DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Refer to DMCH: SJ

Region II
Federal Building
26 Federal Plaza
New York, N.Y. 10278

October 18, 2010

Donna Frescatore
Deputy Commissioner
New York State Department of Health
Corning Tower
Empire State Plaza
Albany, New York 12237

Dear Commissioner Frescatore:

This is to notify you that New York State Plan Amendment (SPA) #07-06 has been approved for adoption into the State Medicaid Plan with an effective date of April 1, 2007. The SPA concerns rates of payment for hospital outpatient clinic, emergency department, certified home health agency, adult day health, and freestanding diagnostic and treatment center services. The SPA continues various cost saving measures for these services which had been enacted by the New York State Legislature and signed into law by the Governor.
.
This SPA approval consists of 17 Pages. We are approving the following Pages which were submitted with New York State's August 20, 2010 electronic submission to CMS: Attachment 4.19-B-Page 1(b). 1(c)(ii), 1(d), 1(e), 2, 2(a)(i), 2(b), 2(b)(i), 2(c), 4, 4(a), 4(a)(iii), 4(a)(iv), 4(a)(iv)(1), 4(a)(iv)(2), 4(a)(v) and 7(a)(i). At that time, New York requested that these submitted Pages replace the all of the Pages which were originally provided with its SPA submission of June 28, 2007. This approval is for the 17 newly submitted Pages.

This amendment satisfies all of the statutory requirements at sections 1902(a)(13) and (a)(30) of the Social Security Act, and the implementing regulations at 42 CFR 447.250 and 447.272. Enclosed are copies of the SPA #07-06 and the HCFA-179, as approved.

If you have any questions or wish to discuss this SPA further, please contact Michael Melendez or Shing Jew of this office. Mr. Melendez may be reached at (212) 616-2430, and Mr. Jew's telephone number is (212) 616-2426.

Sincerely,

/s/

Sue Kelly
Associate Regional Administrator
Division of Medicaid and Children's Health

Enclosure: SPA #07-06
HCFA-179 Form

CC: JUlberg
PMossman
KKnuth
SGaskins
LTavener
GCritelli
PMarra
MSamuel
SJew

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: **07-06**

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
April 1, 2007

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:
§1902 (a)(30) of the Social Security Act
42 CFR Part 447.204

7. FEDERAL BUDGET IMPACT:
a. FFY **4/1/07-9/30/07** **($13,432,500)**
b. FFY **10/1/07-9/30/08** **($26,865,000)**

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-B: Pages 1(b), 1(c)(ii), 1(d), 1(e), 2, 2(a)(i), 2(b), 2(b)(i), 2(c), 4, 4(a), 4(a)(iii), 4(a)(iv), 4(a)(iv)(1), 4(a)(iv)(2), 4(a)(v) & 7(a)(i) **** SEE REMARKS**

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19-B: Pages 1(b), 1(c)(ii), 1(d), 1(e), 2, 2(a)(i), 2(b), 2(b)(i), 2(c), 4, 4(a), 4(a)(iii), 4(a)(iv), 4(a)(iv)(1), 4(a)(iv)(2), 4(a)(v) & 7(a)(i)

10. SUBJECT OF AMENDMENT:
2007 Cost Containment Extensions—Non Institutional
FMAP = 50% (based on effective date of 4/1/07)

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:

13. TYPED NAME: **Donna Frescatore**

14. TITLE: **Medicaid Director & Deputy Commissioner Department of Health**

15. DATE SUBMITTED: **AUG 20 2010**
(Originally Submitted June 28, 2007)

16. RETURN TO:
New York State Department of Health
Corning Tower
Empire State Plaza
Albany, New York 12237

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

18. DATE APPROVED: **OCT 18 2010**

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: **APR 01 2007**

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME: **Sue Kelly**

22. TITLE: **Associate Regional Administrator**
Division of Medicaid and State Operations

23. REMARKS:

Originally submitted pages Attachment 4.19-B-Page 1(b). 1(c)(ii), 1(d), 1(e), 2, 2(a)(i), 2(b), 2(b)(i), 2(c), 4, 4(a), 4(a)(iii), 4(a)(iv), 4(a)(iv)(1), 4(a)(iv)(2), 4(a)(v) and 7(a)(i) have been replaced by revised pages submitted via State e-mail of August 20, 2010.

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(two year trend movement) on a per visit basis, except that commencing April 1, 1995 through March 31, 1999 and on and after July 1, 1999 through March 31, 2000 and on and after April 1, 2000 through March 31, 2003, and on and after April 1, 2003 through March 31, [2007] 2009, for rates of payment for patients eligible for payments made by state governmental agencies, the capital cost per visit components shall be adjusted by the Commissioner to exclude such expenses related to 1) forty-four percent of the costs of major moveable equipment and 2) staff housing. A return on equity is recognized in those instances where the hospital is organized under the auspices of proprietary sponsorship. MMTP services may be reimbursed on a uniform fixed weekly fee per enrolled patient basis. Renal dialysis services are reimbursed on the lower of a facility's actual cost or statewide ceiling of $150.00 per procedure. Payment rates for renal dialysis services are adjusted to reflect utilization patterns for CAPD, CCPD, hemodialysis and extended peritoneal dialysis services. Effective October 1, 1995, the rate for primary care clinic services provided in primary care hospitals, shall be a per visit rate based on allowable reportable operating costs subject to a cap on operating costs of $67.50 per visit. For dates of service beginning on December 1, 2008 through March 31, 2010, primary care clinic and renal dialysis services shall be reimbursed using the Ambulatory Patient Group classification and reimbursement system. Allowable reportable capital costs will be reimbursed on a per visit basis not subject to a ceiling on reimbursement, provided however that for the period October 1, 1995 through March 31, 1999 and on and after July 1, 1999 through March 31, 2000 and on and after April 1, 2000 through March 31, 2003, and on and after April 1, 2003 through March 31, [2007] 2009, the capital cost per visit components shall be adjusted by the Commissioner to exclude such expenses related to 1) forty-four percent of the cost of major movable equipment and 2) staff housing. A return on equity is recognized in those instances where the hospital is organized under the auspices of proprietary sponsorship.

Effective October 1, 1995, the rate for emergency services provided in primary care hospitals, shall be a per visit rate based upon allowable reportable operating costs and limited to a cap on operating costs of $95 per visit provided however, that for the period January 1, 2007 through December 31, 2007 the maximum payment for the operating component shall be $125 per visit; and during the period January 1, 2008 through December 31, 2008, the maximum payment for the operating cost component shall be $140 per visit; and during the period January 1, 2009 through [December] March 31, [2009] 2010 [and for each calendar year thereafter, the maximum payment for the operating cost component shall be $150 per visit] emergency department services shall be reimbursed through the Ambulatory Patient Group (APG) classification and reimbursement system. Allowable reportable capital costs will be reimbursed on a per visit basis not subject to a ceiling on reimbursement, provided however, that for the period of October 1, 1995 through March 31, 1999 and on and after July 1, 1999 through March 31, 2000, and on and after April 1, 2000 through March 31, 2003, and on and after April 1, 2003 through March 31, [2007] 2009, the capital costs per visit components shall be adjusted by the Commissioner to exclude such expenses related to 1) forty-four percent of the cost of major movable equipment and 2) staff housing. A return on equity is recognized in those instances where the hospital is organized under the auspices of proprietary sponsorship.

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Freestanding Clinic Services (diagnostic and treatment facilities) Facilities Certified Under Article 28 of the State Public Health Law

Prospective, all inclusive rates calculated by Department of Health, based on the lower of the allowable average cost per visit or the group ceiling trended to the current year. For purposes of establishing rates of payment for diagnostic and treatment centers for services provided on or after April 1, 1995 through March 31, 1999, and on or after July 1, 1999 through March 31, 2000, and on and after April 1, 2000 through March 31 2003, and on and after April 1, 2003 through March 31, [2007] 2009, the reimbursable base year administrative and general costs of a provider, excluding a provider reimbursed on an initial budget basis, shall not exceed the statewide average of total reimbursable base year administrative and general costs of diagnostic and treatment centers. For the purposes of this provision, reimbursable base year administrative and general costs shall mean those base year administrative and general costs remaining after application of all other efficiency standards, including, but not limited to, peer group cost ceilings or guidelines. The limitation on reimbursement for provider administrative and general expenses shall be expressed as a percentage reduction of the operating cost component of the rate promulgated for each diagnostic and treatment center with base year administrative and general costs exceeding the average. Facilities offering similar types of services and having similar regional economic factors are grouped and ceilings are calculated on the cost experience of facilities within the group taking into account regional economic factors such as geographic location. Costs at or below these ceilings have been determined to be reasonable. The facility-specific impact of eliminating the statewide cap on administrative and general costs, for the period April 1, 1999 through June 30, 1999 shall be included in rates of payment for facilities affected by such elimination for the period October 1, 1999 through December 31, 1999.

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The rates include a capital cost component. For fiscal year ending March 31, 1994, such rates are trended and extended to September 30, 1994. Commencing October 1, 1994 and thereafter, such rates shall be calculated as above for fiscal years beginning October 1, and ending September 30 except that rates of payment for the period ending September 30, 1995, shall continue in effect through September 30, [2007] 2009, provided however that, effective May 1, 2005, such rates may be adjusted to include additional capital costs not previously included in the corresponding rate. MMTP services may be reimbursed on a uniform fixed weekly fee per enrolled patient basis. For the period October 1, 2004 through December 31, 2004, freestanding clinic MMTP services shall be reimbursed on a uniform weekly fee per enrolled patient at the rate of $173.13. For the period beginning on January 1, 2005 and thereafter, the uniform fixed weekly fee for MMTP services will equal 100% of the weekly rate for hospital based MMTP service providers. Payment rates for renal dialysis services of $150.00 per procedure are adjusted to reflect utilization patterns for CAPD, CCPD, hemodialysis and extended peritoneal dialysis services. A single price per visit for day health care services rendered to patients with acquired immunodeficiency syndrome (AIDS) and other human immunodeficiency virus (HIV) related illnesses is determined based on reasonable projections of necessary costs and utilization and trended to later rate years. Price components may be adjusted for service capacity, urban or rural location and regional differences. Rates are subject to approval of the Division of the Budget.

Additional Funding for Diagnostic and Treatment Centers for the period October 1, 1999 through December 31, 1999

Rates for diagnostic and treatment centers for the period October 1, 1999 through December 31, 1999 shall include, in the aggregate, the sum of fourteen million dollars ($14,000,000) which shall be added to rates of payment based on an apportionment of such amount using a ratio of each individual provider's estimated Medicaid expenditures to total estimated Medicaid expenditures for diagnostic and treatment centers, as determined by the Commissioner, for the October 1, 1999 through September 30, 2000 rate period.

Additional Funding for Diagnostic and Treatment Centers Providing Services to Persons With Developmental Disabilities

For the period July 1, 2000, through March 31, 2001 and annual state fiscal periods thereafter, fee-for-service rates of payment for medical assistance services provided to patients eligible for federal financial participation under title XIX of the federal social security act by diagnostic and treatment centers licensed under article 28 of the public health law that provide services to individuals with developmental disabilities as their principal mission, shall be increased by

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The rates are regionally adjusted to reflect differences in labor costs for personnel providing direct patient care and clinic support staff. The rates have been set prospectively by applying an economic trend factor, except that rates of payment for the period ending September 30, 1995, shall continue in effect through September 30, [2007] 2009, provided however that, effective May 1, 2005, such rates may be adjusted to include additional capital costs not previously included in the corresponding rate. A supplemental bad debt and charity care allowance will be established annually for diagnostic and/or treatment centers approved as preferred primary care providers and paid as an addition to the facility's rate of payment. Each facility's allocation shall be based on its losses associated with the delivery of bad debt and charity care and computed on the basis of projected and allowable fiscal and statistical data, adjusted to actual, submitted by the facility. The amount paid per visit shall be based on each facility's allocation divided by projected Medicaid threshold visits adjusted to actual visits. This supplemental bad debt and charity care allowance shall be in effect until December 31, 1996.

For services provided on or after April 1, 1995, by providers designated as preferred primary care providers, rates of payment may be established pursuant to the reimbursement payment methodology described in this section only for services provided by providers which submitted bills prior to December 31, 1994, based on the reimbursement payment methodology described in this section, or by a diagnostic and treatment center operated by a general hospital designated as a financially distressed hospital, which applied on or before April 1, 1995, for designation as a preferred primary care provider. The reimbursement payment methodology described in this section is an alternative to the prospective average cost per visit reimbursement method used for non-participating diagnostic and treatment centers. There are unique features present in the reimbursement program designed to encourage provider participation and foster quality of care. The most notable of these is the financial responsibility of providers for selected laboratory and other ancillary procedures and Medicaid revenue assurances. Financial incentives are employed (within limitations) under this system to assure that these and other features are complied with.

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[responsibility of providers for selected laboratory and other ancillary procedures and Medicaid revenue assurances. Financial incentives are employed (within limitations) under this system to assure that these and other features are complied with.]

Ordered Ambulatory Services (specific services performed by a free-standing clinic on an ambulatory basis upon the order of a qualified physician, physician's assistant, dentist or podiatrist to test, diagnose or treat a recipient or specimen taken from a recipient).

Fee schedule developed by the Department of Health and approved by the Division of the Budget for each type of service, as appropriate. Payment for these services are in compliance with 42 CFR 447.325.

AIDS/HIV Adult Day Health Care Services For Diagnostic And Treatment Centers

Medical assistance rates of payment for adult day health care services provided on and after December 1, 2002 to patients with AIDS/HIV by a free standing ambulatory care facility shall be increased by three percent.

This increase to rates of payment will be for purposes of improving recruitment and retention of non-supervisory workers or any worker with direct patient care responsibility. Programs are prohibited from using the funds for any other purpose. The Commissioner of Health is authorized to audit each program to ensure compliance with the purpose for which this funding is provided and shall recoup any funds determined to have been used for purposes other than recruitment and retention.

To generate a threshold day care bill, the provider must ensure that clients receive a core service and be in attendance for a minimum of three hours, and over the course of the week, receive a minimum of three hours of health care services. Health care services are defined as both the core services and health related services that are therapeutic in nature and directly or indirectly related to the core services, which must be identified on the client's comprehensive care plan. Each visit must include a core service. A bill cannot be generated if these two requirements are not met.

Core services include:

- Medical visits
- Nursing visits

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Hospital Based Ambulatory Surgery Facilities Certified Under Article 28 of the Public Health Law

Case based rates of payment have been calculated for the Products of Ambulatory Surgery Payment groups. All procedures within the same payment group are reimbursed at a single discrete base price. The applicable base price for each payment group is adjusted for regional differences in wage levels, space occupancy, and plant over-head costs. An economic trend factor is applied to make the prices prospective. Rates of payment in effect on March 31, 2003, shall continue in effect for the period April 1, 2003 through [September 30, 2007] March 31, 2009, provided however that, effective May 1, 2005, such rates may be adjusted to include additional capital costs not previously included in the corresponding rate.

Freestanding-Diagnostic and Treatment Centers

Facilities Certified Under Article 28 of the Public Health Law as Freestanding Ambulatory Surgery Centers

Case based rates of payment have been calculated for the Products of Ambulatory Surgery Payment groups. All procedures within the same payment group are reimbursed at a single discrete base price. The applicable base price for each payment group is adjusted for regional differences in wage levels, space occupancy, and plant over-head costs. An economic trend factor is applied to make the prices prospective. Rates in effect on March 31, 2003, shall continue in effect for the period April 1, 2003 through [September 30, 2007] March 31, 2009, provided however that, effective May 1, 2005, such rates may be adjusted to include additional capital costs not previously included in the corresponding rate. The agency may pay the usual and customary rates of such medical facilities or approved services but must not pay more than the prevailing rates for comparable services in the geographic area.

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Attachment 4.19-B
(04/07)

Hospital Based Outpatient Department

Facilities Certified Under Article 28 of the Public Health Law

Services for AIDS and HIV positive patients

Visit based rates of payment have been calculated for five discrete clinic services provided to AIDS and HIV positive patients. For each service a discrete price has been established. The prices have been regionally adjusted to reflect regional differences in labor and facility overhead costs and an economic trend factor has been applied to make the prices prospective. For dates of service beginning on December 1, 2008 through March 31, 2010, the discrete services for comprehensive initial visit, post-test HIV counseling (negative result), and monitoring – asymptomatic HIV disease shall be reimbursed through the Ambulatory Patient Group (APG) classification and reimbursement system.

For outpatient services provided by general hospitals, beginning on and after April 1, 2006, the Commissioner of Health shall apply a trend factor projection of 2.25% attributable to the period January 1, 2006 through December 31, 2006. Upon reconciliation of this trend factor, in accordance with the previously approved state methodology, the final 2006 trend factor shall be the U.S. Consumer Price Index (CPI) for all Urban Consumers, as published by the U.S. Department of Labor, Bureau of Labor Statistics, minus 0.25%.

Freestanding Diagnostic and Treatment Centers

Facilities Certified Under Article 28 of the Public Health Law As Freestanding Diagnostic and Treatment Centers

Services for AIDS and HIV positive patients

Visit based rates of payment have been calculated for five discrete clinic services provided to AIDS and HIV positive patients. For each service a discrete price has been established. The prices have been regionally adjusted to reflect regional differences in labor and facility overhead costs and an economic trend factor has been applied to make the prices prospective, except that rates of payment for the period ending September 30, 1995 shall continue in effect through September 30, [2007] 2009, provided however that, effective May 1, 2005, such rates may be adjusted to include additional capital costs not previously included in the corresponding rate.

TN #07-06 **Approval Date** OCT 18 2010

Supersedes TN #06-45 **Effective Date** APR 01 2007

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Hospital Based Outpatient Department

Facilities Certified Under Article 28 of the Public Health Law

Services for medically supervised chemical dependence treatment and medically supervised withdrawal services

For dates of service beginning on July 1, 2002, for those facilities certified under Article 28 of the State Public Health Law, the Department of Health promulgates prospective, all-inclusive rates based upon reported historical costs. Allowable operating costs per visit are held to legislatively established ceiling limitations. Reported historical operating costs on a per visit basis, which are below or limited by ceilings, are deemed reimbursable and trended forward to the current rate period to adjust for inflation. Non-operating costs (such as capital costs) are not subject to the legislatively established ceiling and are added to the product of reimbursable operating costs times the roll factor (two year trend movement) on a per visit basis, except that commencing April 1, 1995 through March 31, [2007] 2009, for rates of payment for patients eligible for payments made by state governmental agencies, the capital cost per visit components shall be adjusted by the Commissioner to exclude such expenses related to 1) forty-four percent of the costs of major moveable equipment and 2) staff housing. A return on equity is recognized in those instances where the hospital is organized under the auspices of proprietary sponsorship. Effective October 1, 1995, the rate for primary care clinic services provided in primary care hospitals, shall be a per visit rate based on allowable reportable operating costs subject to a cap on operating costs of $67.50 per visit.

For outpatient services provided by general hospitals, beginning on and after April 1, 2006, the Commissioner of Health shall apply a trend factor projection of 2.25% attributable to the period January 1, 2006 through December 31, 2006. Upon reconciliation of this trend factor, in accordance with the previously approved state methodology, the final 2006 trend factor shall be the U.S. Consumer Price Index (CPI) for all Urban Consumers, as published by the U.S. Department of Labor, Bureau of Labor Statistics, minus 0.25%.

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Hospital Based Outpatient Department

Facilities Certified Under Article 28 of the Public Health Law as Hospital-Based Outpatient Departments

Services for Pregnant Women

Visit based rates of payment have been calculated for three discrete clinic services provided to pregnant women, for each service a discrete price has been established. The prices have been regionally adjusted to reflect regional differences in labor and facility overhead costs and an economic trend factor has been applied to make the prices prospective.

For outpatient services provided by general hospitals, beginning on and after April 1, 2006, the Commissioner of Health shall apply a trend factor projection of 2.25% attributable to the period January 1, 2006 through December 31, 2006. Upon reconciliation of this trend factor, in accordance with the previously approved state methodology, the final 2006 trend factor shall be the U.S. Consumer Price Index (CPI) for all Urban Consumers, as published by the U.S. Department of Labor, minus 0.25%.

Effective for services provided on and after January 1, 2007 and April 1 of each state fiscal year thereafter, the Commissioner of Health shall adjust prenatal care assistance program rates to effect a cost of living adjustment (COLA). This COLA will be calculated in accordance with the general Trend Factor section of in this Attachment.

Freestanding Diagnostic and Treatment Centers

Facilities Certified Under Article 28 of the Public Health Law as Freestanding Diagnostic and Treatment Centers

Services for Pregnant Women

Visit based rates of payment have been calculated for three discrete clinic services provided to pregnant women. For each service a discrete price has been established. The prices have been regionally adjusted to reflect regional differences in labor and facility overhead costs and an economic trend factor has been applied to make the prices prospective, except that rates of payment for the period ending September 30, 1995 shall continue in effect through September 30, [2007] 2009, provided however that, effective May 1, 2005, such rates may be adjusted to include additional capital costs not previously included in the corresponding rate.

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Laboratory Services

Fee Schedule developed by Department of Health and approved by Division of the Budget. In compliance with Section 2303 of the Deficit Reduction Act of 1984, on the aggregate, Medicaid fees for clinical diagnostic laboratory tests are not to exceed those amounts recognized by Medicare.

Home Health Services/Certified Home Health Agencies

Prospective, cost based hourly and per visit rates for five services shall be calculated by the Department of Health and approved by Division of the Budget. Rates are based on the lower of cost or ceiling, trended or, if lower, the charge. Providers are grouped geographically into upstate/downstate and by sponsorship, public/voluntary. Ceilings are calculated using the group cost experience. For purposes of establishing rates of payment by governmental agencies for certified home health agencies for the period April 1, 1995 through December 31, 1995, and for rate periods beginning on or after January 1, 1996 through March 31, 1999, and on July 1, 1999 through March 31, 2000, and on and after April 1, 2000 through March 31, 2003, and on and after April 1, 2003 through March 31, [2007] 2009, the reimbursable base year administrative and general costs of a provider of services, excluding a provider of services reimbursed on an initial budget basis, and a new provider, excluding changes in ownership or changes in name, who begins operations in the year prior to the year which is used as base year in determining rates of payment, shall not exceed the statewide average of total reimbursable base year administrative and general costs of such providers of services. In the 1996, 1997, 1998, 1999, 2001, 2002, 2003, 2004, 2005, 2006, [and] 2007, 2008, and 2009, rate periods respectively the amount of such reduction in certified home health agency rates of payments made during the twelve month period running from April 1, of the year prior to the respective rate period through March 31, of such respective rate period shall be adjusted in the respective rate period on a pro-rate basis, if it is determined upon post-audit review by June 15, of the respective rate period and reconciliation, that the savings for the state share, excluding the federal and local government shares, of medical assistance payments is in excess of one million five hundred thousand dollars or is less than one million five hundred thousand dollars for payments made on or before March 31, of the applicable twelve month period to reflect the amount by which such savings are in excess of or lower than one million five hundred thousand dollars. The amount of such reduction in certified home health agency rates of payment made during the period July 1, 1999 through March 31, 2000, shall be adjusted in the 2000 rate period on a pro-rate basis, if it is determined upon post-audit review by June 15, 2000 and reconciliation, that the savings for the state share, excluding the federal and local government shares, of medical assistance payments is in excess of one million one hundred twenty-five thousand dollars or is less than one million one hundred twenty-five thousand dollars for payments made on or before March 31, 2000, to reflect the amount by which such savings are in excess of or lower than one million one hundred twenty-five thousand dollars.

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For the rate periods on and after January 1, 2005 through December 31, 2006, and April 1, 2007 through March 31, 2009, there shall be no such reconciliation of the amount of savings in excess of or lower than one million five hundred thousand dollars.

In addition, separate payment rates for nursing services provided to patients diagnosed with Acquired Immune Deficiency Syndrome (AIDS) shall be established based upon regional services prices. Such prices shall be computed based upon average nursing costs per visit calculated by aggregating base year allowable costs and statistics reported by certified home health agencies within each of four state regions, and increased by a case mix adjustment factor which represents the relative ratio of additional resources needed to provide home care nursing services to AIDS patients when compared to the average case mix of home care patients. Such AIDS regional nursing prices will be trended annually.

The Commissioner shall adjust medical assistance rates of payment for services provided by AIDS home care programs for purposes of improving recruitment and retention of non-supervisory home care services workers or any worker with direct patient care responsibility in the following amounts for services provided on and after December first, two thousand two.

Rates of payment by governmental agencies for AIDS home care programs (including services provided through contracts with licensed home care services agencies) shall be increased by three percent.

Providers which have their rates adjusted for this purpose shall use such funds solely for the recruitment and retention of non-supervisory home care services workers or any worker with direct patient care responsibility. Providers are prohibited from using such funds for any other purpose.

The Commissioner is authorized to audit each provider to ensure compliance with this purpose and shall recoup any funds determined to have been used for purposes other than recruitment and retention of non-supervisory home care services workers or any worker with direct patient care responsibility.

In the case of services provided by providers through contracts with licensed home care services agencies, rate increases received by providers shall be reflected in either the fees paid or benefits or other supports provided to non-supervisory home care services workers or any worker with direct patient care responsibility of such contracted licensed home care services agencies and such fees, benefits or other supports shall be proportionate to the contracted

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Effective for the period August 1, 1996 through November 30, [2007] 2009, certified home health agencies (CHHAs) shall be required to increase their Medicare revenues relative to their Medicaid revenues measured from a base period (calendar year 1995) to a target period (the 1996 target period is August 1, 1996 through March 31, 1997, the 1997 target period is January 1, 1997 through November 30, 1997, the 1998 target period shall mean January 1, 1998 through November 30, 1998, the 1999 target period shall mean January 1, 1999 through November 30, 1999, the 2000 target period shall mean January 1, 2000 through November 30, 2000, the 2001 target period shall mean January 1, 2001 through November 30, 2001, the 2002 target period shall mean January 1, 2002 through November 30, 2002, the 2003 target period shall mean January 1, 2003 through November 30, 2003, the 2004 target period shall mean January 1, 2004 through November 30, 2004, the 2005 target period shall mean January 1, 2005 through November 30, 2005, the 2006 target period shall mean January 1, 2006 through November 30, 2006, [and] the 2007 target period shall mean January 1, 2007 through November 30, 2007, the 2008 target period shall mean January 1, 2008 through November 30, 2008, and the 2009 target period shall mean January 1, 2009 through November 30, 2009, or receive a reduction in their Medicaid payments. For this purpose, regions shall consist of a downstate region comprised of Kings, New York, Richmond, Queens, Bronx, Nassau and Suffolk counties and an upstate region comprised of all other New York State counties. A certified home health agency shall be located in the same county utilized by the Commissioner of Health for the establishment of rates pursuant to Article 36 of the Public Health Law. Regional group shall mean all those CHHAs located within a region. Medicaid revenue percentage shall mean CHHA revenues attributable to services provided to persons eligible for payments pursuant to Title 11 of Article 5 of the Social Services law divided by such revenues plus CHHA revenues attributable to services provided to beneficiaries of Title XVIII of the Federal Social Security Act (Medicare).

Prior to February 1, 1997, for each regional group, 1996 Medicaid revenue percentage for the period commencing August 1, 1996, to the last date for which such data is available and reasonably accurate shall be calculated. Prior to February 1, 1998, prior to February 1, 1999, prior to February 1, 2000, prior to February 1, 2001, prior to February 1, 2002, prior to February 1, 2003, prior to February 1, 2004, prior to February 1, 2005, [and] prior to February 1, 2006, prior to February 1, 2007, prior to February 1, 2008, and prior to February 1, 2009 for each regional group, the Commissioner of Health shall calculate the prior years Medicaid revenue percentages for the period beginning January 1 through November 30 of such prior year. By September 15, 1996, for each regional group, the base period Medicaid revenue percentage shall be calculated.

For each regional group, the 1996 target Medicaid revenue percentage shall be calculated by subtracting the 1996 Medicaid revenue reduction percentages from the base period Medicaid revenue percentages. The 1996 Medicaid revenue reduction percentage, taking into account regional and program differences in utilization of Medicaid and Medicare services, for the following regional groups shall be equal to:

- one and one-tenth percentage points for CHHAs located within the downstate region; and[,]
- six-tenths of one percentage point for CHHAs located within the upstate region.

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For 1997, 1998, 2000, 2001, 2002, 2003, 2004, 2005, 2006, [and] 2007, 2008, and 2009, for each regional group, the target Medicaid revenue percentage for the respective year shall be calculated by subtracting the respective year's Medicaid revenue reduction percentage from the base period Medicaid revenue percentage. The Medicaid revenue reduction percentages for 1997, 1998, 2000, 2001, 2002, 2003, 2004, 2005, 2006, [and] 2007, 2008, and 2009, taking into account regional and program differences in utilization of Medicaid and Medicare services, for the following regional groups shall be equal to:

- one and one-tenth percentage points for CHHAs located within the downstate region; and[,]

- six-tenths of one percentage point for CHHAs located within the upstage region.

For each regional group, the 1999 target Medicaid revenue percentage shall be calculated by subtracting the 1999 Medicaid revenue reduction percentage from the base period Medicaid revenue percentage. The 1999 Medicaid revenue reduction percentages, taking into account regional and program differences in utilization of Medicaid and Medicare services, for the following regional groups shall be equal to:

- eight hundred twenty-five thousandths (.825) of one percentage point for CHHAs located within the downstate region; and

- forty-five hundredths (.45) of one percentage point for CHHAs located within the upstate region;

For each regional group, if the 1996 Medicaid revenue percentage is not equal to or less than the 1996 target Medicaid revenue percentage, a 1996 reduction factor shall be calculated by comparing the 1996 Medicaid revenue percentage to the 1996 target Medicaid revenue percentage to determine the amount of the shortfall and dividing such shortfall by the 1996 Medicaid revenue reduction percentage. These amounts, expressed as a percentage, shall not exceed one hundred percent. If the 1996 Medicaid revenue percentage is equal to or less than 1996 target Medicaid revenue percentage, the 1996 reduction factor shall be zero. For each regional group, the 1996 reduction factor shall be multiplied by the following amounts to determine each regional group's applicable 1996 state share reduction amount.

- two million three hundred ninety thousand dollars ($2,390,000) for CHHAs located within the downstate region; and

- seven hundred fifty thousand dollars ($750,000) for CHHAs located within the upstate region.

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For each regional group reduction, if the 1996 reduction factor shall be zero, there shall be no 1996 state share reduction amount.

For 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, [and] 2007, 2008, and 2009, for each regional group, if the Medicaid revenue percentage for the respective year is not equal to or less than the target Medicaid revenue percentage for such respective year, the Commissioner of Health shall compare such respective year's Medicaid revenue percentage to such respective year's target Medicaid revenue percentage to determine the amount of the shortfall which, when divided by the respective year's Medicaid revenue reduction percentage, shall be called the reduction factor for such respective year. These amounts, expressed as a percentage, shall not exceed one hundred percent. If the Medicaid revenue percentage for a particular year is equal to or less than the target Medicaid revenue percentage for that year, the reduction factor for that year shall be zero.

For 1997, 1998, 2000, 2001, 2002, 2003, 2004, 2005, 2006, [and] 2007, 2008, and 2009, for each regional group, the reduction factor for the respective year shall be multiplied by the following amounts to determine each regional group's applicable state share reduction amount for such respective year.

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- two million three hundred ninety thousand dollars ($2,390,000) for CHHAs located within the downstate region; and

- seven hundred fifty thousand dollars ($750,000) for CHHAs located within the upstate region;

For each regional group reduction, if the reduction factor for a particular year is zero, there shall be no state share reduction amount for such year.

For each regional group, the 1999 reduction factor shall be multiplied by the following amounts to determine each regional group's applicable 1999 state share reduction amount:

- one million seven hundred ninety-two thousand five hundred dollars ($1,792,500) for CHHAs located within the downstate region; and

- five hundred sixty-two thousand five hundred dollars ($562,500) for CHHAs located within the upstate region;

For each regional group reduction, if the 1999 reduction factor is zero, there shall be no 1999 state share reduction amount.

For each regional group, the 1996 state share reduction amount shall be allocated among CHHAs on the basis of the extent of each CHHA's failure to achieve the 1996 target Medicaid revenue percentage, calculated on a provider specific basis utilizing revenues for this purpose, expressed as a proportion of the total of each CHHA's failure to achieve the 1996 target Medicaid revenue percentage within the applicable regional group. This proportion shall be multiplied by the applicable 1996 state share reduction amount. This amount shall be called the 1996 provider specific state share reduction amount.

The 1996 provider specific state share reduction amount shall be due to the state from each CHHA and may be recouped by the State by March 31, 1997, in a lump sum amount or amounts from payments due to the CHHA pursuant to Title 11 of Article 5 of the Social Services Law.

For 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, [and] 2007, 2008, and 2009, for each regional group, the state share reduction amount for the respective year shall be allocated among CHHAs on the basis of the extent of each CHHA's failure to achieve the target Medicaid revenue percentage for the applicable year, calculated on a provider specific basis utilizing revenues for this purpose, expressed as a proportion of the total of each CHHA's failure to achieve the target Medicaid revenue percentage for the applicable year within the applicable regional group. This proportion shall be multiplied by the applicable year's state share reduction amount for the applicable regional group. This amount shall be called the provider specific state share reduction amount for the applicable year.

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The provider specific state share reduction amount for 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, [and] 2007, 2008, and 2009, respectively, shall be due to the state from each CHHA and the amount due for each respective year may be recouped by the state by March 31 of the following year in a lump sum amount or amounts from payments due to the CHHA pursuant to Title 11 of Article 5 of the Social Services Law.

CHHAs shall submit such data and information at such times as the Commissioner of Health may require. The Commissioner of Health may use data available from third party payors.

On or about June 1, 1997, for each regional group, the Commissioner of Health shall calculate for the period of August 1, 1996 through March 31, 1997, a Medicaid revenue percentage, a reduction factor, a state share reduction amount, and a provider specific state share reduction amount in accordance with the methodology provided herein for calculating such amounts for the 1996 target period. The provider specific state share reduction amount calculated shall be compared to the 1996 provider specific state share reduction amount. Any amount in excess of the 1996 provider specific state share reduction amount shall be due to the state from each CHHA and may be recouped. If the amount is less than the 1996 provider specific state share reduction amount, the difference shall be refunded to the CHHA by the state no later than July 15, 1997. CHHAs shall submit data for the period August 1, 1996 through March 31, 1997, to the Commissioner of Health by April 15, 1997.

If a CHHA fails to submit data and information as required, such CHHA shall be presumed to have no decrease in Medicaid revenue percentage between the base period and the applicable target period for purposes of the calculations described herein and the Commissioner of Health shall reduce the current rate paid to such CHHA by state governmental agencies pursuant to Article 36 of the Public Health Law by one percent for the period beginning on the first day of the calendar month following the applicable due date as established by the Commissioner of Health and continuing until the last day of the calendar month in which the required data and information are submitted.

Notwithstanding any inconsistent provision set forth herein, the annual percentage reductions as set forth above, shall be prorated by the Commissioner of Health for the period April 1, [2006] 2007 through March 31, [2007] 2009.

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(c) Allowable costs shall include, but not be limited to the following:

(1) applicable salary and non-salary operating costs;
(2) costs of transportation; and,
(3) appropriate portion of capital costs, allocated according to instructions accompanying the RHCF-4 report.

(d) the maximum daily rate, excluding the allowable costs of transportation, for services provided to a registrant in a 24 hour period as described in Part 425 of this title shall be 75 percent of the sponsoring facility's former skilled nursing facility rate in effect on January 1, 1990, with the operating component trended forward to the rate year by the sponsoring facility's trend factor.

(e) notwithstanding subdivision (d) of this section or any other regulations to the contrary, for the period July 1, 1992 to March 31, 1993 and annual periods beginning April 1, 1993 through March 31, 1999, July 1, 1999 through March 31, 2003, April 1, 2003 through March 31, 2005, and from April 1, 2005 through March 31, [2007] 2009, the maximum daily rate, excluding the allowable costs of transportation, for services provided to a registrant in a 24 hour period as described in Part 425 of this Title shall be 65 percent of the sponsoring facility's former skilled nursing facility rate in effect January 1, 1990, with the operating component trended forward to the rate year by the sponsoring facility's trend factor.

For adult day health care facilities, beginning on and after April 1, 2006, the Commissioner of Health shall apply a trend factor projection of 2.25% attributable to the period January 1, 2006 through December 31, 2006. Upon reconciliation of this trend factor, in accordance with the previously approved state methodology, the final 2006 trend factor shall be the U.S. Consumer Price Index (CPI) for all Urban Consumers, as published by the U.S. Department of Labor, minus 0.25%.