

Financial Management Group

May 26, 2020

Donna Frescatore Medicaid Director NYS Department of Health One Commerce Plaza Suite 1211 Albany, NY 12210

Reference: TN 14-0033

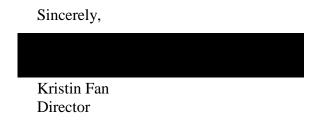
Dear Ms. Frescatore:

We have reviewed the proposed amendment to Attachment 4.19-D of your Medicaid State plan submitted under transmittal number 14-0033. Effective July 1, 2014, this amendment proposes to update the rate methodology for private intermediate care facilities.

We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(2), 1902(a)(13), 1902(a)(30), and 1903(a) of the Social Security Act and the implementing Federal regulations at 42 CFR 447 Subpart C.

This letter is to inform you that Medicaid State Plan Amendment NY-14-0033 is approved effective July 1, 2014. The CMS-179 and the plan pages are attached.

If you have any additional questions or need further assistance, please contact Betsy Pinho at 518-396-3816 or betsy.pinho@cms.hhs.gov.



EPARTMENT OF HEALTH AND HUMAN SERVICES IEALTH CARE FINANCING ADMINISTRATION		FORM APPROVE OMB NO. 0938-01	
TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL	1. TRANSMITTAL NUMBER: 14-033	2. STATE New York	
FOR: HEALTH CARE FINANCING ADMINISTRATION	3. PROGRAM IDENTIFICATION: TI SOCIAL SECURITY ACT (MED	TLE XIX OF THE	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES	4. PROPOSED EFFECTIVE DATE July 1, 2014		
5. TYPE OF PLAN MATERIAL (Check One):			
NEW STATE PLAN AMENDMENT TO BE CONS		AMENDMENT	
COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMEND 6. FEDERAL STATUTE/REGULATION CITATION:	MENT (Separate Transmittal for each an 7. FEDERAL BUDGET IMPACT: (in		
§1902(a) of the Social Security Act and 42 CFR 441.304(e)and 447.205	a. FFY 07/01/14-09/30/14 S 0 b. FFY 10/01/14-09/30/15 S 0		
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:	9. PAGE NUMBER OF THE SUPERS SECTION OR ATTACHMENT (If Ap		
Attachment 4.19-D, Part II: Pages 90, 91, 92, 93, 94, 95, 96, 97, 98 , 99, 100, 101, 102, 103, 104, 105	6,7,8,9,10,11,12,13,14,15,16, 21,22,23,24,25	1	
5,7,8,9,10,11,12,13,14,15,16,17,18,19,20,21,22,23,24,25	, , , , , =		
10. SUBJECT OF AMENDMENT: 7/1/14 ICF Rate Rationalization (FMAP = 50%)			
 11. GOVERNOR'S REVIEW (Check One): 	OTHER, AS SPEC	CIFIED:	
12. SIGNATURE OF STATE AGENCY OFFICIAL:	16. RETURN TO: New York State Department of Heal	th	
13. TYPED NAME: Jason A. Helgerson	Bureau of Federal Relations & Provi 99 Washington Ave – One Commerc	der Assessments	
14. TITLE: Medicaid Director Department of Health			
15. DATE SUBMITTED: SLI 3 0 2014	Attn: Division of Finance and Rate	Setting	
FOR REGIONAL OFFI	CE USE ONLY		
17. DATE RECEIVED: 9/30/2014	18. DATE APPROVED: 05/26/20		
PLAN APPROVED - ONE		the design of the second second	
19. EFFECTIVE DATE OF APPROVED MATERIAL: 7/1/2014	20. SIGNATURE OF REGIONAL OF	FICIAL:	
21. TYPED NAME: Kristin Fan	22. TITLE: Director FMG		
23. REMARKS: On 5i21i2020, New York State authorized pen and ink	changes to Box 8, 9, and 16.		

Rates for ICF/IID services delivered by Non-Government and Voluntary ICFs/IID on and after July 1, 2014 will be determined in accordance with this section.

(1) Definitions (applicable to this section):

Active Treatment (AT) – Habilitation services provided for residents of an ICF/IID who are under the age of 21, in all areas of life and at any location. The ICF/IID can arrange for and reimburse other providers (schools or otherwise) to carry out some of the AT called for in the facility's plan of care for an individual. The purpose of AT provided during normal school hours must be habilitation, not educational.

Allowable Operating Costs – All necessary and proper costs which are appropriate and helpful in developing and maintaining the operation of ICFs/IID. Necessary and proper costs are costs which are common and accepted occurrences in the field of ICFs/IID. These costs will be determined in accordance with the cost principles described in the Medicare Provider Reimbursement Manual (HIM-15). This will include allowable program administration, direct care, support, clinical, fringe benefits, and indirect personal service/non-personal service.

Allowable Capital Costs – Are all necessary and proper capital costs that are appropriate and helpful in developing and maintaining the provision of ICF/IID services to beneficiaries determined in accordance with the cost principles described in the Medicare Provider Reimbursement Manual (HIM-15) except as further defined below. This will include, where appropriate, allowable lease/rental and ancillary costs; amortization of leasehold improvements and depreciation of real property; financing expenditures associated with the purchase of real property and related expenditures, and leasehold improvements.

Capital costs of depreciation, and lease/rental of equipment and vehicles (annual lease, depreciation and interest) will be included in the operating components of the provider's rate.

Base Year Consolidated Fiscal Report (CFR) – For Non-Government and Voluntary Providers, the CFR from which the initial target rate will be calculated. Such period will be January 1, 2011 through December 31, 2011 for providers reporting on a calendar year basis and July 1, 2010 through June 30, 2011 for providers reporting on a fiscal year basis. For subsequent periods, the base year CFR will mean the CFR used to update the methodology.

Base Operating Rate – Reimbursement amount calculated by dividing annual reimbursement by applicable annual units of service, both in effect on June 30, 2014.

Budget Neutrality Adjustment – Factor applied to adjust the proposed amount so that it is equivalent to the base amount of dollars.

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Children's Residential Program (CRP) – Sub-classification of an ICF/IID – This residential program provides 24-hour care and treatment and offers services specific to the individual's needs. The program may incorporate behavioral teaching methods and structured learning experiences to increase and enhance skill development in areas such as personal care, communication, social interaction, recreation/play, and community integration.

Consolidated Fiscal Report (CFR) – A reporting tool prepared in accordance with Generally Accepted Accounting Principles and utilized by all New York State (NYS) government and nongovernment providers to communicate their annual costs incurred as a result of operating Office for People with Developmentally Disabled (OPWDD) programs and services, along with related utilization and staffing statistics.

Day Services are for those individuals who choose to attend In-house Day Programming or Waiver services as their day program.

Facility - The site or physical building where actual services are provided.

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.

Highly Complex Funding Designation – Individuals who require a "highly complex" (enhanced) funding level based upon the intensity/severity/persistence of their behavioral management and oversight needs. All funding requests for individuals with "highly complex" needs must be reviewed on a case-by-case basis and will require approval by an Associate Commissioner of OPWDD.

Individual - A person who resides in an ICF/IID.

ICF/IID - An Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID).

In-house Day Programming – Continuum of care for individuals who, out of necessity, are unable to leave the residence. Day programming activities are performed by staff of the residence as outlined in the individual's plan of care.

Initial Rate Period – The first 12 months of the rate cycle.

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.

Medical Leave Day – are days of Medical leave or an associated day where any other institutional or in-patient Medicaid payment is made for providing services to the individual. A provider is limited to billing 14 Medical Leave days per rate year, per individual, without prior authorization.

Occupancy Adjustment – An adjustment to the calculated daily rate of a Voluntary Provider operating an ICF/IID to account for days when Medicaid billing cannot occur because an individual has passed away or has moved to another site.

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Provider – A Non-government or Voluntary agency that has been issued a Medicaid provider agreement for an ICF/IID. A provider may operate multiple ICFs/IID.

Provider Assessment – An assessment in the amount of 5.5% uniformly imposed on gross Medicaid revenue on all providers of ICF/IID services.

Rate Cycle – The rate cycle is a 24-month period, beginning on July 1st, that consists of two rate periods.

Rate Period – The annual time period of July 1st through June 30th that rates are effective.

Rate Sheet Capacity – The number of ICF/IID individuals for whom a provider is certified or approved by OPWDD as of the last day of the previous rate period.

Regions

- i. Department of Health (DOH) Regions Regions as defined by DOH are, 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:
 - (a) Downstate: 5 boroughs of New York City, Nassau, Suffolk and Westchester;
 - (b) Hudson Valley: Dutchess, Orange, Putnam, Rockland, Sullivan, Ulster;
 - (c) **Upstate Metro:** Albany, Erie, Fulton, Genesee, Madison, Monroe, Montgomery, Niagara, Onondaga, Orleans, Rensselaer, Saratoga, Schenectady, Warren, Washington, Wyoming; and
 - (d) Upstate Non-Metro: Any counties not listed in paragraphs (a), (b) or (c) of this section.

ii. Specialized Populations Funding OPWDD Developmental Disabilities Regional Office (DDRO) Regions

- (a) **Downstate DDRO Regions:** Brooklyn, Bernard Fineson, Hudson Valley, Long Island, Metro, Staten Island and Taconic (Dutchess and Putnam counties only);
- (b) Upstate DDRO Regions: Broome, Capital District, Central, Finger Lakes, Sunmount, Taconic and Western.

iii. In-House Day Programming OPWDD DDRO Regions

- (a) Region 1: Brooklyn, Bernard Fineson, Metro and Staten Island
- (b) <u>Region 2: Long Island, Hudson Valley (Rockland and Westchester Counties), Taconic</u> (Putnam County)

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(c) Region 3: Broome, Capital District, Central, Finger Lakes, Sunmount, Western, Hudson Valley (Sullivan, Orange Counties), Taconic (Greene, Columbia, Ulster and Dutchess Counties)

Reimbursable Cost – The final allowable costs of the rate period after all audit and/or adjustments are made.

Specialized Populations Funding – An all-inclusive fee payment for ICF/IID paid to voluntary ICF/IID providers that serve individuals who left an institutional setting or who have aged out of a New York State residential school setting between November 1, 2011 and March 31, 2013. Special Populations Funding is time-limited. Reimbursement for this Special Population will be from the Special Population Fee Table below for ICFs/IID.

Standard Academic Curricula - The subjects comprising a course of study in an educational institution.

Subsequent Rate Period – The corresponding 12-month rate periods that follow the Initial Rate Period.

Target Rate – The final rate in effect at the end of the transition period for each provider.

Therapy Day – A therapy day is a day when the individual is away from the ICF/IID and is not receiving services from paid Residential Habilitation staff and the absence is for the purpose of a visiting with family or friends, or a vacation. The therapy day must be described in the person's plan of care to be eligible for payment and the person may not receive another Medicaid-funded residential, in-patient service or day service on that day.

Transition Period – The three-year period which the reimbursement methodology will be phased-in, 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.

Wage Equalization Factor (WEF) – The sum of the provider average direct care hourly wage multiplied by .75 and the applicable regional average direct care hourly wage, multiplied by .25.

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(2) Rates for Providers of ICF/IID Services

- i. <u>There will be one provider-wide rate for each provider, except that rates for ICF/IID services</u> provided to individuals identified as special populations by OPWDD. Adjustments may be made to the rate resulting from any final audit findings or reviews.
- ii. Rates will be computed based on a full 12-month base year CFR, adjusted in accordance with the methodology as delineated in this section. The rate will include operating cost components and capital cost components. Such base year may be updated in accordance with subsequent rate section, paragraph p)(8).

iii. Components of Rates for ICF/IID Services

- (a) **Operating Component -** The operating component will be calculated using allowable costs identified in the consolidated fiscal reports. The operating component will be inclusive of the following components:
 - 1. **Regional average direct care wage -** The quotient of base year salaried direct care dollars for each provider in a DOH region, totaled for all such providers in such region, for all residential habilitation-supervised individualized residential alternative (IRA); residential habilitation-supportive IRA; day habilitation services; and ICF/IID, divided by base year salaried direct care hours for each provider in a DOH region, totaled for all such providers in such region, for all residential habilitation-supportive IRA; day habilitation services; and ICF/IID, divided for all such providers in such region, for all residential habilitation-supportive IRA; residential habilitation-supportive IRA; day habilitation services; and ICF/IID services.
 - 2. Regional average employee-related component The sum of the annual change in vacation leave accruals and total fringe benefits for the base year for each provider of a DOH region, totaled for all such providers in such region, with the sum to be divided by base year salaried direct care dollars for each provider of a DOH region, totaled for all such providers in such region, and then multiplied by the applicable regional average direct care wage.
 - 3. **Regional average program support component -** The sum of transportation related-participant staff travel; participant incidentals; expensed adaptive equipment; sub-contract raw materials; participant wages-non-contract; participant wages-contract; participant fringe benefits; staff development; supplies and materials-non-household; other-OTPS; lease/rental vehicle; depreciation-vehicle; interest-vehicle; other-equipment; other than to/from transportation allocation; salaried support dollars (excluding housekeeping and maintenance staff); and salaried program administration dollars for the base year for each provider of a DOH region, totaled by all such providers in such region. Such sum is divided by the total base year salaried direct care dollars for all providers in a DOH region and multiplied by the applicable regional average direct care wage.

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- 4. **Regional average direct care hourly rate excluding general and administrative -** The sum of the applicable regional average direct care wage, the applicable regional average employee-related component, and applicable regional average program support component.
- 5. Regional average general and administrative component The sum of the insurance-general and agency administration allocation for the base year for each provider in a DOH region, totaled 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 supplied; 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 of a DOH region, totaled for all providers in such region). The regional average direct care hourly rate exclusive of general and administrative costs is 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 is subtracted.
- 6. **Regional average direct care hourly rate -** The sum of the applicable regional average direct care wage; the applicable regional average employee-related component; the applicable regional average program support component; and the applicable regional average general and administrative component.
- Provider average direct care wage The quotient of base year salaried direct care dollars divided by the base year salaried direct care hours of a provider.
- 8. **Provider average employee-related component -** The sum of annual change in 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 is multiplied by the provider average direct care wage.
- 9. Provider average program support component The sum of transportation related-participant; staff travel; participant incidentals; expensed adaptive equipment; sub-contract raw materials; participant wagesnon-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. This sum is divided by the base year salaried direct care dollars of such provider and such quotient will be multiplied by the provider average direct care wage.

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- 10. **Provider average direct care hourly rate excluding general and administrative** – The sum of the provider average direct care wage; the provider average employee-related component; and the provider average program support component.
- 11. **Provider average general and administrative component** The sum of insurance-general and agency administration allocation for the base year for a provider, this sum will 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 will then be divided by (one minus the applicable provider average direct care wage hourly rate excluding general and administrative is subtracted.
- 12. **Provider average direct care hourly rate** The sum of the provider average direct care wage; the provider average employee-related component; provider average program support component; and the provider general and administrative component.
- 13. **Provider direct care hours -** The sum of the base year salaried direct care hours and base year contracted direct care hours, this sum divided by the rate sheet capacities for the base year. This quotient is multiplied by the rate sheet capacities for the initial period.
- 14. **Regional average clinical hourly wage -** The quotient of base year salaried clinical dollars for each provider of a DOH region, aggregated for all such providers in such region, divided by base year salaried clinical hours for each provider of a DOH region, totaled for all such providers in such region.
- 15. **Provider average clinical hourly wage -** The quotient of base year salaried clinical dollars of a provider divided by base year salaried clinical hours of such provider.
- 16. **Provider salaried clinical hours** The quotient of base year salaried clinical hours of a provider, divided by the rate sheet capacities for the base year, this quotient is multiplied by the rate sheet capacities for the initial period for such provider.

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- 17. **Regional average contracted clinical hourly wage -** The quotient of base year contracted clinical dollars for each provider of a DOH region aggregated for all such providers in such region divided by the base year contracted clinical hours for each provider of a DOH region, totaled for all providers in such region.
- 18. **Provider contracted clinical hours -** The quotient of a provider's contracted clinical hours for the base year divided by the rate sheet capacities for the base year, this quotient is multiplied by the rate sheet capacities for the initial period.
- 19. **Provider direct care hourly rate-adjusted for wage equalization factor** - The sum of the provider average direct care hourly wage multiplied by .75 and the applicable regional average direct care hourly wage multiplied by .25.
- 20. Provider clinical hourly wage-adjusted for wage equalization factor - The sum of the provider average clinical hourly wage, multiplied by .75 and the applicable regional average clinical hourly wage, multiplied by .25.
- 21. **Provider reimbursement from direct care hourly rate -** The product of the calculated direct care hours and the provider direct care hourly wage adjusted for wage equalization factor.
- 22. **Provider reimbursement from clinical hourly wage -** The product of the provider salaried clinical hours and the provider clinical hourly wage adjusted for wage equalization factor.
- 23. <u>Provider reimbursement from contracted clinical hourly wage -</u> The product of the provider contracted clinical hours and the applicable regional average contracted clinical hourly wage.
- 24. **Provider facility reimbursement -** 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. This sum is divided by provider rate sheet capacities for the base year and then the result is multiplied by rate sheet capacities for the initial period.
- 25. **Provider operating revenue** The sum of provider reimbursement from direct care hourly rate; the provider reimbursement from clinical hourly wage; the provider reimbursement from contracted clinical hourly wage; and the provider facility reimbursement.

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- 26. Statewide budget neutrality adjustment factor for operating dollars - The quotient of the operating portion of all provider rates in accordance with the State Plan in effect on June 30, 2014, divided by the provider operating revenue for all providers.
- 27. **Total provider operating revenue adjusted -** The product of the provider operating revenue and the statewide budget neutrality adjustment factor for operating dollars.
- 28. **Final daily operating rate** This rate is determined by dividing the total provider operating revenue adjusted by the applicable provider rate sheet capacity for the initial period and such quotient to be further divided by 365.

29. Occupancy Adjustment.

- (i) For the initial rate period of July 1, 2014 through June 30, 2015; Providers will be paid 75% of the operating component for up to an annual total of 90 days per bed for days when there is a vacancy.
- (ii) For the rate periods beginning July 1, 2015 and thereafter; Providers will receive an occupancy adjustment to the operating component of their rate for vacancy days. The occupancy adjustment percentage is calculated by dividing the sum of the agency's rate period medical leave days, service days and the therapy days by 100% of the agency's certified capacity. The certified capacity is calculated taking into account capacity changes throughout the year, multiplied by 100% of the year's days. This adjustment will begin on July 1, 2015 and be recalculated on an annual basis based on the most recent 12 months' experience.
- (3) Alternative Operating Component. For providers that did not submit a cost report or submitted a cost report that was incomplete for the base year, the final daily operating rate will be a regional daily operating rate. This rate will be the sum of:
 - i. The result of the appropriate regional average direct care hourly rate and the applicable regional average direct care hours, which is the quotient of base year salaried and contracted direct care hours for each provider of a DOH region, totaled for all providers in such region, divided by the rate sheet capacities, pro-rated for partial year sites for the base year for each provider of a DOH region, totaled for all providers in such region; and
 - ii. The result of the applicable regional average clinical hourly wage and the applicable regional average clinical hours, which is the quotient of base year salaried and contracted clinical hours for each provider of a DOH region, totaled for all providers in

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such region, divided by the rate sheet capacities, pro-rated for partial year sites for the base year for each provider of a DOH region, totaled for all providers in such region; and

- iii. The applicable regional average facility revenue, which is the quotient of the sum of food; repairs and maintenance; utilities; expensed equipment; household supplies; telephone; lease/rental equipment; depreciation; insurance property and casualty; housekeeping and maintenance staff; and program administration property for the base year divided by the rate sheet capacities, pro-rated for partial year sites for the base year for each provider of a DOH region, totaled for all providers in such region.
- iv. This sum is then multiplied by the statewide budget neutrality adjustment factor for operating dollars and divided by 365.
 - (a) 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.
 - (b) If a provider fails to file a cost report by the due date (including one 30 day extension, if granted by OPWDD), OPWDD will impose a penalty of 2% on the provider's Medicaid reimbursement. For cost reporting periods ending December 31, 2014 and later, if a provider fails to file a cost report by the due date (including one 30 day extension, if granted by OPWDD, OPWDD will impose a penalty of 2% on the provider's Medicaid reimbursement, effective the first day of the sixth month following the end of the cost reporting period. 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) that prevented the provider from filing the cost report by the due date.

If a provider has not filed a complete and compliant annual CFR for any CFR reporting period ending between January 1, 2013 and January 1, 2015, the provider will be considered delinquent. The State will give notice to delinquent providers that to avoid the loss of FFP effective April 1, 2016, a complete and compliant CFR must be submitted by October 1, 2015. The State will not claim FFP for any ICF/IID Service provided by the delinquent provider after April 1, 2016.

For CFR cost reporting periods beginning July 1, 2014 and thereafter, providers are required to file an annual CFR to the State within 120 days (150 with a requested extension) following the end of the provider's fiscal reporting period. If a provider fails to file a complete and compliant CFR within 60 days following the imposition of the 2% penalty, the State must provide timely notice to the delinquent provider that FFP will end 240 days following the imposition of the

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<u>2% penalty; and the State will not claim FFP for any ICF/IID service provided by</u> the provider with a date of service after the 240 day period.

- (4) Day Program Services Component. There is a day program services component for individuals who participate in either in-house day programming or day services, or active treatment.
 - i. **In-house day programming** are equal to the sum of the provider in-house day programming amount in accordance with the State Plan in effect on June 30, 2014, plus the product of the units of service for the day services providers as was used in the calculation of the rate in effect on June 30, 2014 and the day service provider's rate in effect on July 1, 2014. A fee schedule follows:

IN-HOUSE DAY PRO	OGRAMMING
OPWDD DDRO Region	Daily Fee
1	<u>\$111.02</u>
2	<u>\$124.89</u>
3	\$103.39

- ii. **Day Services** Effective January 1, 2015 the new day services calculation will be equal to the reimbursement of the applicable day habilitation and/or prevocational service, less capital, as delineated in the supplemental language of the 1915c Wavier.
- iii. Active Treatment (AT) Add-on is equal to the AT fees, as shown below, multiplied by school days attended, less time spent by children in actual standard educational curricula.

ACTIVE TRI Effective	
OPWDD DDRO Region	Daily Fee
<u>Downstate</u>	<u>\$192.98</u>
Upstate	\$179.00

DOH will require a signed attestation annually from Children's Residential Program (CRP) providers documenting the percentage of time spent by an individual in AT versus standard educational curricula.

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(5) Total Capital Reimbursement. Capital reimbursement will be computed as follows:

- i. For Capital Assets Approved by OPWDD on Prior Property Approvals (PPA) 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.
 - (a) Reimbursement rates will include actual straight line depreciation, amortization, interest expense, financing expenses, and lease costs.
 - (b) 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.
 - (c) 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.
 - (d) 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.
 - (e) 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.
- ii. <u>Capital rate for capital assets approved by OPWDD on Prior Property Approvals on or</u> <u>after July 1, 2014. OPWDD regulations under 14 NYCRR Subpart 635-6 establish</u> <u>standards and criteria that describes the Capital acquisition and lease of real property</u> assets which require approval by OPWDD.

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- (a) 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.
- (b) 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.
- (c) 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.
- (d) 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.
- (e) 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.
- iii. The rate will include applicable annual interest, depreciation and/or amortization of the approved appraised costs of an acquisition, or fair market value of a lease, and property associated with ICF/IID facilities, the useful life will be 25 years. Such costs will be included in the rate upon or after submission and approval of the Final Expenditure Report and completion of the property cost verification.

Estimated costs will 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 will 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

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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.

DOH will verify and reconcile the costs submitted on a PPA by requiring the provider to submit to the State supporting documentation of actual costs. Actual costs will be verified by the State reviewing the supporting documentation of such costs. A provider submitting such actual costs will certify that the reimbursement requested reflects allowable capital costs and that such costs were actually expended by such provider. Under no circumstances will the amount included in the rate under this subparagraph exceed the amount authorized in the approval process. Capital costs will be amortized over a 25 year period for acquisition of properties or the life of the lease for leased sites. Capital improvements will 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 will not exceed the life of the loan taken. Amortization or depreciation will begin upon certification by the provider of such costs. Start-up costs will 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 will 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.

iv. DOH will annually update Capital reimbursement twice a year, January for providers filing a CFR on a calendar year and July for providers filing a CFR on a fiscal year cycle. Also, DOH will update capital to include all new and approved PPA's twice a year. The second update may require the Department to annualize the PPA, which could include more than 12 months of costs in the first year.

v. CFR Reporting for Capital Assets

- (a) 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).
- (b) <u>Capital expenses related to real property are included under the Property</u> 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 (iii as identified above) and the Insurance-Property or Casualty reported on CFR-1, Line 55.

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(c) <u>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:</u>

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

(d) Capital Schedule. Beginning with the cost reporting periods ending December 31, 2014 (calendar year filers), and July 31, 2015 (fiscal year filers), any provider required to file a CFR will 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.

- (6) **Tax Assessment.** The provider assessment on ICF/IID services rendered to Medicaid recipients will be considered an allowable cost and reimbursed through Medicaid service rates of payment. The amount of 5.5% assessment uniformly imposed on all ICF/IDD services of all such providers will be included in the rate.
- (7) **Total Per Diem.** This will be the sum of products of paragraphs (2)(iii)(a)(28), (2)(iii)(a)(29), (4), (5) and (6) of this Section.
- (8) Computation of Subsequent Rate Period- Beginning one year after the initial period, the methodology will rebase the costs used in the methodology described in paragraph (2) of this Section using the 1/1 12/31 and 7/1 6/30 CFR one and one half, and two years prior to the rate period, respectively. Thereafter, the Department will rebase within four years of the previous rebase utilizing the base year CFR. For years in which the Department of Health does not update the base year, the Department will update property as described in paragraph (5) of this Section.

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Corp ID	Corp Name	CRP Operating Fee
11440	Devereux Foundation in New York	<u>\$392.62</u>
22270	SCO Family of Services	<u>\$413.70</u>
40640	U C P Handicapped Persons of Utica	<u>\$400.81</u>
86050	Maryhaven Center of Hope, Inc.	<u>\$347.65</u>
22460	Developmental Disabilities Institute	<u>\$488.22</u>
26050	UCPA of Greater Suffolk, Inc.	<u>\$479.06</u>
20600	Heartshare Human Services of New York	<u>\$363.60</u>
21160	Birch Family Services, Inc.	<u>\$465.20</u>
43850	Brookville Center for Children's Services, Inc.	<u>\$577.33</u>
22630	UCP of Ulster County	<u>\$258.32</u>
22620	The Center for Discovery, Inc.	<u>\$525.45</u>
21620	NY Easter Seals Society, Inc.	\$422.89

(9) Computation of Subsequent Rate Period for CRPs – Effective July 1, 2015

- i. <u>Total capital will be an add-on and reimbursed as computed in paragraph (5) of this</u> Section.
- ii. <u>Tax Assessment will be an add-on and reimbursed as computed in paragraph (6) of this Section.</u>

(10) Reporting Requirements

- i. Providers will report costs and maintain financial and statistical records in accordance with the Financial and Audit Requirements of the New York State OPWDD.
- ii. Generally Accepted Accounting Principles (GAAP). The completion of the financial and statistical report forms are in accordance with generally accepted accounting principles as applied to the provider unless the reporting instructions authorized specific variation in such principles. The State will identify provider cost and providers will submit cost data in accordance with GAAP.

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iii. If a provider fails to file a cost report (including the capital reimbursement reconciliation schedule) by the due date (including one 30-day extension, if granted by OPWDD), OPWDD will impose a penalty of 2% on the provider's Medicaid reimbursement. For cost reporting periods ending December 31, 2014 and later, if a provider fails to file a cost report (including the capital schedule) by the due date (including one 30 day extension, if granted by OPWDD), OPWDD will impose a penalty of 2% on the provider's Medicaid reimbursement, effective the first day of the sixth month following the end of the cost reporting period. 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) that prevented the provider from filing the cost report by the due date.

If a provider has not filed a complete and compliant annual Consolidated Fiscal Report (CFR) for any CFR reporting period ending between January 1, 2013 and January 1, 2015, the provider will be considered delinquent. The State will give notice to delinquent providers that to avoid the loss of Federal Financial Participation (FFP) effective April 1, 2016, a complete and compliant CFR must be submitted by October 1, 2015. The State will not claim FFP for any ICF/IID Service provided by the delinquent provider after April 1, 2016.

For CFR cost reporting periods beginning July 1, 2014 and thereafter, providers are required to file an annual CFR to the State within 120 days (150 with a requested extension) following the end of the provider's fiscal reporting period.

If a provider fails to file a complete and compliant CFR within 60 days following the imposition of the 2% penalty, the State must provide timely notice to the delinquent provider that FFP will end 240 days following the imposition of the 2% penalty; and the State will not claim FFP for any ICF/IID service provided by the provider with a date of service after the 240 day period.

(11) Trend Factors

- i. The trend factor used will be the applicable years from the Medical Care Services <u>Index for the period April to April of each year from www.BLS.gov/cpi; Table 1</u> <u>Consumer Price Index for All Urban Consumers (CPI-U); U.S. city average, by</u> <u>expenditure category and commodity and service group.</u>
- ii. Generally, actual index values will be used for all intervening years between the base period and the rate period. However, because the index value for the last year immediately preceding the current rate period will not be available when the current rate is calculated, an average of the previous five years actual known indexes will be calculated and used as a proxy for that one year.

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iii. A compounded trend factor will be calculated in order to bring base period costs to the appropriate rate.

(12) Transition to New Methodology

i. <u>The reimbursement methodology described in this Attachment will be phased-in over</u> <u>a three-year period, with a year for purposes of the transition period meaning a 12-</u> <u>month period from July 1st to the following June 30th, and with full implementation</u> <u>in the beginning of the fourth year.</u> During this transition period, the base operating <u>rate will transition to the target rate as determined by the reimbursement</u> <u>methodology described in this Attachment, according to the phase-in schedule</u> <u>outlined below.</u> The base operating rate will remain fixed and the target rate, as <u>determined by the reimbursement methodology in this Attachment, will be updated to</u> <u>reflect rebasing of cost data, trend factors and/or other appropriate adjustments.</u>

	Phase-in Percentage		
Transition Year	<u>Base</u> Operating Rate	<u>New</u> <u>Methodology</u>	
Year 1 (July 1, 2014 – June 30, 2015)	75%	25%	
Year 2 (July 1, 2015 – June 30, 2016)	50%	<u>50%</u>	
Year 3 (July 1, 2016 - June 30, 2017)	25%	<u>75%</u>	
Year 4 (July 1, 2017 – June 30, 2018)	0%	<u>100%</u>	

- ii. <u>Providers will have the opportunity to apply for additional funding in order to help individuals maintain access to services during the current financial transformation, as well as assist providers in achieving the larger transformation agenda of deinstitutionalization. In order for a provider to receive additional funding the following criteria must be met:</u>
 - (a) Provider must submit a completed application to OPWDD.

(b) Provider must be in a fiscal deficit.

- (c) Provider must be in compliance with CFR submission requirements.
- iii. DOH and OPWDD will utilize the January 1, 2013 through December 31, 2013 CFR for non-New York City providers and the July 1, 2013 through June 30, 2014 CFR for New York City providers to determine the provider's three year deficit for rate periods July 1, 2014 through June 30, 2015; July 1, 2015 through June 30, 2016; and July 1, 2016 through June 30, 2017.
- iv. <u>Providers will be reimbursed 60% of the total deficit over three years beginning with</u> the period July 1, 2014 through June 30, 2015.

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(13) Rate Corrections

- i. Arithmetic or calculation errors will be adjusted accordingly in instances that would result in an annual change of \$5,000 or more in a provider's annual reimbursement for ICFs/IID.
- ii. In order to request a rate correction in accordance with paragraph i. of this section, the provider must send to the Department of Health its request by certified mail, return receipt requested, within ninety days of the provide receiving the rate computation or within 90 days of the first day of the rate period in question, whichever is later.

(14) Specialized Populations Funding

- i. Notwithstanding any other provisions of this Attachment, rates for individuals identified by OPWDD as qualifying for specialized populations funding will be as follows:
- ii. For individuals initially identified as qualifying for specialized populations funding, a fee schedule can be found using the link below:

https://www.health.ny.gov/health_care/medicaid/rates/mental_hygiene/2014rates.htm

iii. The tax assessment as described in paragraph (6) will be applied to these rates.

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