NEW YORK
state department of
HEALTH

Nirav R. Shah, M.D., M.P.H.
Commissioner

Sue Kelly
Executive Deputy Commissioner

September 30,2011

National Institutional Reimbursement Team
Attention: Mark Cooley
CMS, CMCS
7500 Security Boulevard, M/S 3-14-28
Baltimore, MD 21244-1850

RE: SPA #11-85
Long-Term Care Facility Services
(ICF/DDs)

Dear Mr. Cooley:

The State requests approval of the enclosed amendment #11-85 to the Title XIX (Medicaid) State Plan for long-term care facility services to be effective July 1, 2011 (Appendix I). This amendment is being submitted based on enacted legislation and adopted regulation. A summary of the proposed amendment is provided in Appendix II.

This amendment is submitted pursuant to §1902(a) of the Social Security Act (42 USC 1396a(a)) and Title 42 of the Code of Federal Regulations, Part 447, Subpart C, (42 CFR §447).

1. The State of New York pays for long-term care services using rates determined in accordance with methods and standards specified in an approved State Plan following a public process which complies with §1902(a)(13)(A) of the Social Security Act.

2. (a) It is estimated that the changes represented by the estimated average payment rates for long-term care facility services will have no noticeable short-term or long-term effect on the availability of services on a statewide and geographic area basis.

   (b) It is estimated that the changes represented by the estimated average payment rates for long-term care facility services will have no noticeable short-term or long-term effect on care furnished.

   (c) It is estimated that the changes represented by the estimated average payment rates for long-term care facility services will have no noticeable short-term or long-term effect on the extent of provider participation.

In accordance with 42 CFR §447.272, New York assures that the aggregate Medicaid payments for inpatient services provided by ICF/DD facilities for each prescribed category of providers does not exceed the upper payment limit for the particular category of providers.

Copies of the pertinent sections of enacted State statute and adopted regulations are enclosed for your information (Appendix III). Copies of the public notice of this proposed amendment, which was given in the New York State Register on June 1, 2011, is also enclosed for your information (Appendix IV). In addition responses to the five standard funding questions and standard access questions are also enclosed (Appendix V and VI, respectively).

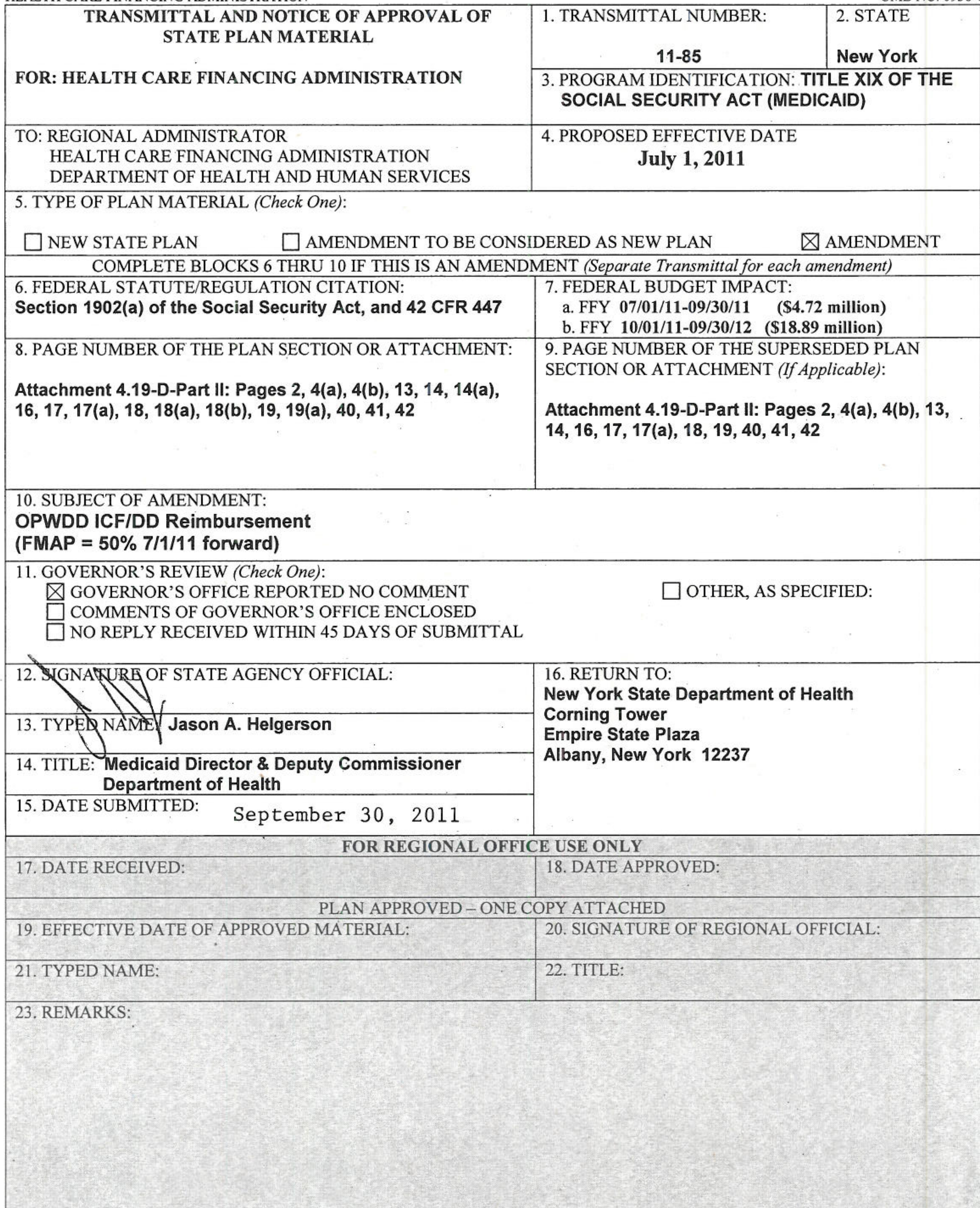
If you have any questions regarding this matter, please do not hesitate to contact John E. Ulberg, Jr., Director, Division of Health Care Financing at (518) 474-6350.

Sincerely,

Jason A. Helgerson
Medicaid Director
Deputy Commissioner
Office of Health Insurance Programs

Enclosures

cc: Mr. Michael Melendez
Mr. Tom Brady



DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL **FOR: HEALTH CARE FINANCING ADMINISTRATION**	1. TRANSMITTAL NUMBER: **11-85**	2. STATE **New York**
	3. PROGRAM IDENTIFICATION: **TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)**	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES	4. PROPOSED EFFECTIVE DATE **July 1, 2011**	

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION: **Section 1902(a) of the Social Security Act, and 42 CFR 447**	7. FEDERAL BUDGET IMPACT: a. FFY **07/01/11-09/30/11 ($4.72 million)** b. FFY **10/01/11-09/30/12 ($18.89 million)**
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: **Attachment 4.19-D-Part II: Pages 2, 4(a), 4(b), 13, 14, 14(a), 16, 17, 17(a), 18, 18(a), 18(b), 19, 19(a), 40, 41, 42**	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: **Attachment 4.19-D-Part II: Pages 2, 4(a), 4(b), 13, 14, 16, 17, 17(a), 18, 19, 40, 41, 42**

10. SUBJECT OF AMENDMENT:
OPWDD ICF/DD Reimbursement
(FMAP = 50% 7/1/11 forward)

11. GOVERNOR'S REVIEW *(Check One)*:
☒ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:	16. RETURN TO: **New York State Department of Health** **Corning Tower** **Empire State Plaza** **Albany, New York 12237**
13. TYPED NAME: **Jason A. Helgerson**	
14. TITLE: **Medicaid Director & Deputy Commissioner Department of Health**	
15. DATE SUBMITTED: September 30, 2011	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:	18. DATE APPROVED:

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:	20. SIGNATURE OF REGIONAL OFFICIAL:
21. TYPED NAME:	22. TITLE:

23. REMARKS:

Appendix I
2011 Title XIX State Plan
Third Quarter Amendment
Non-Institutional Services
SPA Pages

(i) Region I (NYC) is New York City and includes the counties of New York, Bronx, Kings, Queens and Richmond.
(ii) Region II (NYC Suburban) includes the counties of Putnam, Rockland, Nassau, Suffolk and Westchester.
(iii) Region III (Upstate New York) includes all other counties in New York State.

(4) Newly certified facility is an under thirty-one bed facility which has been in operation for less than four full years as of the start of a rate cycle, or an over thirty bed facility which has been in operation for less than two full years as of the start of a rate cycle.

(5) Operating costs are allowable costs which are non-capital in nature and which are allowable as specified in paragraph s (f)(1) and (2) of this section and subdivision (j) General Rules for Capital Costs and Costs of Related Party Transactions, and subdivision (k) Glossary. For purposes of this section, this includes day treatment, day service, transportation and regional FTE add-ons.

(6) Capital Costs are allowable costs as specified in paragraph (f)(1) and (3) of this section and subdivision (j) General Rules for Capital Costs and Costs of Related Party Transactions, and subdivision (k) Glossary.

(7) Reimbursable Costs are allowable costs, either operating or capital, adjusted per the application of this section, and prior to the application of the trend factor.

(8) Total reimbursable costs are reimbursable costs trended, as appropriate, per the application of subdivision (g) of this section.

(9) Budget costs for the purposes of the July 1, 2011 rate calculations are those budget costs relating only to facilities that opened either after January 1, 2008 for Regions II and III facilities or after July 1, 2008 for Region I facilities.

(b) Reporting requirements. Each provider shall submit reports in accordance with the requirements of 14 NYCRR subpart 635-4.

(c) Rate setting.
(1) Units of service.
(i) A unit of service is the unit of measure denoting lodging and services rendered to one consumer between the census-taking hours of the facility on two successive days; the day of admission but not the day of discharge shall be counted. One unit of service shall be counted if the consumer is discharged on the same day the consumer is admitted, providing there was an expectation that the admission would have at least a 24-hour duration.

(ii) Reserve bed days determined in accordance with 18 NYCRR section 505.9 and subdivision (i) of this section are units of service.

[(a)] The desk audit will examine the allocation of costs and [OMRDD] OPWDD will reallocate unidentified and improperly classified costs, if any, to appropriate cost categories.

[(b) The desk audit will examine base year costs against both the prior and subsequent years' costs. OMRDD will determine if costs are recurring, or are atypical and/or expended once in the base year.

(1) If OMRDD determines that base y-ear costs for a facility are recurring, for the base periods beginning January 1, 2003, April 1, 2003 or July 1. 2003, the methodology described in this section will apply.

(2) If OMRDD determines that base year costs for a facility are atypical and/or were expended only in the base year, OMRDD will expand the desk audit. OMRDD may make adjustments to base, year costs so that such costs represent typical and recurring costs.

(3) For a facility whose base year costs are subject to an expanded desk audit per subclause (b)(2) of this subparagraph, OMRDD shall continue the rate in effect on December 31, 2002, March 31, 2003 or June 30, 2003, and, if applicable, trended to 2003 or 2003-2004 dollars, until OMRDD completes the desk audit. For Region II and III facilities, OMRDD shall notify the provider by December 1, 2002 if the December 31, 2002 rate shall continue. For Region I facilities, OMRDD shall notify the provider by June 1, 2003 if the June 30, 2003 rate shall continue. For all State operated facilities. OMRDD shall notify the provider by March 1, 2003 if the March 31, 2003 rate shall continue. Upon OMRDD's completion of the expanded desk audit, for the base periods beginning January 1, 2003, April 1, 2003 or July 1, 2003, the methodology described in this section will apply.]

[(c) Administrative review of expanded desk audits shall be in accordance with subdivision 635-4.6(h) of 14 NYCRR]

(iii) The Commissioner may also make adjustments based on errors which occurred in the computation of the rate[,]. A provider may request a rate revision based on rate computation errors by notifying OPWDD by certified mail, return receipt requested, either within 90 days of the provider receiving the rate computation or within 90 days of the beginning of the rate period in question, whichever is later. However, if the requested rate revision is related to the resubmission of an annual cost report, OPWDD shall not accept the request. The Commissioner may also adjust for changes in certified capacity, changes in payments for real property which have the prior approval of the Commissioner and the Director of the Division of the Budget, or changes based upon previously determined final audit findings. If a facility has undergone a change in certified capacity, the Commissioner may:

(a) request the facility to submit a budget report subject to 14 NYCRR subpart 635-4; or

(b) request the facility to submit incremental/decremental cost data which is associated with the capacity change.

(c) utililizing the submitted incremental/decremental data or budget report, [OMRDD] OPWDD shall make the appropriate upward or downward adjustment in a facility's rate; or

(d) continue the then existing rate for the remainder of the subject rate period in those instances where the Commissioner has determined that the facility is operating at a loss for the rate period in question and adjusting the current rate would further increase such loss, or the facility is operating at a surplus for the rate period in question and adjusting the rate would further increase such surplus.

(iv) Rate adjustments as described in subparagraph [(ii)] (iii) of this paragraph will be limited to those adjustments which will result in an annual increase or decrease in reimbursement of [$1,000] $5,000 or more.

(v) Notwithstanding any other provisions of this section, for over thirty bed facilities the reimbursable operating costs contained in the rates shall be computed as follows.

(a) For over thirty bed facilities other than developmental centers, [OMRDD] OPWDD shall determine the total reimbursable operating costs (with the exception of education and related service costs, sheltered workshop services, and day training services) included in the payment rate in effect on December 31, March 31 or June 30 of the immediately preceding rate period applicable to that facility.

reimbursable operating costs (with the exception of education and related service costs, sheltered workshop services, day training services) included in the payment rate in effect on December 31, March 31 or June 30 of the immediately preceding rate period applicable to that facility. The dollars for sheltered workshop and day training services shall be revised based upon the number of individuals participating in the program. The reimbursable operating costs plus any revised sheltered work and day training costs will be increased by the trend factor described in subdivision (g) of this section and may be adjusted for appropriate appeals. Education and related services will be updated in accordance with clause (4)(ix)(f) of this subdivision. [OMRDD] OPWDD will determine the capital cost portion of the subsequent period rate by reviewing the component relating to capital costs for substantial material changes. If such changes conform to the requirements of paragraphs (f)(1) and (3) of this section and subdivision (j) General Rules for Capital Costs and Costs of Related Party Transactions, and subdivision (k) Glossary, [OMRDD] OPWDD will make corresponding adjustments in computing the subsequent period rate.

(ii) The computation of the rate resulting from the application of this paragraph can also be represented by the following formula:

(a) trended reimbursable operating costs + untrended reimbursable operating costs + reimbursable capital costs = total reimbursable costs.

(b) total reimbursable costs / units of service = the rate.

(iii) For a newly certified facility which begins to provide services that fall within a subsequent period, the initial rate shall be calculated as though it were a base period rate.

(d) Cost category screens, [and] reimbursement for under thirty-one bed facilities, and July 1, 2011 consolidation.

In order to determine the reimbursable operating costs to be included in the rate calculation, the following screens (i.e., the maximum amount that will be allowed for a specific item or group of items) will be used. The regional screens corresponding to the actual geographic location of the facility will be applied.

(1) Administration screens and reimbursement.

(i) Screens.

(a) Administrative screen values shall be equal to the sum of the total reimbursable administrative costs and the total reimbursable administrative fringe benefits, less the value of the efficiency adjustment, included in the rate effective on the last day of the

immediately preceding rate period. This amount shall be detrended to the base period.

(b) For facilities without a screen as determined in clause (a) of this subparagraph, operated by a provider which does operate other facilities, an agency administrative percentage based on the current reimbursement of those other facilities shall be applied.

(c) For facilities without a screen as determined in clauses (a) and (b) of this subparagraph, operated by a provider which operates other [OMRDD] OPWDD certified residential programs, an agency administrative percentage based on the current reimbursement of the other [OMRDD] OPWDD certified residential programs shall be applied.

(d) For facilities without a screen as determined in clauses (a) – (c) of this subparagraph, operated by a provider which does not operate any other [OMRDD] OPWDD certified residential programs, a regional average administrative percentage based on the current reimbursement of facilities operated by other providers shall be applied.

(e) For facilities without a screen value as determined per clause (a) of this subparagraph, the administrative screen value shall be equal to the percentages derived from clause (b), (c) or (d) of this paragraph times the reimbursable operating costs other than administration. This value shall be detrended to the base year.

(ii) Reimbursable administration costs shall be the lesser of administrative base year costs/budget costs, or the screen value as determined in subparagraph (i) of this paragraph. Effective July 1, 2011, for providers in all Regions, rates shall be revised such that reimbursable administration costs shall be the lesser of:

(a) administrative costs as reported in the provider's 2008-2009 cost report for Region I providers or 2008 cost report for Regions II and III providers detrended to the 1999/1999-2000 base year or administrative budget costs detrended to the 1999/1999-2000 base year; or

(b) 85 percent of the screen value as determined in subparagraph (i) of this paragraph.

(2) Direct care screens and reimbursement.

(i) Screen. The direct care screen value shall be the direct care FTEs multiplied by the regional salary.

(a) Direct care FTEs shall be calculated utilizing the facility specific disability increment plus bed size increment. The term disability increment shall mean the process of developing facility specific direct care FTEs based upon aggregate consumer disability characteristics as described in 14 NYCRR subdivision 690.7(g) and reported on the Developmental Disabilities Profile (DDP). The disability "increment methodology will only be calculated if at least 50 percent of the DDP scores are available. If less than 50 percent of the DDP scores are

(b) Direct care regional salaries.

Region	
I	$29,375
II	$29,522
III	$25,005

Note: The above values are in base year dollars.

(ii) Reimbursable direct care costs shall be the lesser of the base year costs/budget costs or the screen values established by subparagraph (i) of this paragraph. Effective July 1, 2011, for providers in all Regions, rates shall be revised such that reimbursable direct care costs shall be the lesser of :

(a) direct care costs as reported in the provider's 2008-2009 cost report for Region I providers or 2008 cost report for Regions II and III providers detrended to the 1999/1999-2000 base year or direct care budget costs detrended to the 1999/1999-2000 base year: or

(b) the screen value as determined in subparagraph (i) of this paragraph.

(3) Support personal service screens and reimbursement.

(i) Screen. The support screen value shall be the support FTEs multiplied by the regional salary.

(a) Support FTE screen values for budget-based facilities:

Bed size	Support FTE value
4	0.55
5	0.71
6	0.87
7	1.03
8	1.19
9	1.35
10	1.50
11	1.66
12	1.82
13	1.98
14	2.14
15	2.30
16	2.46
17	2.61
18	2.77
19	2.93
20	3.09
21	3.25
22	3.41
23	3.56

24	3.72
25	3.88
26	4.04
27	4.20
28	4.36
29	4.52
30	4.67

(b) Support FTE screen values for cost-based facilities are based on the base year cost report.

(c) Support regional salaries.

Region	
I	$29.375
II	$29.522
III	$25.005

Note: The above values are in base year dollars.

(ii) Reimbursable support personal service costs shall be the lesser of the base year costs/budget costs, or the screen values established in subparagraph (i) of this paragraph. Effective July 1, 2011, for providers in all Regions, rates shall be revised such that reimbursable support personal service costs shall be the lesser of:

(a) support personal service costs as reported in the provider's 2008-2009 cost report for Region I providers or 2008 cost report for Regions II and III providers detrended to the 1999/1999-2000 base year or support personal service budget costs detrended to the 1999/1999-2000 base year; or

(b) the screen value as determined in subparagraph (i) of this paragraph.

(4) Clinical screens and reimbursement.

(i) [For facilities which are not newly certified, the clinical screen shall be the appropriate clinical regional salary multiplied by the base year cost report clinical FTEs.] Clinical regional salaries are:

Region	
I	$56,510
II	$53,584
III	$40,414

Note: The above values are in base year dollars.

(ii) Rates prior to July 1, 2011.

(a) For newly certified facilities, that have a rate effective on the last day of the immediately preceding rate period, the reimbursable clinical costs will be the clinical FTEs approved and reimbursed in the rate effective on the last day of theimmediately preceding rate period multiplied by the lesser of;

[(a)] (1) the clinical average salary reimbursed in the rate on the last day of the immediately preceding rate period detrended to the 1999/1999-2000 base year; or

[(b)] (2) the appropriate clinical regional salary listed in subparagraph (i) of this paragraph.

[(iii)] (b) For newly certified facilities, that do not have a rate effective on the last day of the immediately preceding rate period, [OMRDD] OPWDD will consider budgeted FTEs and average salaries, reviewed and adjusted if necessary through a desk audit process. The reimbursable clinical costs shall be the desk-audited budgeted clinical FTEs multiplied by the lesser of:

[(a)] (1) the desk audited budgeted clinical average salary, detrended to the 1999/1999-2000 base year; or

[(b)] (2) the appropriate regional clinical salary listed in subparagraph (i) of this paragraph.

[(iv)] (c) For facilities which are not newly certified the reimbursable clinical costs shall be the base year cost report clinical FTEs multiplied by the lesser of:

[(a)] (1) the base year cost report clinical average salary; or

[(b)] (2) The appropriate clinical regional clinical salary listed in subparagraph (i) of this paragraph.

(iii) Rates effective July 1, 2011.

(a) For Region I providers that do not have a 2008-2009 cost report but that operate an under 31-bed ICF/DD(s) that has (have) a rate in effect on June 30, 2011, or for Regions II and III providers that do not have a 2008 cost report but that operate an under 31-bed ICF/DD(s) that has (have) a rate in effect on June 30, 2011, the reimbursable clinical costs will be the clinical component of the June 30, 2011 rate(s) detrended to the 1999/1999-2000 base year.

(b) For facilities that do not have a rate in effect on June 30, 2011, OPWDD shall use the budgeted FTEs and budgeted average salaries, reviewed and adjusted if necessary through a desk audit process. The reimbursable clinical costs for such facilities shall be the desk-audited budgeted clinical FTEs multiplied by the lesser of:

(1) the desk-audited budgeted clinical average salary, detrended to the 1999/1999-2000 base year; or

(2) the appropriate regional clinical salary listed in subparagraph (i) of this paragraph.

(c) For Region I providers that have a 2008-2009 cost report or for Region II or III providers that have a 2008 cost report, the reimbursable clinical costs shall be the FTEs from the provider's cost report multiplied by the lesser of:

(1) the clinical average salary as reported in the provider's 2008-2009 cost report for Region I providers or 2008 cost report for Regions II and III providers detrended to the 1999/1999-2000 base year; or

(2) the appropriate regional clinical salary listed in subparagraph (i) of this paragraph.

(5) Fringe benefit screens and reimbursement.

(i) Rates prior to July 1, 2011.

(a) For every new rate cycle, [OMRDD] OPWDD shall compute a facility-specific fringe benefit percentage. This percentage shall be determined by summing the direct care; clinical and support fringe benefit costs from the base year budget or cost report and dividing this sum by the sum of direct care, clinical and support personal service costs (exclusive of contracted personal service) from the base year budget or cost report.

[(ii)] (b) For newly certified facilities, that have a rate effective on the last day of the immediately preceding rate period, the fringe benefit percentage screen shall equal the fringe benefit percentage contained in the rate effective on the last day of the immediately preceding rate period.

[(iii)] (c) For newly certified facilities, that do not have a rate effective on the last day of the immediately preceding rate period, the fringe benefit percentage screen (as calculated in subparagraph (i) above) shall equal the average percentage reimbursed to existing facilities currently operated by the provider. If there are no existing facilities, then the fringe benefit percentage screen shall equal the average reimbursed fringe benefit percentage of any other programs operated by the provider. If the provider does not operate any other programs, then the fringe benefit percentage screen shall equal the regional average percentage reimbursed to other facilities.

[(iv)](d) Reimbursable fringe benefit costs shall be equal to the computed fringe benefit percent established in subparagraphs (i), (ii) or (iii) of this paragraph multiplied by the reimbursable direct care, clinical and support personal service dollars, exclusive of contracted personal service.

(ii) Effective July 1, 2011.

(a) OPWDD shall compute a facility-specific fringe benefit percentage by summing a facility's direct care, clinical and support fringe benefit costs detrended to the 1999/1999-2000 base year and dividing this sum by the sum of direct care, clinical and support personal service costs (exclusive of contracted personal service) detrended to the 1999/1999-2000 base year.

(1) For Region I providers that have a 2008-2009 cost report or for Regions II and III providers that have a 2008 cost report, for facilities that are in the cost report, the direct care, clinical, and support fringe benefit costs and direct care, clinical, and support personal service costs shall be those costs reported by the providers in their cost reports; and/or

(2) For facilities that opened after the beginning of the provider's respective reporting period as described in subclause (1) of this clause but that have a rate in effect on June 30, 2011, the direct care, clinical, and support

fringe benefit costs and direct care, clinical, and support personal service costs shall be those costs reflected in the provider's site-specific rates in effect on June 30, 2011; and/or

(3) For facilities that do not have a rate in effect on June 30, 2011, the fringe benefit percentage shall equal the average percentage reimbursed to existing facilities currently operated by the provider. If there are no existing facilities, then the fringe benefit percentage shall equal the average reimbursed fringe benefit percentage of any other programs operated by the provider. If the provider does not operate any other programs, then the fringe benefit percentage shall equal the regional average percentage reimbursed to other facilities.

(b) Reimbursable fringe benefit costs shall be equal to the computed fringe benefit percentage established pursuant to clause (*a*) of this subparagraph multiplied by the reimbursable direct care, clinical and support personal service dollars, exclusive of contracted personal service.

(6) Support OTPS (other than personal service) screens and reimbursement.

(i) The facility's support OTPS screen is determined by multiplying the certified capacity by the appropriate regional per bed value.

(ii) Support OTPS regional per bed values:

Region	
I	$16.097
II	$13.085
III	$16.418

Note: The above values are in base year dollars.

(iii) Reimbursable support OTPS costs shall be the lesser of the base year costs/budget costs, or the screen values established in subparagraph (i) of this paragraph. Effective July1, 2011, for providers in all Regions, rates shall be revised such that reimbursable support OTPS shall be the lesser of:

(a) support OTPS costs as reported in the provider's 2008-2009 cost report for Region I providers or 2008 cost report for Regions II and III providers detrended to the1999/1999-2000 base year or support OTPS budget costs detrended to the 1999/1999-2000 base year; or

(b) the screen value as determined in subparagraph (i) of this paragraph.

(7) Utility costs will not be included within the support OTPS screen. Prior to July 1, 2011,[The] reimbursable utility costs shall be the base year costs or budget costs. Effective July 1, 2011, the reimbursable utility costs shall be the 2008-2009 costs for Region I providers or the 2008 costs for Regions II and III providers detrended to the 1999/1999-2000 base year or the budget costs detrended to the 1999/1999-2000 base year.

(8) Effective July 1, 2011. Consolidation of site-specific rates into a single rate applicable to all facilities operated by a provider.

(i) Site-specific rates shall be revised to effect new July 1, 2011, rates in accordance with the processes outlined in this subdivision. OPWDD shall then consolidate the site-specific rates for each provider to produce a single rate for all facilities operated by a provider according to the steps outlined as follows:

(a) For each provider, the individual cost categories total reimbursable costs contained in the site-specific rates in effect on July 1, 2011 for each site operated by that provider shall be summed.

(b) For each provider, the individual certified capacities upon which the site-specific rates in effect on July 1, 2011 are predicated for each site operated by that provider shall be summed.

(c) For each provider, the individual potential maximum client days upon which the site-specific rates in effect on July 1, 2011 are predicated for each site operated by that provider shall be summed.

(d) If the operating component of the single provider-specific rate calculated in accordance with clauses (a), (b) and (c) of this subparagraph represents an ICF/DD operating funding level which is greater than the aggregate ICF/DD operating funding level at June 30, 2011 for the provider, then the July 1, 2011 provider-specific rate will be the consolidation of the provider's June 30, 2011 ICF/DD rates. If the single provider-specific operating rate calculated in accordance with clauses (a), (b) and (c) of this subdivision represents an ICF/DD operating funding level for the provider which is less than the aggregate ICF/DD operating funding level at June 30, 2011, then the July 1, 2011 provider-specific rate will be the higher of the single provider-specific operating rate calculated in accordance with clauses (a), (b) and (c) of this subparagraph or the operating rate which represents a funding reduction of ten percent of the aggregate ICF/DD operating funding level for the provider at June 30, 2011.

(ii) Sites opening after July 1, 2011. For a facility that was not operating on June 30, 2011, or was not certified as an ICF/DD on June 30, 2011 , the initial site-specific rate shall be the current agency ICF/DD rate or a rate based on budgeted costs if the Commissioner determines that a rate based on budgeted costs is needed because the current agency ICF/DD rate would not appropriately reimburse the ICF/DD when taking into consideration the disability levels of the ICF/DD individuals. In establishing a rate based on budgeted costs, the commissioner shall adjust the budgeted costs for the facility by whichever of the following cost information is available and reflects necessary costs for operating the new facility: actual costs of similar existing facilities operated by the provider, or average costs of other facilities in the same region and historical data for similar facilities, in order to establish a rate that uses the most comparable data when taking into consideration the disability levels of the ICF/DD individuals. The approved site-specific rates shall be incorporated into the single rate for all facilities operated by a provider according to the process outlined in clauses (a), (b) and (c) of subparagraph (i) of this paragraph. The recalculated provider-specific rate will be effective on the date of the certification of the new site.

(iii) As of July 1, 2011, all unresolved desk audits precipitated by rebasing to the base year 1999/1999-2000 shall be closed and there shall be no further attempts to effect rate adjustments or reconciliations.

(3) Where appropriate, the Commissioner shall use some combination in whole or in part of the yearly components to project cost data into the appropriate rate period.

(h) Appeals to rates.

(1) For appeals for rate periods before July 1, 2011, the [The] Commissioner will consider only the following appeals for adjustment to the rates which would result in an annual increase of $1,000 or more in a facility's allowable costs, and are:

(i) needed because of changes in the statistical information used to calculate a facility's staffing or utilization standards; [or]

(ii) requests for relief from the standards contained in subdivisions (d) or (e) of this section which were applied to costs used in calculating the base period and subsequent period rates[.];

(iii) appeals for adjustments needed because of material errors in the information submitted by the facility which [OMRDD] OPWDD used to establish the rate, or material errors in the rate computation[.]; or

(iv) appeals for significant increases or decreases in a facility's overall base period operating costs due to implementation of new programs, changes in staff or service, changes in the characteristics or number of individuals, changes in a lease agreement so as not to involve a related party, capital renovations, expansions or replacements which have been either mandated or approved by the Commissioner and, except in life-threatening situations, approved in advance by the appropriate State agencies.

(2) For rate periods beginning July 1, 2011 and thereafter, the Commissioner will consider appeals for adjustment to the rates which:

(i) would result in an annual increase of $5,000 or more in the provider's allowable costs; and

(ii) are needed because of the occurrence of bed vacancies.

(3) Notification of first level appeal.

(i) In order to appeal a rate in accordance with subparagraphs (1)(ii-iii) of this subdivision, the [facility] provider must send to [OMRDD] OPWDD an appeal application by certified mail, return receipt requested, either within 90 days of the facility receiving the rate computation or within 90 days of the beginning of the rate period in question, whichever is later.

**Attachment 4.19-D
Part II ICF/DD**

(ii) In order to appeal a rate in accordance with subparagraphs (1)(i) [and] or (iv) or paragraph (2) of this subdivision, the [facility] provider must send to [OMRDD] OPWDD, within one year of the close of the rate period in question, a first level appeal application by certified mail, return receipt requested.

[(3)](4) First level rate appeal applications shall be made in writing to the commissioner.

(i) The application shall set forth the basis for the first level appeal and the issues of fact. Appropriate documentation shall accompany the application and [OMRDD] OPWDD may request such additional documentation as it deems necessary.

(ii) Actions on first level rate appeal applications will be processed without unjustifiable delay.

[(4)](5) The burden of proof on the first level appeal shall be on the [facility] provider to demonstrate that the rate requested in the appeal is necessary to ensure efficient and economical operation.

[(5)](6) A rate revised by [OMRDD] OPWDD pursuant to an appeal shall not be considered final unless and until approved by the State Division of the Budget.

[(6)](7) At no point in the first level appeal process shall the [facility] provider have a right to an interim report of any determinations made by any of the parties to the appeal. At the conclusion of the first level appeal process [OMRDD] OPWDD shall notify the [facility] provider of any proposed revised rate or denial of same [by certified mail, return receipt requested]. Once OPWDD has informed the provider of the appeal outcome, a provider which submits a revised cost report for the period reviewed on appeal shall not be entitled to an increase in the award determination based on that resubmission. [OMRDD] OPWDD shall inform the [facility] provider that [the facility] it may either accept the proposed revised rate or request a second level appeal in accordance with 14 NYCRR section 602.9 in the event that the proposed revised rate fails to grant some or all of the relief requested.

[(7)](8) If [OMRDD] OPWDD approves the revision to the rate and State Division of the Budget denies the revision, the [facility] provider shall have no further right to administrative review pursuant to this section.

[(8)](9) Any rate revised in accordance with this subdivision shall be effective according to the dates indicated in the rate appeal notification.

[(9)](10) Any additional reimbursement received by the facility, pursuant to a rate revised in accordance with this subdivision, shall be restricted to the specific purpose set forth in the appeal decision.

[(10)](11) Second level appeals to rates.

(i) [OMRDD's] OPWDD's denial of the first level appeal of any or all of the relief requested in the appeal[s] provided for in [paragraph] paragraphs (1) or (2) of this subdivision shall be final, unless the [facility] provider requests a second level appeal to the commissioner in writing within 30 days of service of notification of denial or proposed revised rate.

(ii) Second level appeals shall be brought and determined in accordance with the applicable provisions of 14 NYCRR Part 602.

(i) Reserve bed days for overnight absences for hospitalization or leaves of absence in facilities.

(1) Payment.

(i) Payment for overnight absences due to hospitalization shall be in accordance with 18 NYCRR section 505.9.

(ii) Payment for overnight absences due to leaves of absence shall be in accordance with 18 NYCRR section 505.9 and the following additional requirements.

(a) A leave of absence due to visits with relatives or friends, must not be medically or programmatically contraindicated.

(b) In the case of a leave of absence due to medically acceptable therapeutic leave or rehabilitative plans of care, the plan of care must be documented.

(c) Leaves of absence covered under the bed reservation program must be provided for in the consumer's individual program plan as designated by the interdisciplinary team.

(d) Such planning should most appropriately take place during the development and monitoring process of the individual program plan during the quarterly and annual reviews. A consumer's assigned bed cannot be reserved if another person is occupying that bed.

(2) Reporting.

(i) Each facility shall maintain an absence register for each consumer who is absent overnight.

Appendix II
2011 Title XIX State Plan
Third Quarter Amendment
Non-Institutional
Summary of Plan Provisions

SUMMARY
SPA #11-85

This state plan amendment implements changes to the reimbursement methodology for ICF/DDs certified by the Office for People With Developmental Disabilities consistent with regulations adopted effective on July 1, 2011.

Appendix III
2011 Title XIX State Plan
Third Quarter Amendment
Non-Institutional Services
Authorizing Provisions

Authorizing Provisions
SPA #11-85

New York State Mental Hygiene Law

§ 13.09 Powers of the office and commissioner; how exercised.

(a) The commissioner shall exercise all powers vested in the office. He may delegate any function, power, or duty assigned to him or to the office to any officer or employee of the office, unless otherwise provided by law. He may enter into agreements with other commissioners of the department in order to ensure that programs and services are provided for all of the mentally disabled.

43.02 Rates or methods of payment for services at facilities subject to licensure or certification by the office of mental health, the office for people with developmental disabilities or the office of alcoholism and substance abuse services.

(a) Notwithstanding any inconsistent provision of law, payment made by government agencies pursuant to title eleven of article five of the social services law for services provided by any facility . . . licensed or operated by the office for people with developmental disabilities pursuant to article sixteen of this chapter . . . shall be at rates or fees certified by the commissioner of the respective office and approved by the director of the division of the budget . . . .

Reimbursement of ICF/DD Facilities
Amendment of 14 NYCRR Section 681.14
Effective Date: July 1, 2011

- **Paragraph 681.14(a)(8) is amended as follows:**

(8) *Total reimbursable costs* are reimbursable costs trended, as appropriate, per the application of subdivision [(g)] (h) of this section except that day program services costs identified in clause (c)(4)(viii)(*e*) of this section are not subject to the trend factors identified in subdivision [(g)] (h) of this section, but will be increased by the trend factors used by [OMRDD] OPWDD for day services similar to those paid for through the add-on described in clause (c)(4)(viii)(*e*) of this section.

- **New paragraph 681.14(a)(9) is added to read as follows:**

(9) *Budget costs for the purposes of the July 1, 2011 rate calculations* are those budget costs relating only to facilities that opened either after January 1, 2008 for Regions II and III facilities or after July 1, 2008 for Region I facilities.

- **Subparagraph 681.14(c)(3)(ii) is amended as follows:**

(ii) The commissioner may make adjustments to rates calculated in accordance with this section based upon the allowability of costs as determined by subdivision (f) of this section and Subpart 635-4 of this Title. In addition, costs may be reallocated and adjusted following a desk audit of cost reports. [(*a*)] The desk audit will examine the allocation of costs and [OMRDD] OPWDD will reallocate unidentified and improperly classified costs, if any, to appropriate costs categories.

- **Clauses 681.14(c)(3)(ii)(*b*)-(*c*) are deleted.**

- **Subparagraph 681.14(c)(3)(iii) is amended as follows:**

(iii) The commissioner may also make adjustments to rates calculated in accordance with subdivision (f) of this section, and Subpart 635-4 of this Title based on errors which occurred in the computation of the rate[,]. A provider may request a rate revision based on rate computation errors by notifying OPWDD by certified mail, return receipt requested, either within 90 days of the provider receiving the rate computation or within 90 days of the beginning of the rate period in question, whichever is later. However, if the requested rate revision is related to the resubmission of an annual cost report, OPWDD shall not accept the request. The commissioner may also adjust for changes in certified capacity, changes in payments for real property which have the prior approval of the commissioner and the Director of the Division of the Budget, or changes based

Note: New material is underlined; deleted material is in [brackets].

upon previously determined final audit findings. If a facility has undergone a change in certified capacity, the commissioner may:

(Note: rest of subparagraph is unchanged.)

- **Subparagraph 681.14(c)(3)(iv) is amended as follows:**

(iv) Rate adjustments as described in subparagraph (iii) of this paragraph will be limited to those adjustments which will result in an annual increase or decrease in reimbursement of [$1,000] $5,000 or more.

- **Subparagraph 681.14(c)(3)(v) is amended as follows:**

(v) Notwithstanding any other provisions of this section, for over 30-bed facilities the reimbursable operating costs contained in the rates shall be computed as follows. [OMRDD] OPWDD shall determine the total reimbursable operating costs (with the exception of education and related service costs, sheltered workshop services, and day training services) included in the payment rate in effect on December 31st or June 30th, of the immediately preceding rate period applicable to that facility. The dollars for sheltered workshop, day program services identified in clause (4)(viii)(*e*) of this subdivision and day training services shall be revised based upon the number of individuals participating in the program. The reimbursable operating cost plus any revised sheltered work and day training costs will be increased by the trend factor identified in subdivision [(g)] (h) of this section and may be adjusted for appropriate appeals, except that day program services costs identified in clause (4)(viii)(*e*) of this subdivision are not subject to the trend factors identified in subdivision [(g)] (h) of this section, but will be increased by the trend factors used by [OMRDD] OPWDD for day services similar to those paid for through the add-on described in clause (4)(viii)(*e*) of this subdivision. Education and related services will be updated in accordance with clause (4)(ix)(*c*) of this subdivision. To determine the capital cost portion of the subsequent period rate, [OMRDD] OPWDD shall review the component relating to capital costs for substantial material changes and, if said changes conform to the requirements of paragraphs (f)(1) and (3) of this section and Subpart 635-4 of this Title, make corresponding adjustments in computing the subsequent period rate.

- **Clause 681.14(c)(3)(vi)(*a*) is amended as follows:**

(*a*) trended reimbursable operating costs + untrended reimbursable operating costs + reimbursable capital costs [sign] equal total reimbursable costs;

- **Subparagraph 681.14(c)(4)(vi) is amended as follows:**

(vi) As appropriate, [OMRDD] OPWDD shall apply trend factors to each facility's reimbursable operating costs, except for education and related services. However, day program services costs

Note: New material is underlined; deleted material is in [brackets].

identified in clause (viii)(*e*) of this paragraph are not subject to the trend factors identified in subdivision [(g)] (h) of this section, but will be increased by the trend factors used by [OMRDD] OPWDD for day services similar to those paid for through the add-on described in clause (viii)(*e*) of this paragraph.

- **Subparagraph 681.14(c)(5)(i) is amended as follows:**

(i) The reimbursable operating costs contained in the subsequent period rates shall be computed as follows. [OMRDD] OPWDD shall determine the total reimbursable operating costs (with the exception of education and related service costs, sheltered workshop services, day training services) included in the payment rate in effect on December 31st or June 30th of the immediately preceding rate period applicable to that facility. The dollars for sheltered workshop and day training services shall be revised based upon the number of individuals participating in the program. The reimbursable operating costs plus any revised sheltered work and day training costs will be increased by the trend factor identified in subdivision [(g)] (h) of this section and may be adjusted for appropriate appeals, except that day program services costs identified in clause (4)(viii)(*e*) of this subdivision are not subject to the trend factors identified in subdivision [(g)] (h) of this section, but will be increased by the trend factors used by [OMRDD] OPWDD for day services similar to those paid for through the add-on described in clause (4)(viii)(*e*) of this subdivision. Education and related services will be updated in accordance with clause (4)(ix)(*c*) of this subdivision. [OMRDD] OPWDD will determine the capital cost portion of the subsequent period rate by reviewing the component relating to capital costs for substantial material changes. If such changes conform to the requirements of paragraphs (f)(1) and (3) of this section and Subpart 635-6 of this Title, [OMRDD] OPWDD will make corresponding adjustments in computing the subsequent period rate.

- **Subdivision 681.14(d) is amended as follows:**

(d) Cost category screens, [and] reimbursement for under 31-bed facilities, and July 1, 2011 consolidation. In order to determine the reimbursable operating costs to be included in the rate calculation, the following screens (*i.e.*, the maximum amount that will be allowed for a specific item or group of items) will be used. The regional screens corresponding to the actual geographic location of the facility will be applied.

(1) Administration screens and reimbursement.

(i) Screens.

(Note: the rest of subparagraph (i) is unchanged.)

(ii) Reimbursable administration costs shall be the lesser of administrative base year costs/budget costs, or the screen value as determined in subparagraph (i) of this

Note: New material is underlined; deleted material is in [brackets].

paragraph. Effective July 1, 2011, for providers in all Regions, rates shall be revised such that reimbursable administration costs shall be the lesser of:

(*a*) administrative costs as reported in the provider's 2008-2009 cost report for Region I providers or 2008 cost report for Regions II and III providers detrended to the 1999/1999-2000 base year or administrative budget costs detrended to the 1999/1999-2000 base year; or

(*b*) 85 percent of the screen value as determined in subparagraph (i) of this paragraph.

(iii) Revenues realized by providers from reimbursement attributable to components of the rate other than the administrative component shall not be used to fund administrative expenses.

(2) Direct care screens and reimbursement.

(i) Screen. The direct care screen value shall be the direct care [of] FTEs multiplied by the regional salary.

(Note: rest of subparagraph is unchanged.)

(ii) Reimbursable direct care costs shall be the lesser of the base year costs/budget costs or the screen values established by subparagraph (i) of this paragraph. Effective July 1, 2011, for providers in all Regions, rates shall be revised such that reimbursable direct care costs shall be the lesser of:

(*a*) direct care costs as reported in the provider's 2008-2009 cost report for Region I providers or 2008 cost report for Regions II and III providers detrended to the 1999/1999-2000 base year or direct care budget costs detrended to the 1999/1999-2000 base year; or

(*b*) the screen value as determined in subparagraph (i) of this paragraph.

(3) Support personal service screens and reimbursement.

(Note: Subparagraph (i) is unchanged.)

(ii) Reimbursable support personal service costs shall be the lesser of the base year costs /budget costs, or the screen values established in subparagraph (i) of this

Note: New material is underlined; deleted material is in [brackets].

paragraph. Effective July 1, 2011, for providers in all Regions, rates shall be revised such that reimbursable support personal service costs shall be the lesser of:

(a) support personal service costs as reported in the provider's 2008-2009 cost report for Region I providers or 2008 cost report for Regions II and III providers detrended to the 1999/1999-2000 base year or support personal service budget costs detrended to the 1999/1999-2000 base year; or

(b) the screen value as determined in subparagraph (i) of this paragraph.

(4) Clinical screens and reimbursement.

(i) [For facilities which are not newly certified, the clinical screen shall be the appropriate clinical regional salary multiplied by the base year cost report clinical FTEs.] Clinical regional salaries are:

(Note: rest of subparagraph is unchanged.)

(ii) Rates prior to July 1, 2011.

(a) For newly certified facilities, that have a rate effective on the last day of the immediately preceding rate period, the reimbursable clinical costs will be the clinical FTEs approved and reimbursed in the rate effective on the last day of the immediately preceding rate period multiplied by the [lessor] lesser of:

[(*a*)] *(1)* the clinical average salary reimbursed in the rate on the last day of the immediately preceding rate period detrended to the 1999/1999-2000 base year; or

[(*b*)] *(2)* the appropriate clinical regional salary listed in subparagraph (i) of this paragraph.

[(iii)] *(b)* For newly certified facilities, that do not have a rate effective on the last day of the immediately preceding rate period, [OMRDD] OPWDD will consider budgeted FTEs and average salaries, reviewed and adjusted if necessary through a desk audit process. The reimbursable clinical costs shall be the desk-audited budgeted clinical FTEs multiplied by the lesser of:

[(*a*)] *(1)* the desk-audited budgeted clinical average salary, detrended to the 1999/1999-2000 base year; or

[(*b*)] (*2*) the appropriate regional clinical salary listed in subparagraph (i) of this paragraph.

[(iv)] (*c*) For facilities which are not newly certified, the reimbursable clinical costs shall be the base year cost report clinical FTEs multiplied by the lesser of:

[(*a*)] (*1*) the base year cost report clinical average salary; or

[(*b*)] (*2*) the appropriate regional clinical salary listed in subparagraph (i) of this paragraph.

(iii) Rates effective July 1, 2011.

(*a*) For Region I providers that do not have a 2008-2009 cost report but that operate an under 31-bed ICF/DD(s) that has (have) a rate in effect on June 30, 2011, or for Regions II and III providers that do not have a 2008 cost report but that operate an under 31-bed ICF/DD(s) that has (have) a rate in effect on June 30, 2011, the reimbursable clinical costs will be the clinical component of the June 30, 2011 rate(s) detrended to the 1999/1999-2000 base year.

(*b*) For facilities that do not have a rate in effect on June 30, 2011, OPWDD shall use the budgeted FTEs and budgeted average salaries, reviewed and adjusted if necessary through a desk audit process. The reimbursable clinical costs for such facilities shall be the desk-audited budgeted clinical FTEs multiplied by the lesser of:

(*1*) the desk-audited budgeted clinical average salary, detrended to the 1999/1999-2000 base year; or

(*2*) the appropriate regional clinical salary listed in subparagraph (i) of this paragraph.

(*c*) For Region I providers that have a 2008-2009 cost report or for Region II or III providers that have a 2008 cost report, the reimbursable clinical costs shall be the FTEs from the provider's cost report multiplied by the lesser of:

(*1*) the clinical average salary as reported in the provider's 2008-2009 cost report for Region I providers or 2008 cost report for Regions II and III providers detrended to the 1999/1999-2000 base year; or

(2) the appropriate regional clinical salary listed in subparagraph (i) of this paragraph.

(5) Fringe benefit screens and reimbursement.

(i) Rates prior to July 1, 2011.

(Note: current subparagraphs (i) – (iv) are renumbered to clauses (i)(*a*) through (i)(*d*).)

(ii) Effective July 1, 2011.

(*a*) OPWDD shall compute a facility-specific fringe benefit percentage by summing a facility's direct care, clinical and support fringe benefit costs detrended to the 1999/1999-2000 base year and dividing this sum by the sum of direct care, clinical and support personal service costs (exclusive of contracted personal service) detrended to the 1999/1999-2000 base year.

(*1*) For Region I providers that have a 2008-2009 cost report or for Regions II and III providers that have a 2008 cost report, for facilities that are in the cost report, the direct care, clinical, and support fringe benefit costs and direct care, clinical, and support personal service costs shall be those costs reported by the providers in their cost reports; and/or

(*2*) For facilities that opened after the beginning of the provider's respective reporting period as described in subclause (*1*) of this clause but that have a rate in effect on June 30, 2011, the direct care, clinical, and support fringe benefit costs and direct care, clinical, and support personal service costs shall be those costs reflected in the provider's site-specific rates in effect on June 30, 2011; and/or

(*3*) For facilities that do not have a rate in effect on June 30, 2011, the fringe benefit percentage shall equal the average percentage reimbursed to existing facilities currently operated by the provider. If there are no existing facilities, then the fringe benefit percentage shall equal the average reimbursed fringe benefit percentage of any other programs operated by the provider. If the provider does not operate any other programs, then the fringe benefit percentage shall equal the regional average percentage reimbursed to other facilities.

(*b*) Reimbursable fringe benefit costs shall be equal to the computed fringe benefit percentage established pursuant to clause (*a*) of this subparagraph

multiplied by the reimbursable direct care, clinical and support personal service dollars, exclusive of contracted personal service.

(6) Support OTPS (other than personal service) screens and reimbursement.

(Note: subparagraphs (i) and (ii) are unchanged.)

(iii) Reimbursable support OTPS costs shall be the lesser of the base year costs/budget costs, or the screen values established in subparagraph (i) of this paragraph. Effective July 1, 2011, for providers in all Regions, rates shall be revised such that reimbursable support OTPS shall be the lesser of:

(*a*) support OTPS costs as reported in the provider's 2008-2009 cost report for Region I providers or 2008 cost report for Regions II and III providers detrended to the1999/1999-2000 base year or support OTPS budget costs detrended to the 1999/1999-2000 base year; or

(*b*) the screen value as determined in subparagraph (i) of this paragraph.

(7) Utility costs will not be included within the support OTPS screen. Prior to July 1, 2011, [The] reimbursable utility costs shall be the base year costs or budget costs. Effective July 1, 2011, the reimbursable utility costs shall be the 2008-2009 costs for Region I providers or the 2008 costs for Regions II and III providers detrended to the 1999/1999-2000 base year or the budget costs detrended to the 1999/1999-2000 base year.

(8) Effective July 1, 2011. Consolidation of site-specific rates into a single rate applicable to all facilities operated by a provider.

(i) Site-specific rates shall be revised to effect new July 1, 2011, rates in accordance with the processes outlined in this subdivision. OPWDD shall then consolidate the site-specific rates for each provider to produce a single rate for all facilities operated by a provider according to the steps outlined as follows:

(*a*) For each provider, the individual cost categories total reimbursable costs contained in the site-specific rates in effect on July 1, 2011 for each site operated by that provider shall be summed.

(*b*) For each provider, the individual certified capacities upon which the site-specific rates in effect on July 1, 2011 are predicated for each site operated by that provider shall be summed.

Note: New material is underlined; deleted material is in [brackets].

(*c*) For each provider, the individual potential maximum client days upon which the site-specific rates in effect on July 1, 2011 are predicated for each site operated by that provider shall be summed.

(*d*) If the operating component of the single provider-specific rate calculated in accordance with clauses (*a*), (*b*) and (*c*) of this subparagraph represents an ICF/DD operating funding level which is greater than the aggregate ICF/DD operating funding level at June 30, 2011 for the provider, then the July 1, 2011 provider-specific rate will be the consolidation of the provider's June 30, 2011 ICF/DD rates. If the single provider-specific operating rate calculated in accordance with clauses (*a*), (*b*) and (*c*) of this subdivision represents an ICF/DD operating funding level for the provider which is less than the aggregate ICF/DD operating funding level at June 30, 2011, then the July 1, 2011 provider-specific rate will be the higher of the single provider-specific operating rate calculated in accordance with clauses (*a*), (*b*) and (*c*) of this subparagraph or the operating rate which represents a funding reduction of ten percent of the aggregate ICF/DD operating funding level for the provider at June 30, 2011.

(ii) Sites opening after July 1, 2011. For a facility that was not operating on June 30, 2011, or was not certified as an ICF/DD on June 30, 2011 , the initial site-specific rate shall be the current agency ICF/DD rate or a rate based on budgeted costs if the Commissioner determines that a rate based on budgeted costs is needed because the current agency ICF/DD rate would not appropriately reimburse the ICF/DD when taking into consideration the disability levels of the ICF/DD individuals. In establishing a rate based on budgeted costs, the commissioner shall adjust the budgeted costs for the facility by whichever of the following cost information is available and reflects necessary costs for operating the new facility: actual costs of similar existing facilities operated by the provider, or average costs of other facilities in the same region and historical data for similar facilities, in order to establish a rate that uses the most comparable data when taking into consideration the disability levels of the ICF/DD individuals.
The approved site-specific rates shall be incorporated into the single rate for all facilities operated by a provider according to the process outlined in clauses (*a*), (*b*) and (*c*) of subparagraph (i) of this paragraph. The recalculated provider-specific rate will be effective on the date of the certification of the new site.

(iii) As of July 1, 2011, all unresolved desk audits precipitated by rebasing to the base year 1999/1999-2000 shall be closed and there shall be no further attempts to effect rate adjustments or reconciliations.

- **Subdivision 681.14(i) is amended as follows:**

(i) *Appeals to rates.*

(1) For appeals for rate periods before July 1, 2011, the [The] commissioner will consider only the following appeals for adjustment to the rates which would result in an annual increase of $1,000 or more in a facility's allowable costs, and are:

(i) needed because of changes in the statistical information used to calculate a facility's staffing or utilization standards;

(ii) requests for relief from the standards contained in subdivision (d) or (e) of this section which were applied to costs used in calculating the base period and subsequent period rates;

(iii) appeals for adjustments needed because of material errors in the information submitted by the facility which [OMRDD] OPWDD used to establish the rate, or material errors in the rate computation; or

(iv) appeals for significant increases or decreases in a facility's overall base period operating costs due to implementation of new programs, changes in staff or service, changes in the characteristics or number of individuals, changes in a lease agreement so as not to involve a related party, capital renovations, expansions or replacements which have been either mandated or approved by the commissioner and, except in life-threatening situations, approved in advance by the appropriate State agencies[; or] .

[(v) OMRDD will no longer accept applications for new appeals to rates effective prior to April 1, 1985.]

(2) For rate periods beginning July 1, 2011 and thereafter, the commissioner will consider appeals for adjustment to the rates which:

(i) would result in an annual increase of $5,000 or more in the provider's allowable costs; and

(ii) are needed because of the occurrence of bed vacancies.

[(2)] (3) Notification of first level appeal.

(i) In order to appeal a rate in accordance with subparagraphs (1)(ii)-(iii) of this subdivision, the [facility] provider must send to [OMRDD] OPWDD an appeal application by certified mail, return receipt requested, either within 90 days of the

Note: New material is underlined; deleted material is in [brackets].

facility receiving the rate computation or within 90 days of the beginning of the rate period in question, whichever is later.

(ii) In order to appeal a rate in accordance with subparagraphs (1)(i) [and]or (iv) or paragraph (2) of this subdivision, the [facility] provider must send to [OMRDD] OPWDD, within one year of the close of the rate period in question, a first level appeal application by certified mail, return receipt requested.

[(3)] (4) First level rate appeal applications shall be made in writing to the commissioner.

(i) The application shall set forth the basis for the first level appeal and the issues of fact. Appropriate documentation shall accompany the application and [OMRDD] OPWDD may request such additional documentation as it deems necessary.

(ii) Actions on first level rate appeal applications will be processed without unjustifiable delay.

[(4)] (5) The burden of proof on the first level appeal shall be on the [facility] provider to demonstrate that the rate requested in the appeal is necessary to ensure efficient and economical operation.

[(5)] (6) A rate revised by [OMRDD] OPWDD pursuant to an appeal shall not be considered final unless and until approved by the State Division of the Budget.

[(6)] (7) At no point in the first level appeal process shall the [facility] provider have a right to an interim report of any determinations made by any of the parties to the appeal. At the conclusion of the first level appeal process [OMRDD] OPWDD shall notify the [facility] provider of any proposed revised rate or denial of same [by certified mail, return receipt requested]. Once OPWDD has informed the provider of the appeal outcome, a provider which submits a revised cost report for the period reviewed on appeal shall not be entitled to an increase in the award determination based on that resubmission. [OMRDD] OPWDD shall inform the [facility] provider that [the facility] it may either accept the proposed revised rate or request a second level appeal in accordance with section 602.9 of this Title in the event that the proposed revised rate fails to grant some or all of the relief requested.

[(7)] (8) If [OMRDD] OPWDD approves the revision to the rate and State Division of the Budget denies the revision, the [facility] provider shall have no further right to administrative review pursuant to this section.

[(8)] (9) Any rate revised in accordance with this subdivision shall be effective according to the dates indicated in the rate appeal notification.

Note: New material is underlined; deleted material is in [brackets].

[(9)] (10) Any additional reimbursement received by the [facility] provider, pursuant to a rate revised in accordance with this subdivision, shall be restricted to the specific purpose set forth in the appeal decision.

[(10)] (11) Second level appeals to rates.

(i) [OMRDD's] OPWDD's denial of the first level appeal of any or all of the relief requested in the appeal[s] provided for in [paragraph] paragraphs (1) or (2) of this subdivision shall be final, unless the [facility] provider requests a second level appeal to the [commission] commissioner in writing within 30 days of service of notification of denial or proposed revised rate.

(ii) Second level appeals shall be brought and determined in accordance with the applicable provisions of Part 602 of this Title.

- **Subdivision 681.14(j) is amended by the addition of a new paragraph (8) as follows and existing paragraph (8) is renumbered to be (9):**

(8) For the purpose of the July 1, 2011, rate calculations, OPWDD shall assume that providers have allocated all expenses matched to their HCE I revenues to the fringe benefit cost category in their cost reports.

- **Subdivision 681.14(k) is amended by the addition of a new paragraph (8) as follows and existing paragraph (8) is renumbered to be (9):**

(8) For the purposes of the July 1, 2011 rate calculations, OPWDD shall assume that providers have allocated all expenses matched to their HCE II revenues to the fringe benefit cost category in their cost reports.

- **Subdivision 681.14(l) is amended by the addition of a new paragraph (3) as follows and existing paragraph (3) is renumbered to be (4):**

(3) For the purpose of the July 1, 2011 rate calculations, OPWDD shall assume that providers have allocated all expenses matched to their HCE III revenues to the fringe benefit cost category in their cost reports.

Appendix IV
2011 Title XIX State Plan
Third Quarter Amendment
Non-Institutional Services
Public Notice

MISCELLANEOUS NOTICES/HEARINGS

Notice of Abandoned Property Received by the State Comptroller

Pursuant to provisions of the Abandoned Property Law and related laws, the Office of the State Comptroller receives unclaimed monies and other property deemed abandoned. A list of the names and last known addresses of the entitled owners of this abandoned property is maintained by the office in accordance with Section 1401 of the Abandoned Property Law. Interested parties may inquire if they appear on the Abandoned Property Listing by contacting the Office of Unclaimed Funds, Monday through Friday from 8:00 a.m. to 4:30 p.m., at:

1-800-221-9311
or visit our web site at:
www.osc.state.ny.us

Claims for abandoned property must be filed with the New York State Comptroller's Office of Unclaimed Funds as provided in Section 1406 of the Abandoned Property Law. For further information contact: Office of the State Comptroller, Office of Unclaimed Funds, 110 State St., Albany, NY 12236.

PUBLIC NOTICE

Department of Civil Service

PURSUANT to the Open Meetings Law, the New York State Civil Service Commission hereby gives public notice of the following:

Please take notice that the regular monthly meeting of the State Civil Service Commission for June 2011 will be conducted on June 16 commencing at 10:00 a.m. This meeting will be conducted at New York Network, Suite 146, South Concourse, Empire State Plaza, Albany, NY. Directions and parking information available at (www.nyn.suny.edu).

For further information, contact: Office of Commission Operations, Department of Civil Service, Alfred E. Smith State Office Bldg., Albany, NY 12239, (518) 473-6598

PUBLIC NOTICE

Homes and Community Renewal

Neighborhood Stabilization Program 3 (NSP3)

Public Comment Period Announcement

The U.S. Department of Housing and Urban Development (HUD) has been authorized to administer the federal Neighborhood Stabilization Program 3 (NSP3). NSP3 will provide grants to States and local governments to continue to redevelop vacant, foreclosed, and abandoned properties into affordable housing, land bank foreclosed homes, and/or demolish blighted structures. The funding is provided under Section 1497 of the Wall Street Reform and Consumer Protection Act of 2010. On September 8, 2010, HUD released the NSP3 allocation amounts for states and other jurisdictions. In accordance with HUD guidelines, New York State submitted to HUD a first NSP3 Substantial Amendment on March 1, 2011, and must submit a second NSP3 Substantial Amendment by June 30, 2011. The NSP3 Substantial Amendments are amendments to the jurisdictions' approved 2010 Action Plan. The allocation under NSP3 for the New York State Program is $5 million and funds will be administered by the Office of Community Renewal. In accordance with HUD guidelines, the NSP3 Substantial Amendment to the 2010 Action Plan for the New York State Program must be published for no less than 15 calendar days for public comment before it is submitted to HUD by the June 30, 2011 deadline. The public comment period will begin on Friday, June 10, 2011 and end on Friday, June 24, 2011. The New York State NSP3 Substantial Amendment to the 2010 Action Plan will be available during the public comment period on the New York State Homes and Community Renewal (HCR) website www.nyshcr.org. Copies can be requested by e-mail at nsp@nyshcr.org or by telephoning 1-866-275-3427. *Written comments must be postmarked no later than June 24, 2011 and addressed to*: Jason Pearson, Homes and Community Renewal, 641 Lexington Ave., Fourth Fl., New York, NY 10022. E-mail comments must be sent by that date and e-mailed to: nsp@nyshcr.org

PUBLIC NOTICE

Orange County, New York

Department of Public Works

Division of Environmental Facilities & Services

Request for Proposals

For the Sustainable Disposal of up to 500 Tons per Day of the County of Orange Solid Waste Stream

PLEASE TAKE NOTICE that the Orange County Department of Public Works is seeking proposals for the sustainable recycling and disposal of the Orange County waste stream. The County is seeking an innovative alternative for solid waste disposal with a preference for the generation of renewable energy.

The County will be issuing a Request For Proposals (RFP) for this project. The RFP, as well as comments and responses to the Draft RFP, will be on file in the Office of the Orange County Executive, 255 Main Street, Goshen, NY 10924; Montgomery Free Library, 133 Clinton Street, Montgomery, NY 12549; and Newburgh Free Library, 124 Grand Street, Newburgh, NY 12550 as of May 24, 2011 as provided by Section 120-w of the GML.

Starting Tuesday May 24, 2011 copies of the RFP may be obtained from: Orange County Department of Public Works, Division of Environmental Facilities and Services, c/o Peter S. Hammond, Deputy Commissioner, P.O. Box 637, 2455-2459 Rte. 17M, Goshen, NY 10924, (845) 291-2640

PLEASE TAKE FURTHER NOTICE that all persons wishing to submit a proposal must do so in writing by regular mail to the Orange County Department of Public Works, Division of Environmental Facilities and Services, c/o Peter S. Hammond, Deputy Commissioner at the above address and must be received by the County by 3 pm on June 22, 2011.

PUBLIC NOTICE

Office for People with Developmental Disabilities and Department of Health

Pursuant to 42 CFR Section 447.205, the New York State Office for People With Developmental Disabilities (OPWDD) and the New York State Department of Health hereby give notice of the following:

New York State proposes to change the reimbursement methodology for Intermediate Care Facilities for individuals who are Developmentally Disabled (ICF/DDs). The State is seeking to achieve efficien-

cies in its Medicaid program including Medicaid funded services overseen by OPWDD. Updating the rate methodology for under 31-bed ICF/DDs serves as one avenue of realizing efficiency. By changing the methodology for the operating component of the rate to utilize more current cost information, it yields rates that more accurately reflect costs. By limiting the criteria to submit appeal requests, providers are incentivized to exercise fiscal prudence in matters which fall under their control. The State estimates the decrease in annual aggregate expenditures to be $38.2 million. Other measures described below are intended to increase administrative efficiencies for providers and the State.

The methodology for under 31-bed sites will hold rates to the lower of 2008/ 2008-2009 costs (depending on whether the provider reports on a calendar or fiscal year basis) or screen values. For sites that opened after the beginning of the cost reporting period, budgeted costs will be compared to the screens. For the purposes of the rate calculations, OPWDD will assume that providers allocated all expenses matched to their HCE I-III revenues to the fringe benefit costs category in the 2008/2008-2009 cost reports. Administrative, clinical and fringe benefit screens will be modified to make them compatible with the new methodology. Once the site-specific rates are recalculated, the site-specific rates for each provider shall be consolidated resulting in a single weighted average ICF/DD rate for each provider applicable to all its sites. The methodology ensures that the operating funding level reflected in the consolidated rate for each provider will range between an amount equal to the June 30, 2011 operating funding level and an amount equal to the June 30, 2011 operating funding level reduced by 10 percent.

Another proposed change will add the option for OPWDD to set new site rates for under 31-bed facilities opening on or after July 1, 2011 using either the current agency rate, agency submitted budgeted costs, or historical data for similar facilities. New site specific rates shall be incorporated into the single weighted average rate for the provider.

OPWDD also proposes changes with respect to appeals for all ICF/DDs regardless of capacity (both under 31-bed and over 30-bed ICF/DDs). Effective for the period beginning July 1, 2011, appeals will be limited to bed vacancies. The loss threshold criterion for providers that submit applications due to bed vacancies shall increase from $1000 to $5000. Once OPWDD notifies a provider of an appeal outcome, a provider which resubmits its annual cost report corresponding to that rate appeal year will not be entitled to an increase in that award based on that resubmission. In addition to the vacancy appeals, OPWDD will continue to make corrections to rates in the event of material errors in computations and cost data upon which the rate is predicated as well as adjustments for capacity changes, capital cost changes and audit findings. This threshold for corrections will also increase from $1000 to $5000.

The proposed changes will become effective July 1, 2011. The new methodology will apply to services delivered on or after that date. Changes to the appeals methodology will apply to rates calculated for rate periods beginning July 1, 2011 and thereafter.

Texts of regulations describing the proposed changes have been distributed to the offices of the local (county) Mental Hygiene Directors and are available for public review. To determine the location of your local Mental Hygiene Director including the office within Manhattan (New York County), you may access a list online at http://clmhd.org/about/countydirectory.aspx.

In New York City, the text of the proposed regulations will be available at the following Developmental Disabilities Services Office locations:

Metro New York DDSO
75 Morton Street
New York, New York 10014

Bernard M. Fineson DDSO
80-45 Winchester Blvd.
Administration Building 80-00
Queens Village, New York 11427

Brooklyn DDSO
888 Fountain Avenue
Brooklyn, New York 11208

Metro New York DDSO
2400 Halsey Street
Bronx, New York 10461

Staten Island DDSO
1150 Forest Hill Road
Staten Island, New York 10314

The text of the proposed regulations may also be found on the OPWDD internet website at http://www.opwdd.ny.gov/regs/index.jsp or at the NYS Department of State website.

The public is invited to review and comment on these proposed changes.

For further information and to review and comment, please contact: Barbara Brundage, Regulatory Affairs Unit, Office of Counsel, Office for People With Developmental Disabilities, 44 Holland Ave., Albany, NY 12229, (518) 474-1830, e-mail: Barbara.brundage@opwdd.ny.gov

PUBLIC NOTICE

Office for People with Developmental Disabilities and Department of Health

Pursuant to 42 CFR Section 447.205, the New York State Office for People With Developmental Disabilities (OPWDD) and the New York State Department of Health hereby give notice of the following:

New York State proposes changes to the methods and standards for setting Medicaid payment rates (fees) for Community Habilitation services funded by OPWDD. This is consistent with New York State's efforts to achieve efficiencies in its Medicaid program including Medicaid funded services overseen by OPWDD. The proposed change will effect a 2 percent reduction to the fees for Community Habilitation services. The State expects the decrease in annual aggregate Medicaid expenditures to be $2.9 million.

The proposed change will become effective July 1, 2011. The new fees will apply to services delivered on or after that date.

Texts of regulations describing the proposed change have been distributed to the offices of the local (county) Mental Hygiene Directors and are available for public review. To determine the location of your local Mental Hygiene Director including the office within Manhattan (New York County), you may access a list online at http://clmhd.org/about/countydirectory.aspx.

In New York City, the text of the proposed regulations will be available at the following Developmental Disabilities Services Office locations:

Metro New York DDSO
75 Morton Street
New York, New York 10014

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80-45 Winchester Blvd.
Administration Building 80-00
Queens Village, New York 11427

Brooklyn DDSO
888 Fountain Avenue
Brooklyn, New York 11208

Metro New York DDSO
2400 Halsey Street
Bronx, New York 10461
Staten Island DDSO
1150 Forest Hill Road
Staten Island, New York 10314

Appendix V
2011 Title XIX State Plan
Third Quarter Amendment
Non-Institutional Services
Responses to Standard Funding Questions

NON-INSTITUTIONAL SERVICES
State Plan Amendment #11-85

CMS Standard Funding Questions

The following questions are being asked and should be answered in relation to all payments made to all providers reimbursed pursuant to a methodology described in Attachment 4.19-D of this SPA. For SPAs that provide for changes to payments for clinic or outpatient hospital services or for enhanced or supplemental payments to physician or other practitioners, the questions must be answered for all payments made under the state plan for such service.

1. **Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by States for services under the approved State plan. Do providers receive and retain the total Medicaid expenditures claimed by the State (includes normal per diem, supplemental, enhanced payments, other) or is any portion of the payments returned to the State, local governmental entity, or any other intermediary organization? If providers are required to return any portion of payments, please provide a full description of the repayment process. Include in your response a full description of the methodology for the return of any of the payments, a complete listing of providers that return a portion of their payments, the amount or percentage of payments that are returned and the disposition and use of the funds once they are returned to the State (i.e., general fund, medical services account, etc.).**

   Response: OPWDD's ICF/DD rate setting methodology includes a 5.5 percent provider assessment on the gross receipts of the ICF/DD facility. This assessment is authorized by Public Law 102-234, Section 43.04 of the New York State Mental Hygiene Law, Federal Medicaid regulations at 42 CFR 433.68, and Attachment 4.19-D, Part II page 29. All voluntary and State-operated ICF/DDs are subject to this provider assessment. Using "Authorization to Withhold" forms submitted by voluntary providers, OPWDD recoups the assessment from the ICF/DD Medicaid payment before the payment is sent to the voluntary provider. This assessment is deposited into a fund called "Assessments for Business Organizations."

   For State operated ICF/DDS, the legislature appropriates an amount for payment of the assessment. Periodically, funds from this appropriation are used to pay the assessment. These amounts are deposited into the general fund of the State Treasury.

   Aside from the assessments, providers receive and retain all the Medicaid payments for ICF/DD services.

2. **Section 1902(a)(2) provides that the lack of adequate funds from local sources will not result in lowering the amount, duration, scope, or quality of care and services available under the plan. Please describe how the state share of each type of Medicaid payment (normal per diem, supplemental, enhanced, other) is funded. Please describe whether the state share is from**

appropriations from the legislature to the Medicaid agency, through intergovernmental transfer agreements (IGTs), certified public expenditures (CPEs), provider taxes, or any other mechanism used by the state to provide state share. Note that, if the appropriation is not to the Medicaid agency, the source of the state share would necessarily be derived through either through an IGT or CPE. In this case, please identify the agency to which the funds are appropriated. Please provide an estimate of total expenditure and State share amounts for each type of Medicaid payment. If any of the non-federal share is being provided using IGTs or CPEs, please fully describe the matching arrangement including when the state agency receives the transferred amounts from the local governmental entity transferring the funds. If CPEs are used, please describe the methodology used by the state to verify that the total expenditures being certified are eligible for Federal matching funds in accordance with 42 CFR 433.51(b). For any payment funded by CPEs or IGTs, please provide the following:

> **(i) a complete list of the names of entities transferring or certifying funds;**
>
> **(ii) the operational nature of the entity (state, county, city, other);**
>
> **(iii) the total amounts transferred or certified by each entity;**
>
> **(iv) clarify whether the certifying or transferring entity has general taxing authority: and,**
>
> **(v) whether the certifying or transferring entity received appropriations (identify level of appropriations).**

Response: For services delivered by non-State operated ICF/DDs, the source of funds for the State share is tax revenues appropriated to OPWDD. When these ICF/DDs bill eMedNY for payment, the Department of Health covers the non-federal share expenditures in the first instance. Throughout the state fiscal year, such expenditures are applied against OPWDD appropriations by the transfer of funds from OPWDD to DOH. The total amount to be transferred from OPWDD to DOH for non-State operated ICF/DDs for the current fiscal year is projected at approximately $331.7 million.

State tax revenues are the source of funds for the state share for ICF/DD services delivered by OPWDD. The non-federal share is appropriated to the DOH and paid to OPWDD along with the federal share. The total amount appropriated to DOH for ICF/DD services delivered by OPWDD and projected to be transferred to OPWDD for the current fiscal year is approximately $1.2 billion.

3. **Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State plan. If supplemental or enhanced payments are made, please provide the total amount for each type of supplemental or enhanced payment made to each provider type.**

Response: No supplemental or enhanced payments are made in the ICF/DD program.

4. **For clinic or outpatient hospital services please provide a detailed description of the methodology used by the state to estimate the upper payment limit (UPL) for each class of providers (State owned or operated, non-state government owned or operated, and privately owned or operated). Please provide a current (i.e., applicable to the current rate year) UPL demonstration.**

   Response: This plan amendment does not concern clinic or outpatient hospital services.

5. **Does any governmental provider receive payments that in the aggregate (normal per diem, supplemental, enhanced, other) exceed their reasonable costs of providing services? If payments exceed the cost of services, do you recoup the excess and return the Federal share of the excess to CMS on the quarterly expenditure report?**

   Response: OPWDD operated ICF/DDs may receive payments that in the aggregate exceed their cost of providing services. The State does not recoup the excess or return the federal share of the excess to CMS.

Appendix VI
2011 Title XIX State Plan
Third Quarter Amendment
Non-Institutional Services
Responses to Standard Access Questions

ICF/DD SERVICES
State Plan Amendment #11-85

<u>**CMS Standard Access Questions**</u>

The following questions have been asked by CMS and are answered by the State in relation to all payments made to all providers under Attachment 4.19-D of the state plan.

1. **Specifically, how did the State determine that the Medicaid provider payments that will result from the change in this amendment are sufficient to comply with the requirements of 1902(a)(30)?**

   Response: The State determined that that the Medicaid provider payments that will result from the change in this amendment are sufficient to comply with the requirements of Social Security Act §1902(a) (30) because the methodology aligns reimbursement with actual costs and because no provider's funding is reduced or increased by more than 10%.

   The first change in the methodology updates the base year for under 31-bed sites from 1999 to 2008/ 2008-2009, and modifies administrative, clinical and fringe benefit screens. The 2008 base year costs were translated into current costs by increasing them by 3.06% and 2.08% trend factors for 2009 and 2010, respectively. Updating the base year and changing screens more closely match reimbursements to costs. Since 1999, trend factors and other adjustments have increased the operating component of rates approximately 67 percent. Also, the changes target reductions at surpluses and administration, thereby minimizing adverse economic impact and realizing efficiencies where they can best be achieved and afforded. To the extent they have surpluses sufficient to absorb the rate reductions, providers will not have to change the way they operate. Providers that do not have sufficient surpluses to absorb the administrative component of the rate reductions may experience a reduction in the administrative component of the rate, but not in the direct care, clinical and support components.

   The second change in the methodology consolidates the site-specific rates for under 31-bed ICF/DDs into a single weighted average rate for all of an agency's under 31-bed sites. This will simplify administration and billing for providers. The provider specific rate will hold the overall operating component of the rate to the June 30, 2011 reimbursed levels or the recalculated operating rate, whichever is less. However, no provider's funding is reduced by more than ten percent from its June 30, 2011 level.

   The third change affects appeals for all ICF/DDs regardless of size. Appeals which have been previously allowed for cost overruns occurring due to a variety of circumstances will be limited to bed vacancies. The loss threshold for appeals increases from $1000 to $5000. Once OPWDD notifies a provider of an appeal outcome, the provider cannot get its appeal amount increased by resubmitting its cost report for the rate appeal year. OPWDD will continue to make corrections to rates in the event of material errors in computations and cost data upon which the rate is predicated, as well as adjustments for capacity changes, capital cost changes and audit findings. Inasmuch as the ICF/DD rate setting uses a prospective methodology, this change more closely aligns the appeals process with the prospective rate methodology.

2. **How does the State intend to monitor the impact of the new rates and implement a remedy should rates be insufficient to guarantee required access levels?**

   Response: Medicaid is essentially the only funding available for ICF/DD services in New York. There are no private insurance programs that cover ICF/DD services and Medicare does not pay for ICF/DD services. It is possible for persons to privately pay for ICF/DD services, but this is extremely rare. There are simply not enough private pay ICF/DD residents to allow providers to deny Medicaid beneficiaries access to their services in favor of other persons. Also, ICF/DDs are long term residential settings and throughout the state, ICF/DDs (other than developmental centers) are operating at approximately 98% capacity. When there is a vacancy at an ICF/DD, it is easily filled. Because of this, the State does not expect there to be any decrease in ICF/DD capacity statewide.

   In addition, the State will continue to collect cost reports from ICF/DDs.

3. **How were providers, advocates and beneficiaries engaged in the discussion around rate modifications? What were their concerns and how did the State address these concerns?**

   Response: The methodology changes were discussed with representatives of provider associations in March of 2011. OPWDD published these changes as proposed amendments to regulations in the State Register on April 20, 2011. A public notice describing the changes was published in the June 1, 2011 State Register. The proposed regulations also appeared on OWPDD's website, and were mailed to providers, self-advocates, family members, advocates, provider associations, advocacy associations (e.g. Self Advocacy Association of New York State), and all members of the public who have requested to be on the mailing list. The public was invited to comment on these proposed changes.

   Only one person submitted a public comment. This person urged that the changes be withdrawn because efficient providers reserve funds to accommodate special needs as they arise, and providers need a safety net in the form of the appeal mechanism to address "unforeseen operating losses". OPWDD responded to this comment by explaining that the changes were designed to reduce surplus funding by more closely aligning reimbursement with actual costs and to better synchronize the appeals process with OPWDD's prospective reimbursement methodology. OPWDD's response was in an assessment of public comment, which was mailed to the person making the comment and published in the State Register.

4. **What action(s) does the State plan to implement after the rate change takes place to counter any decrease to access if the rate decrease is found to prevent sufficient access to care?**

   Response: Should any ICF/DD experience Medicaid revenue issues that would prevent access to ICF/DD services, OPWDD would actively work with the provider or other providers to explore the situation and discuss possible solutions.

5. **Is the State modifying anything else in the State Plan which will counterbalance any impact on access that may be caused by the decrease in rates (e.g. increasing scope of services that other provider types may provide or providing care in other settings)?**

   Response: No. The State does not expect there to be any change in access to ICF/DD services.