SECTION 3614

Payments for certified home health agency services, long term home health care programs and AIDS home care programs

Public Health (PBH) CHAPTER 45, ARTICLE 36

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§ 3614. Payments for certified home health agency services, long term home health care programs and AIDS home care programs. 1. No government agency shall purchase, pay for or make reimbursement or grants-in-aid for services provided by a home care services agency, a provider of a long term home health care program or a provider of an AIDS home care program unless, at the time the services were provided, the home care services agency possessed a valid certificate of approval or the provider of a long term home health care program or AIDS home care program had been authorized by the commissioner to provide such program. However, contractual arrangements between a certified home health agency, provider of a long term home health care program, provider of an AIDS home care program, or government agency and any home care services agency shall not be prohibited, provided that the certified home health agency, provider of a long term home health care program, provider of an AIDS home care program, or government agency maintains full responsibility for the plan of treatment and the care rendered.

2. Payments for certified home health agency services or services provided by long term home health care programs or AIDS home care programs made by government agencies shall be at rates approved by the state director of the budget. No provider of a long term home health care program or AIDS home care program shall establish charges for such program in excess of those established pursuant to the provisions of this section and rules and regulations adopted pursuant to section thirty-six hundred twelve of this article or subchapter XVIII of the federal Social Security Act (Medicare).

2-a. Notwithstanding any contrary law, rule or regulation, for rate periods on and after April first, two thousand eleven, Medicaid rates of payments for services provided by certified home health agencies, by

long term home health care programs or by an AIDS home care program shall not reflect a separate payment for home care nursing services provided to patients diagnosed with Acquired Immune Deficiency Syndrome (AIDS).

3. Prior to the approval of such rates, the commissioner shall determine and certify to the state director of the budget that the proposed rate schedules for payments for certified home health agency services or services provided by long term home health care programs or AIDS home care programs are reasonably related to the costs of the efficient production of such services. In making such certification, the commissioner shall take into consideration the elements of cost, geographical differentials in the elements of cost considered, economic factors in the area in which the certified home health agency, provider of a long term home health care program or provider of an AIDS home care program is located, costs of certified home health agencies, providers of long term home health care programs or providers of AIDS home care programs of comparable size, and the need for incentives to improve services and institute economies.

3-a. Medically fragile children and medically fragile adults. Rates of payment for continuous nursing services for medically fragile children and medically fragile adults provided by a certified home health agency, a licensed home care services agency or a long term home health care program shall be established to ensure the availability of such services, whether provided by registered nurses or licensed practical nurses who are employed by or under contract with such agencies or programs, and shall be established at a rate that is at least equal to rates of payment for such services rendered to patients eligible for AIDS home care programs; provided, however, that a certified home health agency, a licensed home care services agency or a long term home health care program that receives such enhanced rates for continuous nursing services for medically fragile children and medically fragile adults shall use such enhanced rates to increase payments to registered nurses and licensed practical nurses who provide such services. In the case of services provided by certified home health agencies and long term home health care programs through contracts with licensed home care services agencies, rate increases received by such certified home health agencies and long term home health care programs pursuant to this subdivision shall be reflected in payments made to the registered nurses or licensed practical nurses employed by such licensed home care services agencies to render services to these children and medically fragile adults. In

establishing rates of payment under this subdivision, the commissioner shall consider the cost neutrality of such rates as related to the cost effectiveness of caring for medically fragile children and medically fragile adults in a non-institutional setting as compared to an institutional setting. For the purposes of this subdivision, a medically fragile child shall mean a child who is at risk of hospitalization or institutionalization, including but not limited to children who are technologically-dependent for life or health-sustaining functions, require complex medication regimen or medical interventions to maintain or to improve their health status or are in need of ongoing assessment or intervention to prevent serious deterioration of their health status or medical complications that place their life, health or development at risk, but who are capable of being cared for at home if provided with appropriate home care services, including but not limited to case management services and continuous nursing services. The commissioner shall promulgate regulations to implement provisions of this subdivision and may also direct the providers specified in this subdivision to provide such additional information and in such form as the commissioner shall determine is reasonably necessary to implement the provisions of this subdivision.

3-c. Home telehealth. (a) Demonstration rates of payment or fees shall be established for telehealth services provided by a certified home health agency, a long term home health care program or AIDS home care program, or for telehealth services by a licensed home care services agency under contract with such an agency or program, in order to ensure the availability of technology-based patient monitoring, communication and health management. Reimbursement for telehealth services provided pursuant to this section shall be provided only in connection with Federal Food and Drug Administration-approved and interoperable devices, and incorporated as part of the patient's plan of care. The commissioner shall seek federal financial participation with regard to this demonstration initiative.

(b) The purposes of such services shall be to assist in the effective monitoring and management of patients whose medical, functional and/or environmental needs can be appropriately and cost-effectively met at home through the application of telehealth intervention. Reimbursement provided pursuant to this subdivision shall be for services to patients with conditions or clinical circumstances associated with the need for frequent monitoring, and/or the need for frequent physician, skilled nursing or acute care services, and where the provision of telehealth

services can appropriately reduce the need for on-site or in-office visits or acute or long term care facility admissions. Such conditions and clinical circumstances shall include, but not be limited to, congestive heart failure, diabetes, chronic pulmonary obstructive disease, wound care, polypharmacy, mental or behavioral problems limiting self-management, and technology-dependent care such as continuous oxygen, ventilator care, total parenteral nutrition or enteral feeding.

(c) Demonstration rates or fees established by the commissioner and approved by the director of the budget, for such telehealth services shall reflect telehealth services costs on a monthly basis in order to account for daily variation in the intensity and complexity of patients' telehealth service needs; provided that such demonstration rates shall further reflect the cost of the daily operation and provision of such services, which costs shall include the following functions undertaken by the participating certified home health agency, long term home health care program, AIDS home care program or licensed home care services agency:

(i) Monitoring of patient vital signs;

(ii) Patient education;

(iii) Medication management;

(iv) Equipment maintenance;

(v) Review of patient trends and/or other changes in patient condition necessitating professional intervention; and

(vi) Such other activities as the commissioner may deem necessary and appropriate to this section.

(d) The commissioner shall take such additional steps as may be reasonably necessary to implement the provision of this subdivision; provided however that the commissioner shall establish initial demonstration rates or fees for telehealth services as provided for in this subdivision by no later than October first, two thousand seven; and provided, further, however, that the commissioner shall seek the input of representatives from participating providers and other interested parties in the development of such rates or fees and any applicable

requirements established pursuant to this subdivision.

(e) The commissioner shall, within monies appropriated therefor, establish a rural home telehealth delivery demonstration study program in counties having a population of not less than one hundred thirty thousand and not more than one hundred forty thousand, according to the two thousand ten decennial federal census. The commissioner shall direct a home health organization serving in such county to study patients receiving telehealth services, pursuant to this subdivision, who have been diagnosed with congestive heart failure, diabetes and/or chronic pulmonary obstructive disease, and whose medical, functional and/or environmental needs are appropriately met at home through the application of telehealth services interventions. Such a study shall determine the cost of providing telehealth services, the quality of care provided through telehealth services and the outcomes of patients receiving such telehealth services. The commissioner shall reimburse the home health organization for conducting the study with amounts appropriated under this subdivision. The home health organization shall evaluate the findings of the study and report to the governor, the temporary president of the senate, the speaker of the assembly, the commissioner, and the chair of the legislative commission on rural resources on its findings of providing telehealth services for each condition, so as to provide the cost benchmarks with and without telehealth care, as well as providing cost benefit measurements in terms of the quality benefit outcomes for each of the conditions addressed via telehealth.

4. The commissioner shall notify each certified home health agency, long term home health care program and AIDS home care program of its approved rates of payment which shall be used in reimbursing for services provided to persons eligible for payments made by state governmental agencies at least thirty days prior to the beginning of an established rate period for which the rate is to become effective. Such notification shall be made only after approval of rate schedules by the state director of the budget.

* 5. (a) During the period July first, nineteen hundred ninety through December thirty-first, nineteen hundred ninety, the period January first, nineteen hundred ninety-one through December thirty-first, nineteen hundred ninety-one and for each calendar year period commencing on January first thereafter, rates of payment by governmental agencies established in accordance with subdivision three of this section

applicable for services provided by certified home health agencies to individuals eligible for medical assistance pursuant to title eleven of article five of the social services law for certified home health agencies which can demonstrate, on forms provided by the commissioner, losses from a disproportionate share of bad debt and charity care during the base year period as used in determining such rates may include an allowance determined in accordance with this subdivision to reflect the needs of the certified home health agency for the financing of losses resulting from bad debt and the cost of charity care. Losses resulting from bad debt and the delivery of charity care shall be determined by the commissioner considering, but not limited to, such factors as the losses resulting from bad debt and the costs of charity care provided by the certified home health agency and the availability of other financial support, including state local assistance public health aid, to meet the losses resulting from bad debt and the costs of charity care of the certified home health agency. The bad debt and charity care allowance for a certified home health agency for a rate period shall be determined by the commissioner in accordance with rules and regulations adopted by the state hospital review and planning council and approved by the commissioner, and shall be consistent with the purposes for which such allowances are authorized for general hospitals pursuant to the provisions of article twenty-eight of this chapter and rules and regulations promulgated by the commissioner. For purposes of distribution of bad debt and charity care allowances to eligible certified home health agencies, the commissioner, in accordance with rules and regulations adopted by the state hospital review and planning council and approved by the commissioner, may limit application of a bad debt and charity care allowance to a particular home care services unit or units of service, such as nursing service. A certified home health agency applying for a bad debt and charity care allowance pursuant to this subdivision shall provide assurances satisfactory to the commissioner that it shall undertake reasonable efforts to maintain financial support from community and public funding sources and reasonable efforts to collect payments for services from third party insurance payors, governmental payors and self-paying patients. To be eligible for an allowance pursuant to this subdivision, a certified home health agency shall: have professional assistance available on a seven day per week, twenty-four hour per day basis to all registered clients; demonstrate compliance with minimum charity care certification obligation levels established pursuant to rules and regulations adopted by the state hospital review and planning council and approved by the commissioner; and provide to the commissioner and maintain a community

service plan which outlines the agency's organizational mission and commitment to meet the home care needs of the community, in accordance with paragraph (h) of this subdivision.

(b) The total amount of funds to be allocated and distributed for bad debt and charity care allowances to eligible certified home health agencies for a rate period in accordance with this subdivision shall be limited to an annual aggregate amount of six million two hundred fifty thousand dollars; provided, however, that the amount of funds allocated for distribution to eligible publicly sponsored certified home health agencies for bad debt and charity care allowances shall not exceed thirty-five percent of total available funds for all eligible certified home health agencies for bad debt and charity care allowances. In establishing an apportionment of available funds to publicly sponsored certified home health agencies in accordance with this paragraph, the commissioner shall promulgate regulations which may include, but not be limited to, such factors as the ratio of public to nonpublic base year period bad debt and charity care provided by eligible certified home health agencies and differences in costs for delivering such services. Certified home health agencies provided by general hospitals shall not be eligible for any portion of the allocation pursuant to this paragraph for the period of July first, nineteen hundred ninety through December thirty-first, nineteen hundred ninety-four, or for such longer period if extended by law, based on the projected availability of an equitable level of bad debt and charity care coverage for such agencies provided pursuant to chapter two of the laws of nineteen hundred eighty-eight and any future amendments thereto.

(c) No certified home health agency may receive a bad debt and charity care allowance in accordance with this subdivision in an amount which exceeds its need for the financing of losses associated with the delivery of bad debt and charity care.

(d) A nominal payment amount for the financing of losses associated with the delivery of bad debt and charity care will be established for each eligible certified home health agency. The nominal payment amount shall be calculated as the sum of the dollars attributable to the application of an incrementally increasing nominal coverage percentage of base year period losses associated with the delivery of bad debt and charity care for percentage increases in the relationship between base year period losses associated with the delivery of bad debt and charity care and base year period total operating costs according to the

following scale:
% of bad debt and charity care losses to nominal percentage of

total operating cost loss coverage

Up to 3% 50%

3 - 6% 75%

6% + 100%
If the sum of the nominal payment amounts for all eligible voluntary non-profit and private proprietary certified home health agencies or for all eligible public certified home health agencies is less than the amount allocated for bad debt and charity care allowances pursuant to paragraph (b) of this subdivision for such certified home health agencies respectively, the nominal coverage percentages of base year period losses associated with the delivery of bad debt and charity care pursuant to this scale may be increased to not more than one hundred percent for voluntary non-profit and private proprietary certified home health agencies or for public certified home health agencies in accordance with rules and regulations adopted by the state hospital review and planning council and approved by the commissioner.

(e) The bad debt and charity care allowance for each eligible voluntary non-profit and private proprietary certified home health agency shall be based on the dollar value of the result of the ratio of total funds allocated for bad debt and charity care allowances for certified home health agencies pursuant to paragraph (b) of this subdivision to the total statewide nominal payment amounts for all eligible certified home health agencies determined in accordance with paragraph (d) of this subdivision applied to the nominal payment amount for each such certified home health agency.

(f) The bad debt and charity care allowance for each eligible public certified home health agency shall be based on the dollar value of the result of the ratio of total funds allocated for bad debt and charity care allowances for public certified home health agencies pursuant to paragraph (b) of this subdivision to the total statewide nominal payment amounts for all eligible public certified home health agencies determined in accordance with paragraph (d) of this subdivision applied to the nominal payment amount for each such certified home health agency.

(g) Certified home health agencies shall furnish to the department such reports and information as may be required by the commissioner to assess the cost, quality, access to, effectiveness and efficiency of bad debt and charity care provided. The state hospital review and planning council shall adopt rules and regulations, subject to the approval of the commissioner, to establish uniform reporting and accounting principles designed to enable certified home health agencies to fairly and accurately determine and report the costs of bad debt and charity care. In order to be eligible for an allowance pursuant to this subdivision, a certified home health agency must be in compliance with bad debt and charity care reporting requirements.

(h) Community service plans. (i) The governing body of a certified home health agency shall issue an organizational mission statement identifying at a minimum the populations and communities served by the agency and the agency's commitment to meeting the home care needs of the community. The commissioner shall take into consideration the limitations of agency size and resources, and allow flexibility in complying with the provisions of this section.

(ii) The governing body of the certified home health agency shall at least once every three years:

(A) review and amend as necessary the agency's mission statement;

(B) solicit the views of the communities served by the agency on such issues as the agency's performance and service priorities;

(C) demonstrate the agency's operational and financial commitment to meeting community home care needs, to provide charity care service and to improve access to home care services by the underserved; and

(D) prepare and make available to the public a statement showing the provision of free, reduced charge and/or other services of a charitable or community nature.

(iii) The governing body of the certified home health agency shall annually make available to the public a review of the agency's performance in meeting the home care needs of the community, providing charity care services, and improving access to home care services by the underserved.

(iv) The governing body of the certified home health agency shall file with the commissioner its mission statement, its annual performance review, and at least every three years a report detailing amendments to the statement reflecting changes in the agency's operational and financial commitment to meeting the home care needs of the community, providing charity care services, and improving access to home care services by the underserved.

(v) The commissioner shall promulgate regulations establishing a revised percentage for the charity care requirement.

(i) This subdivision shall be effective if, and as long as, federal financial participation is available for expenditures made for beneficiaries eligible for medical assistance under title XIX of the federal social security act based upon the allowances determined in accordance with this subdivision.

* NB Expires June 30, 2029

6. (a) The commissioner shall, subject to the approval of the state director of the budget, establish capitated rates of payment for services provided by assisted living programs as defined by paragraph (a) of subdivision one of section four hundred sixty-one-l of the social services law. Such rates of payment shall be related to costs incurred by residential health care facilities. The rates shall reflect the wage equalization factor established by the commissioner for residential health care facilities in the region in which the assisted living program is provided and real property capital construction costs associated with the construction of a free-standing assisted living program such rate shall include a payment equal to the cost of interest owed and depreciation costs of such construction. The rates shall also reflect the efficient provision of a quality and quantity of services to patients in such residential health care facilities, with needs comparable to the needs of residents served in such assisted living programs. Such rates of payment shall be equal to fifty percent of the amounts which otherwise would have been expended, based upon the mean prices for the first of July, nineteen hundred ninety-two (utilizing nineteen hundred eighty-three costs) for freestanding, low intensity residential health care facilities with less than three hundred beds, and for years subsequent to nineteen hundred ninety-two, adjusted for inflation in accordance with the provisions of subdivision ten of

section twenty-eight hundred seven-c of this chapter, to provide the appropriate level of care for such residents in residential health care facilities in the applicable wage equalization factor regions plus an amount equal to capital construction costs associated with the construction of an assisted living program facility as provided for in this subdivision. The commissioner shall also promulgate regulations, and may promulgate emergency regulations, to provide for reimbursement of the cost of preadmission assessments conducted directly by assisted living programs.

(b) For purposes of this subdivision, real property capital construction costs shall only be included in rates of payment for assisted living programs if: the facility houses exclusively assisted living program beds authorized pursuant to paragraph (j) of subdivision three of section four hundred sixty-one-l of the social services law or (i) the facility is operated by a not-for-profit corporation; (ii) the facility commenced operation after nineteen hundred ninety-eight and at least ninety-five percent of the certified approved beds are provided to residents who are subject to the assisted living program; and (iii) the assisted living program is in a county with a population of no less than two hundred eighty thousand persons. The methodology used to calculate the rate for such capital construction costs shall be the same methodology used to calculate the capital construction costs at residential health care facilities for such costs, provided that the commissioner may adopt rules and regulations which establish a cap on real property capital construction costs for those facilities that house exclusively assisted living program beds authorized pursuant to paragraph (j) of subdivision three of section four hundred sixty-one-l of the social services law.

(c) The department shall conduct a study of the use of resident data collected from a uniform assessment tool identified by the commissioner with respect to its effectiveness in evaluation and adjusting rates of payment for assisted living programs. On or before July thirty-first, two thousand eleven, the commissioner shall provide the governor, the speaker of the assembly, the temporary president of the senate, and the chairpersons of the assembly and senate health committees with a report setting forth the conclusions of such study.

7. * Notwithstanding any inconsistent provision of law or regulation, for purposes of establishing rates of payment by governmental agencies for certified home health agencies for the period April first, nineteen

hundred ninety-five through December thirty-first, nineteen hundred ninety-five and for rate periods beginning on or after January first, nineteen hundred ninety-six, the reimbursable base year administrative and general costs of a provider of services shall not exceed the statewide average of total reimbursable base year administrative and general costs of such providers of services. The amount of such reduction in certified home health agency rates of payments made during the period April first, nineteen hundred ninety-five through March thirty-first, nineteen hundred ninety-six shall be adjusted in the nineteen hundred ninety-six rate period on a pro-rata basis, if it is determined upon post-audit review by June fifteenth, nineteen hundred ninety-six and reconciliation that the savings for the state share, excluding the federal and local government shares, of medical assistance payments pursuant to title eleven of article five of the social services law based on the limitation of such payment pursuant to this subdivision 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 thirty-first, nineteen hundred ninety-six to reflect the amount by which such savings are in excess of or lower than one million five hundred thousand dollars. For rate periods on and after January first, two thousand five through December thirty-first, two thousand six, there shall be no such reconciliation of the amount of savings in excess of or lower than one million five hundred thousand dollars.

* NB Effective until March 31, 2025

* Notwithstanding any inconsistent provision of law or regulation to the contrary, for purposes of establishing rates of payment by governmental agencies for certified home health agencies and long term home health care programs for rate period beginning on or after January first, nineteen hundred ninety-five, the department of health may not by rule or regulation limit the reimbursable base year administrative and general costs of a provider of services to a percentage which is other than thirty percent of total reimbursable base year operational costs of such provider of services.

* NB Effective March 31, 2025

No such limit shall be applied to a provider of services reimbursed on an initial budget basis, or 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 a base year in determining rates of payment.

For the purposes of this subdivision, reimbursable base year operational costs shall mean those base year operational 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 provided by this subdivision shall be expressed as a percentage reduction for the rate promulgated by the commissioner to each certified home health agency and long term home health care program provider.

7-a. Notwithstanding any inconsistent provision of law or regulation, for the purposes of establishing rates of payment by governmental agencies for long term home health care programs for the period April first, two thousand five, through December thirty-first, two thousand five, and for the period January first, two thousand six through March thirty-first, two thousand seven, and on and after April first, two thousand seven through March thirty-first, two thousand nine, and on and after April first, two thousand nine through March thirty-first, two thousand eleven, and on and after April first, two thousand eleven through March thirty-first, two thousand thirteen and on and after April first, two thousand thirteen through March thirty-first, two thousand fifteen, and on and after April 1st, two thousand fifteen through March thirty-first, two thousand seventeen the reimbursable base year administrative and general costs of a provider of services shall not exceed the statewide average of total reimbursable base year administrative and general costs of such providers of services.

No such limit shall be applied to a provider of services reimbursed on an initial budget basis, or 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 a base year in determining rates of payment.

For the purposes of this subdivision, reimbursable base year operational costs shall mean those base year operational costs remaining after application of all other efficiency standards, including, but not limited to, cost guidelines.

The limitation on reimbursement for provider administrative and general expenses provided by this subdivision shall be expressed as a percentage reduction for the rate promulgated by the commissioner to

each long term home health care program provider.

8. (a) Notwithstanding any inconsistent provision of law, rule or regulation and subject to the provisions of paragraph (b) of this subdivision and to the availability of federal financial participation, the commissioner shall adjust medical assistance rates of payment for services provided by certified home health agencies for such services provided to children under eighteen years of age and for services provided to a special needs population of medically complex and fragile children, adolescents and young disabled adults by a CHHA operating under a pilot program approved by the department, long term home health care programs and AIDS home care programs in accordance with this paragraph and paragraph (b) of this subdivision 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.

(i) rates of payment by governmental agencies for certified home health agency services for such services provided to children under eighteen years of age and for services provided to a special needs population of medically complex and fragile children, adolescents and young disabled adults by a CHHA operating under a pilot program approved by the department (including services provided through contracts with licensed home care services agencies) shall be increased by three percent;

(ii) rates of payment by governmental agencies for long term home health care program services (including services provided through contracts with licensed home care services agencies) shall be increased by three percent; and

(iii) 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.

(b) (i) Providers which have their rates adjusted pursuant to this subdivision shall use such funds solely for the purposes of recruitment and retention of non-supervisory home care services workers or any worker with direct patient care responsibility. Such purposes shall include the recruitment and retention of non-supervisory home care services workers or any worker with direct patient care responsibility

employed in licensed home care services agencies under contract with such providers. Providers are prohibited from using such funds for any other purpose.

(ii) Each such provider shall submit, at a time and in a manner determined by the commissioner, a written certification attesting that such funds will be used solely for the purpose of recruitment and retention of non-supervisory home care services workers or any worker with direct patient care responsibility. The commissioner is authorized to audit each such provider to ensure compliance with the written certification required by this subdivision 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. Such recoupment shall be in addition to any other penalties provided by law.

(iii) In the case of services provided by such providers through contracts with licensed home care services agencies, rate increases received by such providers pursuant to this subdivision shall be reflected, consistent with the purposes of subparagraph (i) of this paragraph, 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 volume of services attributable to each contracted agency. Such agencies shall submit to providers with which they contract written certifications attesting that such funds will be used solely for the purposes of recruitment and retention of non-supervisory home care services workers or any worker with direct patient care responsibility and shall maintain in their files expenditure plans specifying how such funds will be used for such purposes. The commissioner is authorized to audit such agencies to ensure compliance with such certifications and expenditure plans and shall recoup any funds determined to have been used for purposes other than those set forth in this subdivision. Such recoupment will be in addition to any other penalties provided by law.

(iv) Funds under this subdivision are not intended to supplant support provided by local government.

9. Notwithstanding any law to the contrary, the commissioner shall, subject to the availability of federal financial participation, adjust

medical assistance rates of payment for certified home health agencies for such services provided to children under eighteen years of age and for services provided to a special needs population of medically complex and fragile children, adolescents and young disabled adults by a CHHA operating under a pilot program approved by the department, long term home health care programs, AIDS home care programs established pursuant to this article, hospice programs established under article forty of this chapter and for managed long term care plans and approved managed long term care operating demonstrations as defined in section forty-four hundred three-f of this chapter. Such adjustments shall be for purposes of improving recruitment, training and retention of home health aides or other personnel with direct patient care responsibility in the following aggregate amounts for the following periods:

(a) for the period June first, two thousand six through December thirty-first, two thousand six, fifty million dollars;

(b) for the period January first, two thousand seven through June thirtieth, two thousand seven, fifty million dollars;

(c) for the period July first, two thousand seven through March thirty-first, two thousand eight, up to one hundred million dollars;

(d) for the period April first, two thousand eight through March thirty-first, two thousand nine, up to one hundred million dollars;

(e) for the period April first, two thousand nine through March thirty-first, two thousand ten, up to one hundred million dollars;

(f) for the period April first, two thousand ten through March thirty-first, two thousand eleven, up to one hundred million dollars;

(g) for the period April first, two thousand eleven through March thirty-first, two thousand twelve, up to one hundred million dollars;

(h) for the period April first, two thousand twelve through March thirty-first, two thousand thirteen, up to one hundred million dollars;

(i) for the period April first, two thousand thirteen through March thirty-first, two thousand fourteen, up to one hundred million dollars;

(j) for the period April first, two thousand fourteen through March

thirty-first, two thousand fifteen, up to one hundred million dollars;

(k) for the period April first, two thousand fifteen through March thirty-first, two thousand sixteen, up to one hundred million dollars;

(l) for the period April first, two thousand sixteen through March thirty-first, two thousand seventeen, up to one hundred million dollars;

(m) for the period April first, two thousand seventeen through March thirty-first, two thousand eighteen, up to one hundred million dollars;

(n) for the period April first, two thousand eighteen through March thirty-first, two thousand nineteen, up to one hundred million dollars;

(o) for the period April first, two thousand nineteen through March thirty-first, two thousand twenty, up to one hundred million dollars;

(p) for the period April first, two thousand twenty through March thirty-first, two thousand twenty-one, up to one hundred million dollars;

(q) for the period April first, two thousand twenty-one through March thirty-first, two thousand twenty-two, up to one hundred million dollars;

(r) for the period April first, two thousand twenty-two through March thirty-first, two thousand twenty-three, up to one hundred million dollars;

(s) for the period April first, two thousand twenty-three through March thirty-first, two thousand twenty-four, up to one hundred million dollars;

(t) for the period April first, two thousand twenty-four through March thirty-first, two thousand twenty-five, up to one hundred million dollars;

(u) for the period April first, two thousand twenty-five through March thirty-first, two thousand twenty-six, up to one hundred million dollars.

10. (a) Such adjustments to rates of payments shall be allocated

proportionally based on each certified home health agency, long term home health care program, AIDS home care and hospice program's home health aide or other direct care services total annual hours of service provided to medicaid patients, as reported in each such agency's most recently available cost report as submitted to the department or for the purpose of the managed long term care program a suitable proxy developed by the department in consultation with the interested parties. Payments made pursuant to this section shall not be subject to subsequent adjustment or reconciliation; provided that such adjustments to rates of payments to certified home health agencies shall only be for that portion of services provided to children under eighteen years of age and for services provided to a special needs population of medically complex and fragile children, adolescents and young disabled adults by a CHHA operating under a pilot program approved by the department.

(b) Programs which have their rates adjusted pursuant to this subdivision shall use such funds solely for the purposes of recruitment, training and retention of non-supervisory home care services workers or other personnel with direct patient care responsibility. Such purpose shall include the recruitment, training and retention of non-supervisory home care services workers or any worker with direct patient care responsibility employed in licensed home care services agencies under contract with such agencies. Such agencies are prohibited from using such fund for any other purpose. For purposes of the long term home health care program, such payment shall be treated as supplemental payments and not effect any current cost cap requirement. Each such agency shall submit, at a time and in a manner determined by the commissioner, a written certification attesting that such funds will be used solely for the purpose of recruitment, training and retention of non-supervisory home health aides or any personnel with direct patient care responsibility. The commissioner is authorized to audit each such agency or program to ensure compliance with the written certification required by this subdivision and shall recoup any funds determined to have been used for purposes other than recruitment and retention of non-supervisory home health aides or other personnel with direct patient care responsibility. Such recoupment shall be in addition to any other penalties provided by law.

(c) In the case of services provided by such agencies or programs through contracts with licensed home care services agencies, rate increases received by such agencies or programs pursuant to this subdivision shall be reflected, consistent with the purposes of this

subdivision, in either the fees paid or benefits or other supports, including training, provided to non-supervisory home health aides or any other personnel 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 volume of services attributable to each contracted agency. Such agencies or programs shall submit to providers with which they contract written certifications attesting that such funds will be used solely for the purposes of recruitment, training and retention of non-supervisory home health aides or other personnel with direct patient care responsibility and shall maintain in their files expenditure plans specifying how such funds will be used for such purposes. The commissioner is authorized to audit such agencies or programs to ensure compliance with such certifications and expenditure plans and shall recoup any funds determined to have been used for purposes other than those set forth in this subdivision. Such recoupment shall be in addition to any other penalties provided by law.

(d) Funds under this subdivision are not intended to supplant support provided by local government.

11. (a) Notwithstanding any inconsistent provision of law, rule or regulation and subject to the availability of federal financial participation, the commissioner is authorized and directed to implement a program whereby he or she shall adjust medical assistance rates of payment for services provided by certified home health agencies, long term home health care programs, AIDS home care programs and providers of personal care services and/or providers of private duty nursing services under the social services law in accordance with this subdivision for purposes of enhancing the provision, accessibility, quality and/or efficiency of home care services. Such rate adjustments shall be for the purposes of assisting such providers, located in social services districts which do not include a city with a population of over one million persons, in meeting the cost of:

(i) Increased use of technology in the delivery of services, including telehealth and clinical and administrative management information system;

(ii) Specialty training of direct service personnel in dementia care, pediatric care and/or the care of other conditions or populations with complex needs;

(iii) Increased auto and travel expenses associated with rising fuel prices, including the increased cost of providing services in remote areas; and/or

(iv) Providing enhanced access to care for high need populations;

(v) Such other purposes related to the provision of quality, accessible home care services as the commissioner may deem appropriate.

(b) The commissioner shall increase the medical assistance rates of payment pursuant to this subdivision in an amount up to an aggregate of sixteen million dollars for the period June first, two thousand six through March thirty-first, two thousand seven, and sixteen million dollars for the period April first, two thousand seven through March thirty-first, two thousand eight, and sixteen million dollars for the period April first, two thousand eight through March thirty-first, two thousand nine, provided however that if federal financial participation is not available for rate adjustments pursuant to this subdivision such aggregate amount shall not exceed eight million dollars, and provided, further, however, that for purposes of long term home health care programs, such payments provided pursuant to this subdivision shall be treated as supplemental payments and shall not effect any current cost cap requirement.

(c) Such rate adjustments shall be in the form of a uniform percentage add-on to the rates, as determined by the department, based on the proportion of the total allocated adjustment dollars, as determined in paragraph (b) of this subdivision, to the total medicaid expenditures for services provided for certified home health agencies, long-term home health care programs, AIDS nursing, personal care assistants and private duty nurses services in local social services districts which do not include a city with a population over one million.

12. (a) Notwithstanding any inconsistent provision of law or regulation and subject to the availability of federal financial participation, effective on and after April first, two thousand eleven through March thirty-first, two thousand twelve, rates of payment by government agencies for services provided by certified home health agencies, except for such services provided to children under eighteen years of age and other discrete groups as may be determined by the commissioner pursuant to regulations, shall reflect ceiling limitations

determined in accordance with this subdivision, provided, however, that at the discretion of the commissioner such ceilings may, as an alternative, be applied to payments for services provided on and after April first, two thousand eleven, except for such services provided to children and other discrete groups as may be determined by the commissioner pursuant to regulations. In determining such payments or rates of payment, agency ceilings shall be established. Such ceilings shall be applied to payments or rates of payment for certified home health agency services as established pursuant to this section and applicable regulations. Ceilings shall be based on a blend of: (i) an agency's two thousand nine average per patient Medicaid claims, weighted at a percentage as determined by the commissioner; and (ii) the two thousand nine statewide average per patient Medicaid claims adjusted by a regional wage index factor and an agency patient case mix index, weighted at a percentage as determined by the commissioner. Such ceilings will be effective April first, two thousand eleven through March thirty-first, two thousand twelve. An interim payment or rate of payment adjustment effective April first, two thousand eleven, shall be applied to agencies with projected average per patient Medicaid claims, as determined by the commissioner, to be over their ceilings. Such agencies shall have their payments or rates of payment reduced to reflect the amount by which such claims exceed their ceilings.

(b) Ceiling limitations determined pursuant to paragraph (a) of this subdivision shall be subject to reconciliation. In determining payment or rate of payment adjustments based on such reconciliation, adjusted agency ceilings shall be established. Such adjusted ceilings shall be based on a blend of: (i) an agency's two thousand nine average per patient Medicaid claims adjusted by the percentage of increase or decrease in such agency's patient case mix from the two thousand nine calendar year to the annual period April first, two thousand eleven through March thirty-first, two thousand twelve, weighted at a percentage as determined by the commissioner; and (ii) the two thousand nine statewide average per patient Medicaid claims adjusted by a regional wage index factor and the agency's patient case mix index for the annual period April first, two thousand eleven through March thirty-first, two thousand twelve, weighted at a percentage as determined by the commissioner. Such adjusted agency ceiling shall be compared to actual Medicaid paid claims for the period April first, two thousand eleven through March thirty-first, two thousand twelve. In those instances when an agency's actual per patient Medicaid claims are determined to exceed the agency's adjusted ceiling, the amount of such

excess shall be due from each such agency to the state and may be recouped by the department in a lump sum amount or through reductions in the Medicaid payments due to the agency. In those instances where an interim payment or rate of payment adjustment was applied to an agency in accordance with paragraph (a) of this subdivision, and such agency's actual per patient Medicaid claims are determined to be less than the agency's adjusted ceiling, the amount by which such Medicaid claims are less than the agency's adjusted ceiling shall be remitted to each such agency by the department in a lump sum amount or through an increase in the Medicaid payments due to the agency.

(c) Interim payment or rate of payment adjustments pursuant to this subdivision shall be based on Medicaid paid claims, as determined by the commissioner, for services provided by agencies in the base year two thousand nine. Amounts due from reconciling rate adjustments shall be based on Medicaid paid claims, as determined by the commissioner, for services provided by agencies in the base year two thousand nine and Medicaid paid claims, as determined by the commissioner, for services provided by agencies in the reconciliation period April first, two thousand eleven through March thirty-first, two thousand twelve. In determining case mix, each patient shall be classified using a system based on measures which may include, but not be limited to, clinical and functional measures, as reported on the federal Outcome and Assessment Information Set (OASIS), as may be amended.

(d) The commissioner may require agencies to collect and submit any data required to implement the provisions of this subdivision. The commissioner may promulgate regulations to implement the provisions of this subdivision.

(e) Payments or rate of payment adjustments determined pursuant to this subdivision shall, for the period April first, two thousand eleven through March thirty-first, two thousand twelve, be retroactively reconciled utilizing the methodology in paragraph (b) of this subdivision and utilizing actual paid claims from such period.

(f) Notwithstanding any inconsistent provision of this subdivision, payments or rate of payment adjustments made pursuant to this subdivision shall not result in an aggregate annual decrease in Medicaid payments to providers subject to this subdivision that is in excess of two hundred million dollars, as determined by the commissioner and not subject to subsequent adjustment, and the commissioner shall make such

adjustments to such payments or rates of payment as are necessary to ensure that such aggregate limits on payment decreases are not exceeded.

13. (a) Notwithstanding any inconsistent provision of law or regulation and subject to the availability of federal financial participation, effective April first, two thousand twelve through March thirty-first, two thousand twenty-nine, payments by government agencies for services provided by certified home health agencies, except for such services provided to children under eighteen years of age and other discreet groups as may be determined by the commissioner pursuant to regulations, shall be based on episodic payments. In establishing such payments, a statewide base price shall be established for each sixty day episode of care and adjusted by a regional wage index factor and an individual patient case mix index. Such episodic payments may be further adjusted for low utilization cases and to reflect a percentage limitation of the cost for high-utilization cases that exceed outlier thresholds of such payments.

(b) Initial base year episodic payments shall be based on Medicaid paid claims, as determined and adjusted by the commissioner to achieve savings comparable to the prior state fiscal year, for services provided by all certified home health agencies in the base year two thousand nine. Subsequent base year episodic payments may be based on Medicaid paid claims for services provided by all certified home health agencies in a base year subsequent to two thousand nine, as determined by the commissioner, provided, however, that such base year adjustment shall be made not less frequently than every three years. In determining case mix, each patient shall be classified using a system based on measures which may include, but not limited to, clinical and functional measures, as reported on the federal Outcome and Assessment Information Set (OASIS), as may be amended.

(c) The commissioner may require agencies to collect and submit any data required to implement this subdivision. The commissioner may promulgate regulations to implement the provisions of this subdivision.

14. (a) Notwithstanding any contrary provision of law and subject to the availability of federal financial participation, for periods on and after March first, two thousand fourteen the commissioner shall adjust Medicaid rates of payment for services provided by certified home health agencies to address cost increases stemming from the wage increases required by implementation of the provisions of section thirty-six

hundred fourteen-c of this article. Such rate adjustments shall be based on a comparison, as determined by the commissioner, of the hourly compensation levels for home health aides and personal care aides as reflected in the existing Medicaid rates for certified home health agencies to the hourly compensation levels incurred as a result of complying with the provisions of section thirty-six hundred fourteen-c of this article.

(b) Notwithstanding any contrary provision of law and subject to the availability of federal financial participation, for periods on and after March first, two thousand fourteen the commissioner shall adjust Medicaid rates of payment for services provided by long term home health care programs to address cost increases stemming from the wage increases required by implementation of the provisions of section thirty-six hundred fourteen-c of this article. Such rate adjustments shall be based on a comparison, as determined by the commissioner, of the hourly compensation levels for home health aides and personal care aides as reflected in the existing Medicaid rates for long term home health care programs to the hourly compensation levels incurred as a result of complying with the provisions of section thirty-six hundred fourteen-c of this article.