Compilation of Codes, Rules and Regulations of the State of New York
Title 14. Department of Mental Hygiene
Chapter XIV. Office for People with Developmental Disabilities
Part 686. Operation of Community Residences (Refs & Annos)

14 NYCRR 686.13

Section 686.13. Fee-setting and financial reporting for voluntary-operated community residences

Currentness

(a) *Reporting requirements.*

(1) Each provider shall submit reports in accordance with the requirements of Subpart 635-4 of this Title.

(2) Each provider shall report on its cost report the amount of funded depreciation for each of its community residences, and expenditures from funded depreciation for each of its community residences. See subdivision (i) of this section.

(3) Financial records shall be maintained for individuals and shall consist of four separate accounts to record the revenue and expense as follows:

(i) an account to record the use of the total rent charged to individuals in accordance with subdivision (c) of this section. Such account shall record both the monthly amount collected by the provider as income and any direct payments by individuals for rent and utilities, as well as living expense allowances for such items as transportation, clothing, etc.;

(ii) an account to record personal allowance, in cases where the individual has chosen the option of management of such funds by the provider; and

(iii) an account to record the payments made to providers in the amount of $250 per individual per year, paid semiannually by OPWDD, whereby such payments are in addition to the personal allowance. Such records shall document the use of the payments for the following needs of individuals:

(*a*) replacement of necessary clothing;

(*b*) personal requirements and incidental needs; and

(*c*) recreational and cultural activities;

(iv) an account of all food stamp benefits obtained and redeemed for individuals living in a residence with 16 or fewer beds, of all purchases and expenditures for food on behalf of such individuals, of all payments the provider receives from or for such individuals for food, and of all money given to such individuals for the purchase of food. The provider shall maintain such records for four years. Such records shall be subject to audit and review by OPWDD and any other Federal or State agencies which regulate the provider or the food stamp benefit program.

(4) All such financial records and any related records shall be subject to audit by the commissioner and the Office of the State Comptroller or their agent.

(b) *Allowable costs.*

(1) General conditions.

(i) Allowable costs shall be determined from either a budget or cost report submitted in accordance with the reporting requirements of subdivision (a) of this section.

(ii) To be considered allowable, costs must be properly chargeable to necessary care for individuals rendered in accordance with the requirements of this section and sections 635-10.4 and 671.5 of this Title.

(*a*) The commissioner shall determine allowable costs pursuant to Subpart 635-6 of this Title and pursuant to this paragraph. Subpart 635-6 of this Title shall govern except where this paragraph is inconsistent with Subpart 635-6 of this Title.

(*b*) Except where specific rules concerning allowability of costs are stated herein, or in Subpart 635-6 of this Title, the commissioner shall determine allowability of costs based on reasonableness and relationship to individual care and generally accepted accounting principles.

(*c*) As determined by the commissioner, expenses or portions of expenses reported by an individual community residence, that are not reasonably related to the efficient and economical provision of care in accordance with the certification standards in Part 86 of this Title because of either the nature or amount of the item, shall not be allowed.

(*d*) Except where specific rules concerning allowability of costs are stated herein, or in Subpart 635-6 of this Title, the *Medicare Provider Reimbursement Manual,* commonly referred to as HIM-15 shall be used to determine the allowability of costs as to nature and amount. Said guidelines are published by the U.S. Department of Health and Human Services' Health Care Financing Administration (HCFA).

(*1*) The HIM-15 document is available from:

Health Care Financing Administration

Division of Communication Services

Production and Distribution Branch

Room 577, East High Rise Building

6325 Security Boulevard

Baltimore, MD 21207

(*2*) It may be reviewed in person during regular business hours:

(*i*) at the New York State Department of State, 41 State Street, Albany, NY 12231; or

(*ii*) by appointment at the New York State Office for People With Developmental Disabilities, Division of Revenue Management, 30 Russell Road, Albany, NY 12206.

(iii) The OPWDD shall reduce a community residence's reported costs or estimated costs for price calculation purposes by the cost of services and activities that are not chargeable to the care of the individuals receiving services in accordance with this subdivision and subdivision (d) of this section. In the event that the commissioner determines that it is not practical to establish the costs of such services and activities, and if there is income derived therefrom, the income shall be substituted.

(iv) *Income* shall mean those revenues received by a provider incidental to the operation of a community residence. Income shall include, but not be limited to:

(*a*) revenues received from other units of State, local or Federal government in consideration for the provision of care to a person with developmental disabilities, excluding that portion of such revenue specifically intended to offset capital costs; and

(*b*) monies received from persons in residence or on their behalf from third-party insurers or medical assistance programs.

(v) Notwithstanding the above, income shall not include:

(*a*) the value of food stamps received by individuals or a provider on behalf of individuals; and

(*b*) unrestricted grants, gifts or income from endowments.

(vi) *Restricted funds* are funds expended by the community residence which include grants, gifts and income from endowments, whether cash or otherwise, which must be used only for a specific purpose as designated by the donor or grant instrument. Restricted funds are to be deducted from the designated costs when determining allowable costs. Such restricted funds shall include, but not be limited to, lower income housing assistance under section 8 of the United States Housing Act of 1937, as amended (42 USC 1337 [f]). The commissioner may waive the provisions of this subparagraph at his discretion only in those instances where the provider makes a reasonable demonstration that the imposition of the requirements of this subparagraph would cause undue financial harm to the existence of the community residence.

(vii) When regional comparisons are involved in determining the allowable costs, the geographic regions which OPWDD will consider are: New York City (Region I); New York City Suburban (Region II); and Upstate New York (Region III).

(*a*) New York City includes the Counties of New York, Bronx, Queens, Kings and Richmond.

(*b*) New York City Suburban includes the Counties of Putnam, Rockland, Nassau, Suffolk and Westchester.

(*c*) Upstate New York includes all counties not included in the previous two categories.

(2) Operating costs.

(i) As determined by the commissioner, costs which are not properly related to individual care or treatment, and which principally afford diversion, entertainment or amusement to owners, operators or employees of the community residence, shall not be allowed.

(ii) As determined by the commissioner, costs of contributions or other payments to political parties, candidates or organizations shall not be allowed.

(iii) As determined by the commissioner, only that portion of the dues paid to any professional association which has been demonstrated to be attributable to expenditures other than for lobbying or political contributions shall be allowed.

(iv) As determined by the commissioner, costs for any interest expense related to funding expenses in excess of an approved price, except as provided for in subparagraph (3)(iv) of this subdivision, or penalty imposed by governmental agencies or courts and the costs of insurance policies obtained solely to insure against such penalty, shall not be allowed. OPWDD shall not pay interest on the final dollar amount resulting from the retrospective impact of price adjustments.

(v) Allowable respite care costs include the cost of the following services in accordance with section 686.15(a)(1)(i)(*b*) of this Part:

(*a*) basic 24-hour supervision of activities for persons living in the community residence;

(*b*) assistance in health care and self-care services, including overseeing routine medical care and managing any medical emergency;

(*c*) coordination of the established treatment program; and

(*d*) room and board.

(vi) Supervised community residences shall be responsible for the cost of services which:

(*a*) are necessary to meet the needs of individuals while in residence; and

(*b*) prior to August 1, 2004 could have been met by home health aide or personal care services separately billed to Medicaid.

(3) Capital costs.

(i) The provisions of this paragraph shall only apply where costs of ownership of real property under section 635-6.4 of this Title are limited to depreciation, interest, costs of alteration, construction, rehabilitation and/or renovation to real property, and costs attributable to the negotiation or settlement of sale or purchase of real property.

(ii) For construction or acquisition of a new community residence, or acquisition of an interest in real property manifested by cooperative shares, which was first issued an operating certificate pursuant to article 16 of the Mental Hygiene Law on or after February 1, 1985, the estimated useful life of the building, for purposes of determining depreciation, or the interest in real property manifested by cooperative shares, shall be the greater of the term of the mortgage or 15 years. Community residences in operation prior to July 1, 1985 may apply to the commissioner to have the useful life of the building changed to the guidelines pursuant to this paragraph. Such application shall be granted at the discretion of the commissioner upon a showing that such change is necessary to the financial viability of the community residence and will not impede the community residence's efficient and economical operation. All amortization of cooperative shares shall be 15 years or the life of the mortgage, whichever is longer.

(iii) Depreciation and interest expense related to a real or personal depreciable property acquired prior to the bridge contract period (10/1/82 for some community residences and 1/1/83 for the remaining community residences), are not allowable, except for those assets where the community residence can document that the

purchase was made using funds of, or assets donated to, the sponsoring not-for-profit corporation.

(4) *Start-up costs* are those costs which are incurred from the period the provider receives approval pursuant to Part 53 of this Title to become a community residence to the date the first person is admitted. However, costs incurred during the period from the first admission to the effective date of the initial provider agreement shall not be considered as start-up costs.

(i) OPWDD may, at the discretion of the commissioner, reimburse a community residence for all allowable start-up costs incurred in the preparation of the community residence during that six-month period prior to the date of the first admission. A community residence may apply to the commissioner for an extension of the six-month reimbursable start-up period, provided that the community residence can demonstrate why such an extension is necessary. However, under no circumstances shall a community residence be allowed reimbursement of start-up costs for any period of time exceeding 18 months prior to the date of the first admission.

(ii) Allowable start-up costs must be cost efficient and may include, but not be limited to:

(*a*) personal service expenses;

(*b*) utility expenses;

(*c*) taxes;

(*d*) insurance expenses;

(*e*) employee training expenses;

(*f*) housekeeping expenses;

(*g*) repair and maintenance expenses; and

(*h*) administrative expenses.

(iii) Any costs that are properly identifiable as organization costs or construction costs shall be classified as such and excluded from start-up costs.

(iv) Revenues from community residence development grants will offset allowable start-up costs, organization costs or construction costs for legal fees, initial staffing, rent, furniture and minor rehabilitation costs.

(v) If all portions of the community residence are prepared at the same time, start-up costs for all portions of the community residence shall be accumulated in a single deferred account and shall be amortized from the date of the first admission. However, if only portions of the community residence are prepared (*e.g.,* preparation of a floor or wing), start-up costs shall be capitalized and amortized separately. In either case, unless reimbursed as described in section 635-6.4(i) of this Title, start-up costs shall be amortized over a period not to exceed 60 months from the date of the first admission.

(5) Room and board costs associated with supervised or supportive community residences shall be reimbursed in accordance with section 671.7 of this Title.

(c) *Rent charged to individuals.*

(1) *Rent* shall mean the amount of the income and assets which may be used on a monthly basis in payment to the community residence for the goods and services the community residence is required to provide to the individual, or used by the individual in direct payment to someone other than the community residence for maintenance costs such as housing, utilities and transportation. Rent shall not include payment for food under section 686.17 of this Part.

(2) For any individual eligible for SSI, the rent for other than respite services is equal to the monthly SSI payment as the standard of monthly need for persons in residential care less the monthly personal allowance for individuals in residential care. *SSI* shall mean supplemental security income benefits and additional State payments made pursuant to title XVI of the Federal Social Security Act and title 6 of article 5 of the New York Social Services Law. For respite services, the rent is equal to one half of the daily SSI level at congregate care level II less one half of the daily personal allowance for individuals in residential care.

(3) For individuals who are not SSI-eligible, but who are authorized to receive a home relief grant from the local social services district, rent shall be equal to the amount of the home relief grant less the amount of personal allowance for individuals in residential care.

(4) For individuals who are not SSI-eligible and who are not authorized to receive a home relief grant from the local social services district, rent shall be determined in accordance with the following guidelines.

(i) General principles.

(*a*) The maximum monthly rent charged to a person who does not have SSI shall not exceed the amount of the provider payment established for individuals who have SSI in accordance with paragraph (2) of this subdivision.

(*b*) Current monthly income shall be used according to the guidelines which follow before principal assets are considered as a source of payment in any given month.

(*c*) In no case shall principal assets be considered a source of payment if the total principal assets are less than the current SSI asset limit.

(*d*) Individuals who do not have SSI with principal assets shall use those assets as described in subparagraph (iii) of this paragraph until the assets are reduced to the current SSI asset limit, unless either of the following conditions exists:

(*1*) the Social Security Administration has already determined lack of a disabling medical condition; or

(*2*) the individual's unsubsidized gross earnings exceed $300 per month.

(*e*) If either condition in clause (*d*) of this subparagraph applies, the individual who does not have SSI, who has principal assets shall use those assets as described in subparagraph (iii) of this paragraph until the assets are reduced to the current Medicaid asset limit.

(ii) Use of monthly income. The amount of an individual income available for contribution to the maximum monthly rent is determined by subtracting the following deductions, exemptions and allowances from gross monthly unearned, or earned income, or both.

(*a*) Unearned income only.

(*1*) A $20 income disregard.

(*2*) The personal allowance for individuals in residential care, rounded to the next highest exact dollar amount, if the stipulated amount is not an exact dollar amount.

(*b*) Earned income only.

(*1*) The first $20 as an income disregard.

(*2*) The next $65 as a work-related exemption.

(*3*) One half of the remainder after subclauses (*1*) and (*2*) of this clause are applied. This is also a work-related exemption.

(*4*) The personal allowance for individuals in residential care, rounded to the next highest exact dollar amount, if the stipulated amount is not an exact dollar amount.

(*c*) Earned and unearned income.

(*1*) $20 of the unearned income as an income disregard.

(*2*) The first $65 of earned income as a work-related exemption.

(*3*) One half of the remaining earnings after subclause (*2*) of this clause is applied. This is also a work-related exemption.

(*4*) The personal allowance for individuals in residential care, rounded to the next highest exact dollar amount, if the stipulated amount is not an exact dollar amount.

(iii) Use of principal assets. If the amount of available income as determined by the Social Security Administration is less than the SSI maximum monthly rent, principal assets shall be used to make up the full amount of the shortfall if either set of the following conditions exists:

(*a*) There is no existing written documentation from the Social Security Administration that the individual lacks a disabling medical condition and the individual's unsubsidized gross earnings are less than $300, and total principal assets are more than the SSI asset limit.

(*b*) There is written documentation from the Social Security Administration that the individual lacks a disabling medical condition or the unsubsidized

gross earnings are greater than $300, and total principal assets are more than the current asset limit for a single-person household under the Medicaid program.

(5) Principal assets are considered to be real or personal property, either liquid or nonliquid.

(i) *Liquid assets* are cash or property that can be easily converted into cash, including but not limited to: ordinary life insurance, stocks, bonds, mutual fund shares, bank accounts and promissory notes.

(ii) *Nonliquid assets* are property that cannot be easily converted into cash. The fair market value of such assets is considered in determining principal assets, including but not limited to: trust funds, real property and vehicles.

(iii) Principal assets shall not include:

(*a*) a homestead that is the home and land owned and occupied by an individual and the members of an individual's family, including adjacent parts, such as garages. Homes may be trailers or mobile homes, and apartments or flats;

(*b*) personal effects, household goods and furnishings, and life insurance with a total face value of $1,500 or less; and

(*c*) one vehicle which belongs to and is used by the individuals.

(d) *Residency.*

(1) Census-taking.

(i) In order for an individual to be considered in residence, that person shall be present between the census-taking hours of the community residence on two

successive days; the day of admission as well as the day of discharge shall be counted. An individual shall be considered in residence if that person is discharged on the same day as admitted, providing there was an expectation that the admission would have had at least a 24-hour duration.

(ii) A *respite day* shall mean a period of at least 10 hours within the 24-hour period between the census-taking hours of the community residence on two successive days, during which a person living with family or in family care receives overnight lodging, at least one meal, and services according to subparagraph (b)(2)(v) of this section.

(iii) A *temporary transfer day* shall mean a 24-hour period between the census-taking hours of the community residence on two successive days during which an individual on therapeutic leave from his or her permanent residence receives lodging and services. Temporary transfer days shall not be reimbursable when the person' s permanent residence is another community residence or a family care home. Temporary transfer days shall be reimbursable when the person's permanent residence is with family or an independent living situation.

(iv) A *trial visit day* shall mean a 24-hour period between the census-taking hours of the community residence on two successive days during which a person with developmental disabilities is being considered for admission to the community residence receives lodging and services. For any given person, the number of trial visit days shall not exceed seven in a continuous six-month period.

(v) *Emergency housing day* shall mean a 24-hour period between the census-taking hours of the community residence on two successive days during which a person who requires alternative housing due to natural disaster which rendered the individual's existing residence temporarily uninhabitable (*e.g.,* due to fire, extended power failure, etc.) receives lodging and services.

(2) For a community residence that provides respite services to individuals who do not reside in it, reimbursement of those services is in accordance with section 635-10.5(h) of this Title. A community residence may provide respite services to individuals who do not reside in it by utilizing temporary use beds and/or vacant certified beds.

(e) *Reserved.*

(f) *Reserved.*

(g) *Funded depreciation.*

(1) Applicability. This paragraph shall apply to all community residences except those for which the provider is receiving or has a commitment to receive HUD funding. *HUD funding* shall mean lower income housing assistance under section 8 of the United States Housing Act of 1937, as amended (42 USC 1437 [f]), and/or a loan or loans pursuant to section 202 of the Housing Act of 1959, as amended (12 USC 1701 [q]).

(2) Effective July 1, 1986, for any price period during which the reimbursement attributable to depreciation on a community residence's real property, excluding equipment, exceeds the provider's principal repayment obligations on indebtedness attributable to such real property, such provider shall fund depreciation by depositing such difference in an interest-bearing checking account or other secure investment. If the provider operates more than one community residence governed by this paragraph, the provider may maintain one funded depreciation account for two or more community residences. The provider shall not commingle such funded depreciation account(s) with other monies of the provider. The provider shall not be required to fund depreciation attributable to the provider's equity in such real property. The provider may expend the funds in such account, including accrued interest, to retire all or a portion of the indebtedness attributable to such real property, or for building improvements and/or fixed equipment necessary to the community residence.

(h) *Price corrections for service periods beginning on or after July 1, 2011.*

(1) The commissioner will correct prices in instances where there are material errors in the information submitted by the provider which OPWDD used to

establish the price or where there are material errors in the price computation and only in instances which would result in an annual increase of $5,000 or more in a provider's allowable costs.

(2) In order to request a price correction in accordance with paragraph (1) of this subdivision, the provider must send to OPWDD its request by certified mail, return receipt requested, within 90 days of the provider receiving the price computation or within 90 days of the first day of the price period in question, whichever is later.

(i) *Appeals to prices determined pursuant to sections 635-10.5 and 671.7 of this Title.*

(1) Threshold. For price periods before July 1, 2011, the commissioner will consider only appeals for adjustment to the prices which would result in an annual increase of $1,000 or more in the allowable costs of the program or service being appealed. For price periods beginning on or after July 1, 2011, the threshold is $5,000.

(2) The bases for appeals. For price periods before July 1, 2011, appeals that shall be considered are those that are:

(i) needed because of changes in the statistical information used to calculate the staffing or utilization standards included in the program or service; or

(ii) appeals for adjustments needed because of material errors in the information submitted by the provider which OPWDD used to establish the price or material errors in the price computation; or

(iii) appeals for significant increases or decreases in the overall operating costs of the program or service being appealed due to implementation of new programs, changes in staff or services, changes in the characteristics or number of individuals receiving services, 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.

(3) For all price periods, the bases for appeals shall also include:

(i) rent appeals for any month during the price period that an individual is unable to pay an amount, whether from SSI, other benefits or earnings, equal to the rent charged each individual and this affects the efficient and economical operation of the residence; or

(ii) board appeals for any month during the price period that a person is unable to pay an amount, whether from benefits, earnings or other assets, equal to the amount charged each person for food under section 686.17 of this Part and this affects the efficient and economical operation of the residence; or

(iii) vacancy appeals.

(4) Notification of first level appeal.

(i) In order to appeal a price in accordance with subparagraph (2)(ii) of this subdivision, the provider must send to OPWDD a first level appeal application by certified mail, return receipt requested, within either 90 days of the provider receiving the price computation or 90 days of the first day of the price period in question, whichever is later.

(ii) In order to appeal a price in accordance with subparagraphs (2)(i) and (iii) and (3)(i), (ii) and (iii) of this subdivision, the provider must send to OPWDD within one year of the close of the price period in question, a first level appeal application by certified mail, return receipt requested.

(5) First level price 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 OPWDD may request such additional documentation as it deems necessary.

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

(6) The burden of proof on first level appeal shall be on the provider to demonstrate that the price requested in the first level appeal is necessary to ensure efficient and economical operation of the program or service. In first level rent or board appeals, the burden of proof shall be on the provider to demonstrate that an individual who has been admitted to the individualized residential alternative or community residence is not able to pay the rent or board charged him or her.

(7) A price revised by OPWDD pursuant to an appeal shall not be considered final unless and until approved by the State Division of the Budget.

(8) At no point in the first level appeal process shall the 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 OPWDD shall notify the provider of any proposed revised price, board or rent, or denial of same. OPWDD shall inform the provider that it may either accept the proposed revised price, board or rent or request a second level appeal in accordance with the provisions of section 602.9 of this Title, in the event that the proposed revised price, board or rent fails to grant some or all of the relief requested.

(9) At the conclusion of the first level appeal process, OPWDD shall notify the provider of any revised price or denial of the request. Once OPWDD has informed the provider of the appeal outcome, a provider which submits a revised cost report for the period reviewed shall not be entitled to an increase in the award determination based on that resubmission.

(10) If OPWDD approves the revision to the price and the State Division of the Budget denies the revision, the provider shall have no further right to administrative review pursuant to this section.

(11) If at the conclusion of a first or second level rent appeal or board appeal, OPWDD has revised the rent or board, and if the individual whose inability to pay was the basis for the appeal is subsequently able to pay the rent or board or other charges, the provider shall pay OPWDD the amount of additional payment OPWDD made for such individual or the amount of rent or board or charges the individual was able to pay the provider, whichever is less.

(12) Any price revised in accordance with this subdivision shall be effective according to the dates indicated in the approval of the price appeal notification, and adjustments to subsequent period prices shall be made accordingly.

(13) Any additional reimbursement received by the facility pursuant to a price revised in accordance with this subdivision shall be restricted to the specific purpose set forth in the first or second level appeal decision. If the provider does not spend such reimbursement on such specific purpose, OPWDD shall be entitled to recover such reimbursement.

(14) Second level appeals to prices.

(i) OPWDD's denial of the first level appeal of any or all of the relief requested in the appeals provided for in paragraphs (2) and (3) of this subdivision shall be final, unless the provider requests a second level appeal to the commissioner in writing within 30 days of service of notification of denial or proposed revised price.

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

(j) *Audits.*

(1) After administrative review pursuant to section 635-4.6 of this Title, the community residence shall be notified in writing of the determination of those items to which the community residence objected, including a statement of the reasons therefor. Audit findings pertaining to allowable costs and offsetting revenues for funding under this section shall be final, unless the community residence requests a hearing pursuant to Part 602 of this Title.

(2) Audit findings which are final, as defined in paragraph (1) of this subdivision, shall, where appropriate, constitute grounds for the recoupment of overpayments and the reimbursement of underpayments. Such adjustments shall be made at the discretion of the commissioner, and shall result in corresponding adjustments to prices.

(3) The foregoing notwithstanding, when a hearing has been requested pursuant to this paragraph, audit findings shall also constitute grounds for recoupment to the extent that the audit findings are not matters in dispute for the purposes of the hearing.

(k) *Computation of the reimbursable costs for the facility class known as the individualized residential alternative (IRA).*

(1) For reimbursement of residential habilitation provided for residents by an IRA with a certified capacity which does not consist of only temporary use beds, see section 635-10.5(b) of this Title.

(2) In addition to the IRA price for residential habilitation, another portion of the price for an IRA with a certified capacity which does not consist of only temporary use beds includes allowable room, board and protective oversight costs. This portion of the price shall be determined by taking into account total allowable room, board and protective oversight costs. The price shall be net of income and lower income housing assistance.

(i) For the monthly supervised IRA price the total allowable net annual costs for all IRAs and community residences included in the monthly supervised IRA price shall be divided by 12, and then divided by the total certified capacities less any certified temporary use bed(s). Payment for these costs shall be contingent on meeting the enrollment and services requirements in section 635-10.5(b) of this Title.

(ii) For the monthly supportive IRA price the total allowable net annual costs for all IRAs and community residences included in the monthly supportive IRA price shall be divided by 12, and then divided by the total certified capacities less any certified temporary use bed(s). Payment for these costs shall be contingent on meeting the enrollment and services requirements in section 635-10.5(b) of this Title.

(iii) For a monthly site-specific IRA price (see section 635-10.5(b)(10) of this Title) the total allowable net annual costs shall be divided by 12, and then divided by the total certified capacity less any certified temporary use bed(s). Payment for these costs will be contingent on meeting the enrollment and services requirements in section 635-10.5(b) of this Title.

(iv) The total budgeted costs for the IRA facility shall be compared to the actual costs of other existing facilities serving persons with comparable needs including those operated by the provider. The submitted budget costs may be adjusted to be comparable to the costs of such programs.

(v) Total allowable room, board and protective oversight costs shall be determined pursuant to subdivision (b) of this section. Total reimbursable room, board and protective oversight costs shall be the allowable room, board and protective oversight costs net of rent determined pursuant to subdivision (c) of this section and net of the offsets specified in section 671.7(a)(9) and (10) of this Title, both times the certified capacity minus temporary use beds (TUBS). Room, board and protective oversight costs shall include, but not be limited to the following: capital and start-up costs, administrative personal service costs for protective oversight, building maintenance, cooking or housekeeping, where such functions cannot be integrated as part of the person's residential habilitation services portion of the ISP, as defined in section 635-10.4(b)(1) of this Title and associated fringe benefits,

food, repairs, utilities, equipment other than adaptive technologies, household supplies, linen, clothing and prorated administration and overhead costs.

(vi) Total reimbursable capital costs including related administrative costs, shall mean the IRA facility's budget costs as determined by subdivision (b) of this section, or by Subpart 635-6 of this Title, or an amount agreed to by the provider and OPWDD.

(vii) Total reimbursable non-capital IRA room, board and protective oversight costs shall be equal to the least of the budget costs, the reimbursable costs determined through the application of subdivision (b) of this section and Subpart 635-6 of this Title; or costs agreed to by the provider and OPWDD. With prior approval of OPWDD and upon submission of supporting documentation substantiating programmatic necessity, certain reasonable additional non-capital IRA room, board and protective oversight budgeted costs in excess of the recommendations from the budget review process may be reimbursed.

(viii) The total reimbursable operating costs derived through the application of the above methodology shall be trended as appropriate. Reimbursable capital costs shall be added to the trended reimbursable costs. For the IRA facility, the OPWDD shall apply trend factor components in accordance with section 635-10.5(i) of this Title.

(ix) The total reimbursable operating costs derived through the application of the above methodology shall be subject to efficiency adjustments in section 635-10.5(b)(18) of this Title.

(x) Unless otherwise agreed to by the provider, the price determined through the application of this subdivision may be appealed. Such appeal shall be pursuant to subdivision (i) of this section, except that the determination following such first level appeal shall be the commissioner's final decision.

(xi) The price determined in accordance with this subdivision shall not be considered final unless approved by the director of the Division of the Budget.

(3) For an IRA that provides respite services to individuals who do not reside in it, reimbursement of those services is in accordance with section 635-10.5(h) of this Title.

(i) An IRA, other than a free-standing respite center, may provide respite services to individuals who do not reside in it by utilizing temporary use beds and/or vacant certified beds.

(ii) Respite services may also be provided in IRAs which are free-standing respite centers. These facilities have a certified capacity which consists only of temporary use beds.

(l) *Employee health care enhancement (HCE).*

(1) Providers are eligible to have additional funding included in their rate if they submitted a completed 2005 OPWDD survey on health care benefits for all full- and part-time employees.

(2) Based on a survey of providers, OPWDD determined a benchmark of health care benefits offered to employees by providers. In September 2005, OPWDD notified those providers if their health care benefits were at, above, or below the benchmark.

(3) Providers whose employee health care benefits are below the benchmark may apply to OPWDD for additional funding to be effective January 1, 2006 as follows:

(i) For providers which reported on the survey that no health care benefits are offered, OPWDD determined an allocation for each provider based on the total number of employees reported multiplied by $2,500, except that if there are any employees who were reported on the survey and to whom the provider chooses not to offer this funding, the allocation based on the total number of employees reported will be reduced by the number of excluded employees reported multiplied

by $2,500. These funds must be used to establish employee health care benefits or to reduce employee out-of-pocket health-related expenses.

(ii) For providers which reported on the survey that employee health care benefits are offered to some or all employees, OPWDD determined an allocation for each provider based on the total number of employees reported multiplied by $325, except that if there are any employees who were reported on the survey and to whom the provider chooses not to offer this funding, the allocation based on the total number of employees reported will be reduced by the number of excluded employees reported multiplied by $325. These funds must be used to enhance employee health care benefits or to reduce employee out-of-pocket health-related expenses.

(4) Effective January 1, 2006, providers may receive additional funding that would have been received during the period of April 1, 2004 through December 31, 2005 if the funding described in paragraph (3) of this subdivision had been paid. Providers whose employee health care benefits are below the benchmark may apply to OPWDD for additional funding as follows:

(i) For providers which reported on the survey that no employee health care benefits are offered, no additional funding for the period of April 1, 2004 through December 31, 2005 is available.

(ii) For providers which reported on the survey that employee health care benefits are offered to some or all employees, OPWDD determined an allocation for each provider based on the total number of employees reported multiplied by $325, except that if there are any employees who were reported on the survey and to whom the provider chooses not to offer this funding, the allocation based on the total number of employees reported will be reduced by the number of excluded employees reported multiplied by $325. The annual allocation of $325 will be adjusted for the 21-month period of April 1, 2004 through December 31, 2005. These funds must be used to reimburse health care expenses paid by employees.

(5) In order to receive an allocation described in paragraph (3) or (4) of this subdivision, the provider must send to OPWDD a completed written application submitted in the form and format specified by the commissioner.

(6) Funding is contingent upon OPWDD's approval of the application. OPWDD will base its decision on whether the application is complete; whether it complies with the requirements of this subdivision; and whether the application recognizes the provider's lowest paid employees. OPWDD may request additional information and/or documentation as needed before approving the application.

(7) Payment of the allocation described in paragraph (3) or (4) of this subdivision shall be subject to the provider submitting a resolution by its governing body that funds received will be used to implement the plans described in the provider's approved application. To receive the allocation, the provider must submit the resolution and the commissioner may approve it.

(8) A rate revised by OPWDD pursuant to this subdivision shall not be considered final unless and until approved by the State Division of the Budget.

(m) *Employee health care enhancement II.*

(1) Effective January 1, 2007 providers may be eligible to receive funding for the health care enhancement II (HCE II). Provides must use these funds to establish or enhance employee health care benefits or to reduce employee out of pocket health care expenses.

(2) In order to receive funding described in this subdivision, the provider must have sent to OPWDD a completed written application by July 31, 2006, unless this deadline was extended by the commissioner.

(3) Funding is contingent upon OPWDD's approval of the application. OPWDD shall decide whether to approve the application based on whether the application is complete; whether it complies with the requirements

of this subdivision; and whether the application recognizes the provider's lowest paid employees. OPWDD may request additional information and/or documentation, or revisions to an application, before approving the application.

(4) Funding for HCE II is available at either $2,500 per employee or $425 per employee, as follows:

(i) The annual allocation at the $2,500 level is determined by OPWDD based on the total number of employees included in the provider's approved HCE II application multiplied by $2,500. Funding at the $2,500 level is available to providers which:

(*a*) submitted an application for HCE II funding at the $2,500 level; and

(*b*) do not offer health care benefits; and

(*c*) were insufficiently funded for health care, as determined by OPWDD. Affected providers were notified by OPWDD of this determination.

(ii) The annual allocation at the $425 level is determined by OPWDD based on the total number of employees included in the provider's approved HCE II application multiplied by $425. Funding at the $425 level is available to providers which:

(*a*) offer health care benefits to some or all employees and submitted an application for HCE II funding at the $425 level; or

(*b*) applied for HCE II funding at the $2,500 level but received funding at the $2,500 per employee level pursuant to subdivision (l) of this section; or

(*c*) submitted an application at the $2,500 level but have sufficient funding for health care, as determined by OPWDD. Affected providers were notified by OPWDD of this determination.

(5) The application submitted to OPWDD shall include plans for the expenditure of the HCE II allocation in conformance with this subdivision. Such HCE II plans shall assure that all employees included in the application are entitled to some benefit from HCE II, although the value per employee may be lesser or greater than $2,500 or $425 per employee. Higher paid employees whose earnings exceed a salary cap established by the provider may be excluded from receipt of any HCE II funds if these funds are reallocated to lower paid staff.

(6) A provide approved to receive HCE II funding pursuant to subparagraph (4)(ii) of this subdivision shall receive an amount that would have been paid if the HCE II initiative had been implemented April 1, 2006.

(7) Payment of the HCE II funding shall be subject to the provider submitting a resolution by its governing body that funds received shall be used to implement the plans described in the provider's approved application. To receive the allocation the provider must submit the resolution and the commissioner must approve it.

(8) A rate revised by OPWDD pursuant to this subdivision shall not be considered final unless and until approved by the State Division of the Budget.

(n) *Employee Health Care Enhancement III.*

(1) Effective January 1, 2008 providers may be eligible to receive funding for the Health Care Enhancement III (HCE III) included in their price.

(2) Funding. Based on a survey of providers' historical data as of January 1, 2005, OPWDD determined a benchmark of health care benefits offered to employees by providers. Prior to September 30, 2007, OPWDD notified those providers which OPWDD deemed eligible for HCE III at below the benchmark level. Providers deemed eligible for

HCE III funding below the benchmark level were mailed applications with instructions.

(i) Providers deemed eligible for HCE III funding at the benchmark level shall receive an amount equaling 1.0 percent of the operating costs exclusive of any HCE III component contained in the fee in effect on January 1, 2008 net of any funding provided pursuant to subparagraph (iii) of this paragraph. Providers which also operate programs and services eligible for the 3.0 percent funding level increase under this Chapter may not receive this 1.0 percent funding level increase unless they have declined the 3.0 percent funding level increase in the eligible programs and services. Providers which receive this 1.0 percent funding level increase may not apply for employee health care funding described in subparagraph (ii) of this paragraph.

(ii) Providers deemed eligible for HCE III funding below the benchmark level may apply to OPWDD to receive an amount equaling 1.0 percent of the operating costs exclusive of any HCE III component contained in the fee in effect on January 1, 2008 net of any funding provided pursuant to subparagraph (iii) of this paragraph.

(*a*) Providers shall use these funds to establish or enhance employee health care benefits and/or to reduce employee out-of-pocket health care expenses and/or to offset the portion of premium increases paid by the provider which exceeds the portion of the trend factor or COLA applicable to those premium increases. Providers shall assure that benefits resulting from this additional funding recognize their lower paid employees.

(*b*) In order to receive the funding described in this subparagraph, the provider must have sent to OPWDD a completed application and attestation received or postmarked by October 1, 2007, unless the deadline was extended by the commissioner. In the application and attestation, the provider must have indicated its intended use of the funds; agreed to obtain a resolution by December 31, 2007 from its governing body authorizing such use; and agreed to maintain on file the resolution as well as records detailing the distribution of HCE III funds.

(*c*) Funding is contingent upon OPWDD's approval of the application and attestation. OPWDD shall decide whether to approve the application and attestation based on whether it is complete and conforms to the requirements of this subdivision. OPWDD may request additional information or documentation before approving the application and attestation.

(iii) A provider approved to receive HCE III funding pursuant to subparagraph (i) or (ii) of this paragraph shall receive an amount that would have been paid if the HCE III initiative had been implemented April 1, 2007.

(3) A fee revised by OPWDD pursuant to this subdivision shall not be considered final unless and until approved by the State Division of the Budget.

(o) *Health Care Adjustments (HCA) IV and V*.

(1) Effective November 1, 2009, providers may be eligible to receive funding for the Health Care Adjustments (HCA) IV and V included in their fees.

(2) Benchmark providers and non-benchmark providers. Based on a survey of providers' historical data as of January 1, 2005, OPWDD determined a benchmark of health care related benefits offered to employees by providers. Prior to October 31, 2007, OPWDD notified those providers which OPWDD deemed eligible for HCE III funding at the benchmark level. Providers eligible for HCE III funding at the benchmark level are eligible for HCA IV and HCA V funding at the benchmark level. All other providers are eligible for HCA IV and HCA V funding below the benchmark level.

(3) Funding.

(i) Providers eligible for HCA IV and HCA V funding at the benchmark level.

(*a*) The HCA IV and HCA V funding levels for benchmark providers shall be 1.0 percent of the allowable operating costs used in establishing the

provider specific fees. Each adjustment shall be applied sequentially to effect compounding of the adjustments.

(*b*) Providers which also operate programs and services eligible for the 3.0 percent funding level increase under this Chapter may not receive this 1.0 percent funding level increase unless they have declined the 3.0 percent funding level increase in the eligible programs and services. Providers which receive this 1.0 percent funding level increase may not apply for employee health care funding described in subparagraph (ii) of this paragraph.

(ii) Providers eligible for HCA IV and HCA V funding below the benchmark level may apply to OPWDD to receive these funds.

(*a*) The HCA IV and HCA V funding levels for providers eligible for HCA IV and HCA V funding below the benchmark level shall be 1.0 percent of the allowable operating costs used in establishing the provider specific fees. Each adjustment shall be applied sequentially to effect compounding of the adjustments.

(*b*) Providers shall use these funds first to offset health care premium increases. Remaining funds shall be used to establish or enhance employee health care related benefits and/or to reduce employee out-of-pocket health care related expenses.

(*c*) In order to receive HCA IV and HCA V funds, the provider must have sent to OPWDD a completed application and attestation received or postmarked no later than September 11, 2009 unless the deadline was extended by the commissioner. In the application and attestation, the provider must have indicated its intended use of the funds; agreed to obtain a resolution by October 31, 2009 from its governing body authorizing such use; and agreed to maintain on file the resolution as well as records detailing the distribution of HCA IV and HCA V funds.

(*d*) Funding is contingent upon OPWDD's approval of the application and attestation based on whether it is complete and conforms to the requirements

of this subdivision. OPWDD may request additional information or documentation before approving the application and attestation.

(4) Catch-up provisions. Effective November 1, 2009, benchmark providers which do not receive any HCA funding at the 3.0 percent level and non-benchmark providers with approved applications shall be eligible to receive additional funding for HCA IV in an amount that would have been received for the period of April 1, 2008 through October 31, 2009 if the 1.0 percent increment had been implemented on April 1, 2008. Effective November 1, 2009 benchmark providers which do not receive any HCA funding at the 3.0 percent level and non-benchmark providers with approved applications shall be eligible to receive additional funding for HCA V in an amount that would have been received for the period of April 1, 2009 through October 31, 2009 if the 1.0 percent increment had been implemented on April 1, 2009. Nothing in this paragraph shall entitle a provider to receive payment for services which have not been provided.

(5) Consolidation of HCE and HCA funds effective January 1, 2010.

(i) Effective January 1, 2010, the HCE I through III and HCA IV and HCA V components included in the price shall be consolidated into a single discrete amount. For purposes of determining this amount, OPWDD shall combine the HCE I through III and HCA IV and HCA V components contained in the initial fee in effect on January 1, 2010. OPWDD shall use this fixed amount as the HCA payment for the fee periods beginning on or after January 1, 2010.

(ii) Effective January 1, 2010, with the consolidation of the health care adjustments, non-benchmark providers shall use HCE I, II and III funds first to either offset health care premium increases and/or to maintain benefits that were established and funded with previous HCE I, II and III receipts. Remaining funds shall be used to establish or enhance employee health care related benefits and/or to reduce employee out-of-pocket health care related expenses. Non-benchmark providers shall continue to use HCA IV and V funds first to offset health care premium increases. Remaining funds shall be used to establish or enhance employee health care related benefits and/or to reduce employee out-of-pocket health care related expenses. Health care enhancement/adjustment funds included in prices

for services delivered on or after July 6, 2011 shall be used by non-benchmark providers for the purposes described in this subparagraph and/or for any other options that continue and/or enhance existing health care benefits and/or improve the recruitment and/or retention of the provider's lower paid employees. However, in using these funds accordingly, non-benchmark providers may establish which priorities serve the needs of such employees. Additionally, on July 6, 2011, health care enhancement/adjustment funding shall be included in the reimbursable cost category of fringe benefits in the price.

(6) Provider's distribution of HCA IV and HCA V funds is subject to audit to ensure conformity with the requirements of this paragraph and distribution of funds consistent with the provider's approved application.

(p) *Health Care Adjustment (HCA) VI.*

(1) Effective October 1, 2010, providers may be eligible to receive funding for the Health Care Adjustments (HCA) VI included in their prices.

(2) Benchmark providers and non-benchmark providers. Based on a survey of providers' historical data as of January 1, 2005, OPWDD determined a benchmark of health care related benefits offered to employees by providers. Prior to October 31, 2007, OPWDD notified those providers which OPWDD deemed eligible for Health Care Enhancement (HCE) III funding at the benchmark level. These providers are “benchmark providers” and are eligible for HCA VI funding at the benchmark level. All other providers (“non-benchmark providers” are eligible for HCA VI funding below the benchmark level.

(3) Funding.

(i) Providers eligible for HCA VI funding at the benchmark level.

(*a*) The HCA VI funding level for benchmark providers shall be 3.0 percent of the allowable operating costs used in establishing the provider specific prices in effect on April 1, 2010.

(*b*) Alternatively, a provider eligible for HCA VI funding at the benchmark level shall receive a 1.0 percent funding increase in all its programs and services eligible under this Chapter if the provider notified OPWDD by August 13, 2010 in writing that it was declining the 3.0 percent funding level increase and electing instead to receive a 1.0 percent funding level increase in all its programs and services eligible under this Chapter.

(*c*) Providers eligible for funding at the benchmark level may not apply for HCA VI funding described in subparagraph (ii) of this paragraph.

(ii) Providers eligible for HCA VI funding below the benchmark level may apply to OPWDD to receive these funds.

(*a*) The HCA VI funding level for providers eligible for HCA VI funding below the benchmark level shall be 1.0 percent of the allowable operating costs used in establishing the provider specific prices in effect on April 1, 2010.

(*b*) Providers shall use these funds first to offset health care premium increases. Remaining funds shall be used to establish or enhance employee health care related benefits and/or to reduce employee out-of-pocket health care related expenses. Health care adjustment funds included in prices for services delivered on or after July 6, 2011 shall be used by non-benchmark providers for the purposes described in this clause and/or for any other options that continue and/or enhance existing health care benefits and/or improve the recruitment and/or retention of the provider's lower paid employees. However, in using these funds accordingly, non-benchmark providers may establish which priorities serve the needs of such employees. Additionally, on July 6, 2011, health care adjustment funding shall be included in the reimbursable cost category of fringe benefits in the price.

(*c*) In order to receive HCA VI funds, the provider must have sent to OPWDD a completed application and attestation received or postmarked no later than August 13, 2010 unless the deadline was extended by the commissioner. In the application and attestation, the provider must have indicated its intended

use of the funds; agreed to obtain a resolution by September 30, 2010 from its governing body authorizing such use; and agreed to maintain on file the resolution as well as records detailing the distribution of HCA VI funds.

(*d*) Funding is contingent upon OPWDD's approval of the application and attestation based on whether it is complete and conforms to the requirements of this subdivision. OPWDD may request additional information or documentation before approving the application and attestation.

(iii) Effective October 1, 2010, benchmark providers shall be eligible and non-benchmark providers with approved applications shall be eligible to receive additional funding for HCA VI in an amount that they would have received if the Health Care Adjustment VI had been in effect for the period from April 1, 2010 through September 30, 2010 Nothing in this subparagraph shall entitle a provider to receive payment for services which have not been provided.

(4) Providers' distribution of HCA VI funds is subject to audit to ensure conformity with the requirements of this subdivision and distribution of funds consistent with the provider's approved application.

Credits

Sec. added by renum. 686.4, filed Nov. 10, 1987 eff. Jan. 31, 1988; amds. to former 686.4 filed: Dec. 29, 1987 as emergency measure; Feb. 23, 1988; Feb. 24, 1988 as emergency measure; amds. filed: May 31, 1988; Dec. 30, 1988 as emergency measure; March 14, 1989 as emergency measure; March 21, 1989; June 13, 1989; Oct. 3, 1989; Dec. 29, 1989 as emergency measure; March 13, 1990; June 29, 1990 as emergency measure; July 31, 1990 as emergency measure, expired 60 days after filing; Oct. 4, 1990 as emergency measure; Nov. 27, 1990; Dec. 31, 1990 as emergency measure; March 29, 1991 as emergency measure; April 26, 1991 as emergency measure; May 24, 1991 as emergency measure; June 18, 1991; June 28, 1991 as emergency measure; July 2, 1991; July 9, 1991 as emergency measure; Aug. 27, 1991 as emergency measure; Aug. 27, 1991; Sept. 17, 1991 as emergency measure; Oct. 4, 1991 as emergency measure; Nov. 12, 1991 as emergency measure; Nov. 12, 1991; Dec. 31, 1991 as emergency measure; Feb. 25, 1992 as emergency measure; Feb. 25, 1992; March 17, 1992 as emergency measure; March 17, 1992; Aug. 18, 1992; Dec. 31, 1992 as emergency measure, expired 90 days after filing; March 1, 1993 as emergency measure; May 28, 1993 as emergency measure; July 26, 1993 as emergency measure; Sept. 13, 1993 as emergency measure;

Nov. 12, 1993 as emergency measure; Nov. 30, 1993; May 1, 1996 as emergency measure; June 24, 1996 as emergency measure; Aug. 20, 1996 as emergency measure; Aug. 20, 1996; June 2, 1998; July 7, 1998; Dec. 8, 1998; June 27, 2000; June 11, 2002; Dec. 17, 2004; Dec. 13, 2005; Jan. 10, 2006; Dec. 12, 2006 eff. Jan. 1, 2007. Amd. (l); added (m); amd. filed Dec. 11, 2007 eff. Jan. 1, 2008; amd. filed Oct. 13, 2009 eff. Nov. 1, 2009; amd. filed Dec. 15, 2009 eff. Jan. 1, 2010; amds. filed May 11, 2010 eff. June 1, 2010; amds. filed June 8, 2010 eff. June 23, 2010; amds. filed Sept. 14, 2010 eff. Oct. 1, 2010; amd. filed June 14, 2011 eff. July 1, 2011; amd. filed June 21, 2011 eff. July 6, 2011; amd. filed Jan. 15, 2013 eff. Feb. 1, 2013; amd. filed Sept. 6, 2016 eff. Sept. 21, 2016.

Current with amendments included in the New York State Register, Volume XXLII, Issue 38 dated September 23, 2020. Court rules under Title 22 and Executive Orders under Title 9 may be more current.

N.Y. Comp. Codes R. & Regs. tit. 14, § 686.13, 14 NY ADC 686.13

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