15 or 2015 salaried clinical dollars and associated fringe benefits will be calculated.
 - B) The annual impact of the three and a quarter percent increase for salaried clinical dollars and associated fringe will be added to the appropriate operating components in the rate methodology. This will result in a recalculation of provider and regional average employee-related components, provider and regional average clinical hourly wages.
 - C) The provider clinical hourly wage – adjusted for wage equalization factor will be recalculated to utilize the provider average clinical hourly wage and regional average clinical hourly wage, as calculated in subparagraph 2) of this paragraph.
 - D) An identification will be made of the dollar difference between the provider clinical hourly wage – adjusted for wage equalization factor, which is in the rate in effect on December 31, 2017, and the provider clinical hourly wage – adjusted for wage equalization factor, as calculated in subparagraph 3) of this paragraph.
 - E) The rate difference identified in subparagraph 4) of this paragraph will be multiplied by the provider salaried clinical hours in the rate in effect on December 31, 2017 to calculate the additional funding generated by the clinical compensation adjustment.
 - F) The rate add-on for the compensation increase shall be determined by dividing the additional funding, as calculated in subparagraph 5) of this paragraph by the rate sheet units in effect on January 1, 2018.
- iv. When the costs for this adjustment appear in the CFR and are included in the rebase of the methodology, the add-on will sunset.
- d. Increases to Compensation - These increases will be displayed as a separate line and calculated as stated below.
 - v. Applicability. On or after January 1, 2020, rates of reimbursement for providers that operate eligible programs as defined in this section will be revised to incorporate funding for compensation increases to their direct support professional employees. Such rate increases will be

effective January 1, 2020. The compensation increase funding will be included in the provider's rate issued for January 1, 2020 and in a subsequent rate with the inclusion of funding in the amount necessary to achieve the same funding impact as if the rate had been issued on January 1, 2020. The compensation increase funding will be inclusive of associated fringe benefits.

- vi. Definitions. As described in subparagraph VII.a.ii of this section.
 - vii. January 1, 2020 Increase. Rates for eligible rate-based programs will be revised to incorporate funding for compensation increases to direct support professional employees. Such rate increases will be effective January 1, 2020. The compensation increase funding will be included in the provider's rate issued for January 1, 2020, and in a subsequent rate with the inclusion of funding in the amount necessary to achieve the same funding impact as if the rate had been issued on January 1, 2020. The compensation increase funding will be inclusive of associated fringe benefits. The inclusion of this provision will be included until the use of the January 1, 2020 through December 31, 2020 CFR (Upstate) and the July 1, 2020 through June 30, 2021 CFR (Downstate) as a base at which time the adjustment will be included in the CFR and no longer necessary. The July 1, 2020 through June 30, 2021 Downstate CFR data will be adjusted to annualize the six-month increase.
- (c) April 1, 2020 Increase. In addition to the compensation funding effective January 1, 2020, providers that operate supervised IRAs, including supervised community residences, supportive IRAs, including supportive community residences, and group day habilitation will receive a compensation increase targeted to direct support professional and clinical employees to be effective April 1, 2020. The compensation increase funding will be inclusive of associated fringe benefits. The April 1, 2020 direct support professionals' compensation funding will be the same, on an annualized basis, as that which was calculated for the January 1, 2020 compensation increase and will be an augmentation to the January 1, 2020 increase.
 - (d) Calculations. The basis for the calculation of provider and regional direct care, support and clinical salary averages and associated fringe benefit percentages will be the data in providers' CFRs for July 1, 2017 through June 30, 2018 for providers reporting on a fiscal year basis or January 1, 2017 through December 31, 2017 for providers reporting on a calendar year basis.
1. The January 1, 2020 and April 1, 2020 Direct Support Professionals compensation increase funding formula will be as follows:
 - G) The annual impact of a two percent increase to 2017-18 or 2017 salaried direct care dollars, salaried support dollars and associated fringe benefits will be calculated.

- H) The annual impact of the two percent increase for salaried direct care dollars, salaried support dollars and associated fringe will be added to the appropriate operating components in the rate methodology. This will result in a recalculation of provider and regional average direct care wages, provider and regional average employee-related components, provider and regional average program support components, and provider and regional average direct care hourly rates.
 - I) The provider direct care hourly rate – adjusted for wage equalization factor will be recalculated to utilize the provider average direct care hourly rate and regional average direct care hourly rate, as calculated in subparagraph 2) of this paragraph.
 - J) An identification will be made of the dollar difference between the provider direct care hourly rate – adjusted for wage equalization factor, which is in the rate in effect on December 31, 2019, and the provider direct care hourly rate – adjusted for wage equalization factor, as calculated in subparagraph 3) of this paragraph.
 - K) The rate difference identified in subparagraph 4) of this paragraph will be multiplied by the calculated direct care hours in the rate in effect on December 31, 2019 to calculate the additional funding generated by the direct care compensation adjustment.
 - L) The rate add-on for the compensation increase shall be determined by dividing the additional funding, as calculated in subparagraph 5) of this paragraph by the rate sheet units in effect on January 1, 2020.
3. The April 1, 2020 Clinical compensation increase funding formula will be as follows:
- A) The annual impact of a two percent increase to 2017-18 or 2017 salaried clinical dollars and associated fringe benefits will be calculated.
 - B) The annual impact of the two percent increase for salaried clinical dollars and associated fringe will be added to the appropriate operating components in the rate methodology. This will result in a recalculation of provider and regional average employee-related components, provider and regional average clinical hourly wages.
 - C) The provider clinical hourly wage – adjusted for wage equalization factor will be recalculated to utilize the provider average clinical hourly wage and regional

average clinical hourly wage, as calculated in subparagraph 2) of this paragraph.

- D) An identification will be made of the dollar difference between the provider clinical hourly wage – adjusted for wage equalization factor, which is in the rate in effect on December 31, 2019, and the provider clinical hourly wage – adjusted for wage equalization factor, as calculated in subparagraph 3) of this paragraph.
 - E) The rate difference identified in subparagraph 4) of this paragraph will be multiplied by the provider salaried clinical hours in the rate in effect on December 31, 2019 to calculate the additional funding generated by the clinical compensation adjustment.
 - F) The rate add-on for the compensation increase shall be determined by dividing the additional funding, as calculated in subparagraph 5) of this paragraph by the rate sheet units in effect on January 1, 2020.
- viii. When the costs for this adjustment appear in the CFR and are included in the rebase of the methodology, the add-on will sunset.

Addendum A.2 Audit Organization's Report

The following is a sample report on an audit organization's examination of a CFR prepared by OPWDD which has been determined acceptable for CMS purposes. Material omissions in an actual report may result in CMS rejecting the report.

[Addressee]

We examined the Consolidated Fiscal Report (CFR) prepared by the New York State Office for People With Developmental Disabilities (OPWDD) for its fiscal year ended March 31, 20XX (Document Control Number #####). OPWDD's management is responsible for implementing and maintaining internal controls that ensure the CFR's conformity with all applicable requirements, including adherence to the New York State Consolidated Fiscal Reporting and Claiming Manual and any exceptions thereto for which approvals of the United States Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS) takes precedence. OPWDD management identified for us the following such exceptions as being applicable to the CFR which is the subject of our examination:

1. Agreement between OPWDD and CMS dated [insert date] on [insert topic and brief overview of key matters].
2. State Plan Amendment [insert identifying number] approved by CMS on [insert date] regarding [insert topic and brief overview of key matters].
3. Etc.

Our responsibility is to obtain sufficient, appropriate evidence to express an opinion on whether OPWDD's reported CFR data is complete and in compliance with required criteria in all material respects.

We performed an examination-level attestation engagement conducted in accordance with the standards and guidance contained in Government Auditing Standards issued by the Comptroller General of the United States (2011 revision) which is commonly referred to as generally accepted government auditing standards. These standards require that we design our engagement to provide reasonable assurance of detecting fraud, illegal acts, or violations of provisions of contracts or grant agreements that could have a material effect on OPWDD's CFR.

We obtained an understanding of internal control as it relates to OPWDD's CFR. A deficiency in internal control exists when the design or operation of a control does not allow management or employees, in the normal course of performing their assigned functions, to prevent, detect, or correct errors in assertions made by management, on a timely basis. A deficiency in design exists when (1) a control necessary to meet the control objective is missing or (2) an existing control is not properly designed so that, even if the control operates as designed, the control objective is not met. A deficiency in operation exists when a properly designed control does not operate as designed, or when the person performing the control does not possess the necessary authority or qualifications to perform the control effectively. Deficiencies in internal control, if any, are identified in our findings below.

In our opinion, except as noted in our findings below, OPWDD's reported CFR data is complete and in compliance with required criteria in all material respects.

Findings

- 1.
- 2.
- 3.

Recommendations

- 1.
- 2.
- 3.

[*Signature*]

[*Date*]

Addendum A.3 to NYS Waiver 0238.R04.07 (OPWDD/Comprehensive Waiver)- August, 2015

CMS Counterproposal Regarding Clinical Therapies (OT, PT, S/L) Being Included in Residential and Day Habilitation Rates - CMS 64 Claiming/Re-Claiming to Eliminate any Potential Duplicate Payments

Effective July 1, 2014

- 1. Beginning with service dates of July 1, 2014, NYS shall credit to CMS, via the CMS 64, the value of off-site clinic services delivered in Supervised Residential Habilitation and Day Habilitation Sites, or any other waiver rate that might include a service in the state plan.** This will be accomplished as follows:
 - a. The full value of the federal share of all retroactive off-site claims will be credited on a quarterly basis. The voluntary adjustment for the retroactive period will be made on the Quarterly Expenditure Report for July – September 2015.
 - b. Prospectively, at the close of each quarter, NYS will calculate the value of off-site services and will continue to refund the federal share value of off-site services until the date when all off-site claims will cease.
- 2. NYS will evaluate Supervised Residential Habilitation and Day Habilitation services to establish where ‘hands-on’ therapies are provided.**
- 3. NYS will reclaim the federal share for the value of any off-site services that meet the following criteria:**
 - a. Any off-site services that are determined to be delivered at a day habilitation program, or any other service location that does not include funding in its rate for hands-on therapies.
- 4. Following the above “reclaiming process,” NYS shall limit the residual value of the repayment of the federal share to the federal share value of off-site services that are delivered at a day habilitation program site that are deemed to include funding for direct, hands-on therapies.**
- 5. This process shall continue each quarter until claims run out is complete for off-site services. *All reclaiming is subject to the two-year timely-filing requirements.**

Effective January 1, 2016

- 1. The state will submit new, draft State Plan language by 9/30/15 (SPA10-18) to implement changes to the Other Licensed Providers and rehabilitation portions of the State Plan, in order to allow certain off-site Article 16 clinic services and certain therapies provided within HCBS waiver programs to transition to the new State Plan Option effective with service dates of 1/1/16. The SPA will authorize special rates for the provision of the following services when accessed by individuals with IDD and when provided by clinicians experienced in delivering services to the IDD population:**
 - a. Occupational Therapy
 - b. Physical Therapy
 - c. Speech and Language Pathology

d. Psychology

- 2. Also effective with 1/1/16 service dates, funding within Supervised Residential and Day Service rates that are attributable to 'direct – hands on' therapy costs will be removed from waiver rates effective 1/1/16 when the state is able to implement the new State Plan option. Further changes in the Renewal will be necessary to describe the removal of the clinical funding effective 1/1/16.**

The removal of the services have been included in the .07 waiver document effective 07/01/2014; CMS has agreed to acknowledge that the actual payment amount in the State's MMIS system will exclude the associated payment amount effective 1/1/16. During the transition period of 7/1/2014 through 12/31/15, the State will make correcting adjustments when claiming for this time period on the quarterly CMS – 64s. These correcting adjustments will report the value of direct clinic therapy expenses on the appropriate line of the CMS-64, not as an HCBS waiver expense.