**§ 2808. Residential health care facilities; rates of payment.**

1-a. Notwithstanding sections one hundred twelve and one hundred sixty-three of the state finance law and any other inconsistent provision of law, the commissioner shall make grants to public residential health care facilities without a competitive bid or request for proposal process for the purposes of addressing the overall increases in input costs borne by such facilities. Such modifications shall also be primarily intended to promote the provision of quality health care, quality operation, updated technology and improved staff development and support by such facilities. Such grants shall be in the following aggregate amounts for the following periods: five million for the period April first, two thousand six through March thirty-first, two thousand seven; fifteen million for the period April first, two thousand seven through March thirty-first, two thousand eight; and ten million for the period April first, two thousand eight through March thirty-first, two thousand nine.

The amount allocated to each eligible public residential health care facility for each period shall be calculated as the result of (i) the total payment for each period multiplied by (ii) the ratio of patient days for patients eligible for medical assistance pursuant to title eleven of article five of the social services law provided by the public residential health care facility, divided by the total of such patient days summed for all eligible public residential health care facilities. Grants under this subdivision shall be made on a quarterly basis.

* 2. (a) The commissioner, with the approval of the state hospital review and planning council, shall promulgate regulations to be effective the first day of January, nineteen hundred seventy-eight, relating the rate of payment for each residential health care facility to real property costs.

(b) Such regulations may differentiate based upon the form of ownership of the facility, and shall provide for consideration of such factors as the age, size, location and condition of the facility.

(c) For facilities granted operating certificates prior to March tenth, nineteen hundred seventy-five, the real property costs shall be computed upon a cost valuation basis of the facility as determined by

the commissioner, who, subject to the approval of the director of the budget, may provide exceptions in circumstances where he finds that application of the regulations would result in excessive reimbursement or in severe economic hardship to the facility not caused by circumstances reasonably under the control of the facility.

(d) For facilities granted operating certificates on or after March tenth, nineteen hundred seventy-five, recognition of real property costs in such regulations shall be based upon historical costs to the owner of the facility, provided that payment for real property costs shall not be in excess of the actual debt service, including principal and interest, and payment with respect to owner's equity. For purposes of this subdivision, owner's equity shall be calculated without regard to any surplus created by revaluation of assets and shall not include amounts resulting from mortgage amortization where the payment therefor has been provided by real property cost reimbursement.

(e) All transactions, including leases and mortgages, which are not bona fide and reasonable shall be disregarded.

* NB Expired December 31, 1978

2-a. (a) The commissioner, with the approval of the state hospital review and planning council, shall promulgate regulations to be effective the first day of January, nineteen hundred seventy-nine, relating the rate of payment for each residential health care facility to real property costs.

(b) Such regulations may differentiate based upon the form of ownership of the facility, and shall provide for consideration of such factors as the age, size, location and condition of the facility.

(c) For facilities granted operating certificates prior to March tenth, nineteen hundred seventy-five, the real property costs shall be computed upon a cost valuation basis of the facility as determined by the commissioner, who, subject to the approval of the director of the budget, may provide exceptions in circumstances where he finds that application of the regulations would result in excessive reimbursement or in severe economic hardship to the facility not caused by circumstances reasonably under the control of the facility.

* (d) For facilities granted operating certificates on or after March tenth, nineteen hundred seventy-five, recognition of real property costs

in such regulations shall be based upon historical costs to the owner of the facility, provided that payment for real property costs shall not be in excess of the actual debt service, including principal and interest, and payment with respect to owner's equity, and further provided that, subject to federal financial participation, and subject to the approval of the commissioner, effective April first, two thousand fifteen, the commissioner may modify such payments for real property costs for purposes of effectuating a shared savings program, whereby facilities share a minimum of fifty percent of savings, for facilities that elect to refinance their mortgage loans. For purposes of this subdivision, owner's equity shall be calculated without regard to any surplus created by revaluation of assets and shall not include amounts resulting from mortgage amortization where the payment therefor has been provided by real property cost reimbursement.

* NB Effective until March 31, 2030

* (d) For facilities granted operating certificates on or after March tenth, nineteen hundred seventy-five, recognition of real property costs in such regulations shall be based upon historical costs to the owner of the facility, provided that payment for real property costs shall not be in excess of the actual debt service, including principal and interest, and payment with respect to owner's equity. For purposes of this subdivision, owner's equity shall be calculated without regard to any surplus created by revaluation of assets and shall not include amounts resulting from mortgage amortization where the payment therefor has been provided by real property cost reimbursement.

* NB Effective March 31, 2030

(e) All transactions, including leases and mortgages, which are not bona fide and reasonable shall be disregarded.

2-b. Notwithstanding any inconsistent provision of this section, or any other contrary provision of law and subject to the availability of federal financial participation, the operating cost component of rates of payment by governmental agencies for inpatient services provided on and after January first, two thousand seven by residential health care facilities shall be in accordance with the following:

(a) (i) Subject to the provisions of subparagraphs (ii) through (vi) of this paragraph, for the two thousand seven rate period the operating

cost component of rates of payment shall reflect the operating cost component of rates effective for October first, two thousand six, as adjusted for inflation in accordance with paragraph (c) of subdivision ten of section twenty-eight hundred seven-c of this article; and for the January first, two thousand eight through March thirty-first, two thousand nine rate period the operating cost component of rates of payment shall reflect the operating cost component of rates effective for December thirty-first, two thousand six, as adjusted for inflation in accordance with paragraph (c) of subdivision ten of section twenty-eight hundred seven-c of this article.

(ii) Rates for the periods two thousand seven and two thousand eight shall be further adjusted by a per diem add-on amount, as determined by the commissioner, reflecting the proportional amount of each facility's projected Medicaid benefit to the total projected Medicaid benefit for all facilities of the imputed use of the rate-setting methodology set forth in paragraph (b) of this subdivision, provided, however, that for those facilities that do not receive a per diem add-on adjustment pursuant to this subparagraph, rates shall be further adjusted to include the proportionate benefit, as determined by the commissioner, of the expiration of the opening paragraph and paragraph (a) of subdivision sixteen of this section and of paragraph (a) of subdivision fourteen of this section, provided, further, however, that the aggregate total of the rate adjustments made pursuant to this subparagraph shall not exceed one hundred thirty-seven million five hundred thousand dollars for the two thousand seven rate period and one hundred sixty-seven million five hundred thousand dollars for the two thousand eight rate period and provided further, however, that such rate adjustments as made pursuant to this subparagraph prior to two thousand twelve shall not be subject to subsequent adjustment or reconciliation.

(iii) Revisions to two thousand six rates occurring on and after January first, two thousand seven, shall be annually incorporated, retroactively and prospectively, into two thousand seven and two thousand eight rates on or about November thirtieth, two thousand seven and November thirtieth, two thousand eight, respectively.

(iv) The capital cost component of rates pursuant to this paragraph shall fully reflect the cost of local property taxes and payments made in lieu of local property taxes, as reported in each facility's cost

report submitted for the year two years prior to the rate year.

(v) Rates for the two thousand seven and two thousand eight rate periods, as computed pursuant to this paragraph, shall not be subject to case mix adjustment, provided, however, that a facility may, in accordance with its existing full house schedule of submission of patient review instruments, submit data in support of a request for a rate adjustment to reflect an increased facility case mix equal to or greater than .05, provided further, however, that such a facility will be required to continue to make such full house submissions in accordance with its existing submission schedule for rate periods up through December thirty-first, two thousand eight.

(vi) For the period January first, two thousand seven through December thirty-first, two thousand eight, notwithstanding any contrary provision of law or regulation, voluntary facilities shall not be required to deposit reimbursement received for depreciation expenses into a segregated depreciation fund account.

(b) (i) (A) Subject to the provisions of subparagraphs (ii) through (xiv) of this paragraph, for periods on and after April first, two thousand nine the operating cost component of rates of payment shall reflect allowable operating costs as reported in each facility's cost report for the two thousand two calendar year, as adjusted for inflation on an annual basis in accordance with the methodology set forth in paragraph (c) of subdivision ten of section twenty-eight hundred seven-c of this article, provided, however, that for those facilities which are determined by the commissioner to be qualifying facilities in accordance with the provisions of clause (B) of this subparagraph, rates shall be further adjusted to include the proportionate benefit, as determined by the commissioner, of the expiration of the opening paragraph and paragraph (a) of subdivision sixteen of this section and of paragraph (a) of subdivision fourteen of this section, and provided further that the operating cost component of rates of payment for those facilities which are determined by the commissioner to be qualifying facilities in accordance with the provisions of clause (B) of this subparagraph shall not be less than the operating component such facilities received in the two thousand eight rate period, as adjusted for inflation on an annual basis in accordance with the methodology set forth in paragraph (c) of subdivision ten of section twenty-eight hundred seven-c of this article

and further provided, however, that rates for facilities whose operating cost component reflects base year costs subsequent to January first, two thousand two shall have rates computed in accordance with this paragraph, utilizing allowable operating costs as reported in such subsequent base year period, and trended forward to the rate year in accordance with applicable inflation factors.

(B) For the purposes of this subparagraph qualifying facilities are those facilities for which the commissioner determines that their reported two thousand two base year operating cost component, as defined in accordance with the regulations of the department as set forth in 10 NYCRR 86-2.10(a)(7); is less than the operating component such facilities received in the two thousand eight rate period, as adjusted by applicable trend factors.

(ii) (A) The operating component of rates shall be subject to case mix adjustment through application of the relative resource utilization groups system of patient classification (RUG-III) employed by the federal government with regard to payments to skilled nursing facilities pursuant to title XVIII of the federal social security act (Medicare), as revised by regulation to reflect New York state wages and fringe benefits, provided, however, that such RUG-III classification system weights shall be increased in the following amounts for the following categories of residents: (1) thirty minutes for the impaired cognition A category, (2) forty minutes for the impaired cognition B category, and (3) twenty-five minutes for the reduced physical functions B category. Such adjustments shall be made in January and July of each calendar year. Such adjustments and related patient classifications in each facility shall be subject to audit review in accordance with regulations promulgated by the commissioner.

(B) Effective April first, two thousand twenty-four, the case mix adjustment from the operating component of the rates for skilled nursing facilities shall remain unchanged from the July two thousand twenty-three rates during the development and until full implementation of a case mix methodology using the Patient Driven Payment Model.

(iii) Specified adjustments to the operating component of rates in effect for periods prior to January first, two thousand nine, with regard to extended care for persons with traumatic brain injury and for the cost of providing hepatitis B vaccinations shall continue on and

after January first, two thousand nine.

(iv) The capital cost component of rates on and after January first, two thousand nine shall: (A) fully reflect the cost of local property taxes and payments made in lieu of local property taxes, as reported in each facility's cost report submitted for the year two years prior to the rate year; (B) provided, however, notwithstanding any inconsistent provision of this article, commencing April first, two thousand twenty for rates of payment for patients eligible for payments made by state governmental agencies, the capital cost component determined in accordance with this subparagraph and inclusive of any shared savings for eligible facilities that elect to refinance their mortgage loans pursuant to paragraph (d) of subdivision two-a of this section, shall be reduced by the commissioner by five percent; and (C) provided, however, notwithstanding any inconsistent provision of this article, commencing April first, two thousand twenty-four and ending March thirty-first, two thousand twenty-six for rates of payment for patients eligible for payments made by state governmental agencies, the capital cost component determined in accordance with this subparagraph and inclusive of any shared savings for eligible facilities that elect to refinance their mortgage loans pursuant to paragraph (d) of subdivision two-a of this section, shall be reduced by the commissioner by an additional ten percent, provided, however, that such reduction shall not apply to rates of payment for patients in pediatric residential health care facilities as defined in paragraph (c) of subdivision two of section twenty-eight hundred eight-e of this article.

(v) The direct component of the operating component of rates of payment shall include allowable direct therapy costs and associated overhead costs and shall exclude administrative overhead costs related to pharmacy services and the costs of non-prescription drugs and supplies, which shall be reflected in facility rates as non-comparable costs.

(vi) For purposes of computing peer group cost ceilings for the direct and indirect component of the operating component of rates, facilities shall be organized into peer groups consisting of: (A) free-standing facilities with certified bed capacities of less than three hundred beds; (B) free-standing facilities with certified bed capacities of three hundred beds or more; and (C) hospital based facilities.

(vii) In determining the operating cost component of rates, for each peer group, a corridor shall be developed around the statewide mean direct and indirect price per day, provided, however, that the corridor around each mean direct and indirect price per day shall have a base no less than eighty-five percent and no greater than ninety percent of each mean direct and indirect price per day and a ceiling no greater than one hundred fifteen percent and no less than one hundred ten percent of each mean direct and indirect price per day, and further provided, however, that the total financial impact of the application of the ceiling shall be substantially equal to the total financial impact of the application of the base.

(viii) The operating component of rates shall be adjusted to reflect a per diem add-on amount of eight dollars, trended forward to reflect applicable inflation factors from two thousand six to two thousand nine and prospectively thereafter, for each patient who: (A) qualifies under both the RUG-III impaired cognition and the behavioral problems categories, or (B) has been diagnosed with Alzheimer's disease or dementia, is classified in the reduced physical functions A, B or C, or in behavioral problems A or B categories, and has an activities of daily living index score of ten or less.

(ix) The operating component of rates shall be adjusted to reflect a per diem add-on amount of seventeen dollars, trended forward to reflect applicable inflation factors from two thousand six to two thousand nine and prospectively thereafter, for each patient whose body mass index is greater than thirty-five.

(x) For periods on and after January first, two thousand nine, notwithstanding any contrary provision of law or regulation, voluntary facilities shall not be required to deposit reimbursement received for depreciation expenses into a segregated depreciation fund account.

(xi) Public facilities, and non-public facilities with fewer than eighty certified beds, which have a facility specific direct adjusted payment price per day equal to the ceiling direct price per day shall have such direct adjusted payment price per day further adjusted through the addition of fifty percent of the difference between the facility's specific direct cost per day and the ceiling direct price per day. Public facilities, and non-public facilities with fewer than eighty certified beds, which have a facility specific indirect adjusted payment

price per day equal to the ceiling indirect price per day shall have such indirect adjusted payment price per day further adjusted through the addition of fifty percent of the difference between the facility's specific indirect cost per day and the ceiling indirect price per day. Such adjustments to direct and indirect adjusted payment prices per day shall be increased to the rate year by application of the applicable inflation factor and adjusted by the regional direct and indirect input price adjustment factors calculated pursuant to subdivision seventeen of this section.

(xii) Public facilities shall receive rates that are consistent with the provisions of this paragraph, provided, however, that in no event shall such rates, in aggregate, exceed the amount permitted under federal upper payment limits applicable to public facilities. In the event such public facilities are, pursuant to this subparagraph, subject to limitations on such rates, the commissioner shall make grants from state funds to such facilities equal to one-half of the additional amount that such facilities would have received if such limitations had not been applied.

(xiii) The appointment of a receiver or the establishment of a new operator or replacement or renovation of an existing facility on or after January first, two thousand seven shall not result in a revision to the operating component of the facility's rates for any rate period through December thirty-first, two thousand eleven, provided, however, that the provisions of this subparagraph shall not apply to a facility which has a certificate of need application filed with the department as of December thirty-first, two thousand six, which is subsequently approved and which otherwise meets existing department criteria for the establishment of a new base year for rate-setting purposes.

(xiv) The commissioner may promulgate regulations, including emergency regulations, to implement the provisions of this paragraph.

(c) In order to ensure that the quality of resident care is maintained and improved for rate periods on and after January first, two thousand seven, no less than sixty-five percent of the additional Medicaid reimbursement received by a residential health care facility that is attributable to the per-diem add-on amount received pursuant to subparagraph (ii) of paragraph (a) of this subdivision or, for rate periods on and after January first, two thousand nine, that is related

to utilization of two thousand two reported base year costs, as compared to the reimbursement each such facility would have received had such facility's Medicaid reimbursement rates continued to reflect base year costs used with regard to such facility's two thousand six rates, shall be allocated for the purpose of recruitment and retention of non-supervisory workers or any worker with direct resident care responsibility or for purposes authorized under the nursing home quality improvement demonstration program as established by section twenty-eight hundred eight-d of this article, provided, however, in no circumstance shall facilities be required to spend more than seventy-five percent of such funds for these purposes, and provided further, the commissioner is authorized to audit each such facility for the purpose of ensuring compliance with the provisions of this paragraph and shall recoup any amount determined to have been in contravention of the requirements of this paragraph, provided, however, that, upon application of a facility, the commissioner may, after determining that other funds are not available, waive the application of this paragraph insofar as it is determined by the commissioner that additional funds must be expended by such facility to correct deficiencies that constitute a threat to resident safety.

(d) Cost reports submitted by residential health care facilities for the two thousand two calendar year or any part thereof shall, notwithstanding any contrary provision of law, be subject to audit through December thirty-first, two thousand eighteen and facilities shall retain for the purpose of such audits all fiscal and statistical records relevant to such cost reports, provided, however, that any such audit commenced on or before December thirty-first, two thousand eighteen, may be completed and used for the purpose of adjusting any Medicaid rates which utilize such costs.

(e) For rate periods subsequent to two thousand nine which utilize reported costs from a base year subsequent to two thousand two, the following categories of facilities, as established pursuant to applicable regulations, shall receive rates that are no less than equivalent, as determined by the commissioner, to the rates that were in effect for such facilities on December thirty-first, two thousand six, trended forward for inflation to the applicable rate period: (A) AIDS facilities or discrete AIDS units within facilities, (B) discrete units

for residents receiving care in a long term inpatient rehabilitation program for traumatic brain injured persons, (C) discrete units for long term ventilator dependent residents, (D) discrete units providing specialized programs for residents requiring behavioral interventions, and (E) facilities or discrete units within facilities that provide extensive nursing, medical, psychological and counseling support services solely to children.

(f) The operating component of Medicaid rates of payment shall, by no later than the two thousand twelve rate period, be based on allowable costs, as reported on annual facility cost reports, from a base year period no earlier than three years prior to the initial rate year, and then trended forward by applicable inflation factors. Thereafter, the base year utilized for rate-setting purposes shall be updated to be current no less frequently than every six years provided, however, that for the purposes of this paragraph, current shall mean that the operating components of the initial rate year utilizing such updated base year shall reflect allowable costs as reported in annual facility cost reports for periods no earlier than three years prior to such initial rate year and then trended forward to the rate year in accordance with applicable inflation factors.

(g) Notwithstanding any contrary provision of this subdivision or any other contrary provision of law, rule or regulation, rates of payment for inpatient services provided on and after April first, two thousand nine by residential health care facilities shall, except for the establishment of any statewide or any peer group base, mean or ceiling prices per day, be calculated utilizing only the number of patients properly assessed and reported in each patient classification group and eligible for medical assistance pursuant to title eleven of article five of the social services law.

(h) Notwithstanding any contrary provision of law and subject to the availability of federal financial participation, for the period April first, two thousand eleven through June thirtieth, two thousand eleven, the non-capital components of rates shall be subject to a uniform percentage reduction sufficient to reduce such rates by an aggregate amount of twenty-seven million one hundred thousand dollars, and provided further, however, that such reductions shall be disregarded in computations made pursuant to section two of part D of chapter

fifty-eight of the laws of two thousand nine, as amended.

2-c. (a) Notwithstanding any inconsistent provision of this section or any other contrary provision of law and subject to the availability of federal financial participation, the non-capital component of rates of payment by governmental agencies for inpatient services provided by residential health care facilities on or after October first, two thousand eleven, but no later than January first, two thousand twelve, shall reflect a direct statewide price component, and indirect statewide price component, and a facility specific non-comparable component, utilizing allowable operating costs for a base year as determined by the commissioner by regulation. Such rate components shall be periodically updated to reflect changes in operating costs.

(b) The direct and indirect statewide price components shall be adjusted by a wage equalization factor and such other factors as determined to be appropriate to recognize legitimate cost differentials and the direct statewide price component shall be subject to a case mix adjustment utilizing the patients that are eligible for medical assistance pursuant to title eleven of article five of the social services law. Such wage equalization factor shall be periodically updated to reflect current labor market conditions.

(c) The non-capital component of the rates for: (i) AIDS facilities or discrete AIDS units within facilities; (ii) discrete units for residents receiving care in a long-term inpatient rehabilitation program for traumatic brain injured persons; (iii) discrete units providing specialized programs for residents requiring behavioral interventions; (iv) discrete units for long-term ventilator dependent residents; and (v) facilities or discrete units within facilities that provide extensive nursing, medical, psychological and counseling support services solely to children shall reflect the rates in effect for such facilities on January first, two thousand nine, as adjusted for inflation and rate appeals in accordance with applicable statutes, provided, however, that such rates for facilities described in subparagraph (i) of this paragraph shall reflect the application of the provisions of section twelve of part D of chapter fifty-eight of the laws of two thousand nine, and provided further, however, that insofar as such rates reflect trend adjustments for trend factors attributable

to the two thousand eight and two thousand nine calendar years the aggregate amount of such trend factor adjustments shall be subject to the provisions of section two of part D of chapter fifty-eight of the laws of two thousand nine, as amended.

(d) The commissioner shall promulgate regulations, and may promulgate emergency regulations, to implement the provisions of this subdivision. Such regulations shall be developed in consultation with the nursing home industry and advocates for residential health care facility residents and, further, the commissioner shall provide notification concerning such regulations to the chairs of the senate and assembly health committees, the chair of the senate finance committee and the chair of the assembly ways and means committee. Such regulations shall include provisions for rate adjustments or payment enhancements to facilitate a minimum four-year transition of facilities to the rate-setting methodology established by this subdivision and may also include, but not be limited to, provisions for facilitating quality improvements in residential health care facilities. For purposes of facilitating quality improvements through the establishment of a nursing home quality pool to be funded at the discretion of the commissioner by (i) adjustments in medical assistance rates, (ii) funds made available through state appropriations, or (iii) a combination thereof, those facilities that contribute to the quality pool, but are deemed ineligible for quality pool payments due exclusively to a specific case of employee misconduct, shall nevertheless be eligible for a quality pool payment if the facility properly reported the incident, did not receive a survey citation from the commissioner or the Centers for Medicare and Medicaid Services establishing the facility's culpability with regard to such misconduct and, but for the specific case of employee misconduct, the facility would have otherwise received a quality pool payment. Regulations pertaining to the facilitation of quality improvement may be made effective for periods on and after January first, two thousand thirteen.

(e) With the exception of those enrollees covered under a payment rate methodology agreement negotiated with a residential health care facility, payments for inpatient residential health care facility services provided to patients eligible for medical assistance pursuant to title eleven of article five of the social services law made by

organizations operating in accordance with the provisions of article forty-four of this chapter or by health maintenance organizations organized and operating in accordance with article forty-three of the insurance law, shall be the rates of payment that would be paid for such patients under the medical assistance program as determined pursuant to this section and subdivision ten of section twenty-eight hundred seven-d of this article and as in effect at the time such services were provided. The provisions of this paragraph shall not apply to payments for patients whose placement in a residential health care facility is for the purpose of receiving time-limited rehabilitation, to be followed by discharge from the facility, during the period such time-limited services are provided.

(f) The commissioner shall establish a prospective per diem adjustment for all nursing homes, other than nursing homes providing services primarily to children under the age of twenty-one, beginning April first, two thousand seventeen and each year thereafter sufficient to achieve eighteen million dollars in savings in each state fiscal year.

* (g) Notwithstanding any other provision of law or regulation to the contrary, any residential health care facility established pursuant to this article located in a county with a population of more than seventy-two thousand and less then seventy-five thousand persons based on the two thousand ten federal census, and operating between one hundred ten and one hundred thirty beds, being reimbursed by the department on a fee-for-services basis, shall be reimbursed at a rate of no less than one hundred seventeen percent of the fee-for-service rate of reimbursement calculated pursuant to this section for that facility for inpatient services provided on or after March first, two thousand eighteen.

* NB There are 2 par (g)'s

* (g) The commissioner shall reduce Medicaid revenue to a residential health care facility in a payment year by two percent if in each of the two most recent payment years for which New York state nursing home quality initiative data is available, the facility was ranked in the lowest two quintiles of facilities based on its nursing home quality initiative performance, and was ranked in the lowest quintile in the most recent payment year. The commissioner shall waive the application of this paragraph to a facility if the commissioner determines that the

facility is in financial distress.

* NB There are 2 par (g)'s

2-d. Residential health care facility supplemental payments. Notwithstanding any inconsistent provision of law, rule or regulation and subject to the availability of federal financial participation, for the period May first, two thousand eleven through May thirty-first, two thousand eleven, the commissioner shall adjust inpatient medicaid rates of payment established pursuant to this article for eligible residential health care facilities in accordance with the following:

(a) Rate adjustments made pursuant to this subdivision shall be in the form of rate add-ons and shall not exceed an aggregate amount of two hundred twenty-one million three hundred thousand dollars.

(b) Eligible facilities are those facilities which the commissioner determines have experienced a net reduction in their inpatient Medicaid reimbursement for the period April first, two thousand nine through March thirty-first, two thousand eleven as a result of the following:

(i) inpatient rate adjustments made pursuant to paragraph (b) of subdivision two-b of this section;

(ii) use of the case mix methodology described in paragraph (g) of subdivision two-b of this section;

(iii) inpatient rate adjustments made pursuant to section two of part D of chapter fifty-eight of the laws of two thousand nine, as amended.

(c) The following eligible facilities shall receive rate adjustments pursuant to this subdivision equal to one hundred percent of their net reimbursement reduction as computed by the commissioner in accordance with paragraph (b) of this subdivision:

(i) facilities that have been determined by the commissioner as being eligible for distributions of amounts available for the two thousand nine period as provided in subdivision twenty-one of this section;

(ii) non-public facilities whose total operating losses equal or exceed five percent of total operating revenue and whose medicaid utilization equals or exceeds seventy percent, based on either their two thousand nine cost report or based on the otherwise most recently available cost report, as determined by the commissioner;

(iii) facilities or distinct units of facilities providing inpatient services primarily to children under the age of twenty-one.

(d) Eligible facilities, other than eligible facilities described in paragraph (c) of this subdivision, shall receive rate adjustments pursuant to this subdivision equal to fifty percent of their net reimbursement reduction as computed by the commissioner in accordance with paragraph (b) of this subdivision.

(e) Eligible facilities as described in paragraph (d) of this subdivision which, as determined by the commissioner, after application of the rate adjustments authorized by paragraph (d) of this subdivision, remain subject to a net reduction in their inpatient Medicaid revenue that is in excess of two percent, as measured with regard to the non-capital components of facility inpatient rates in effect on March thirty-first, two thousand nine as computed prior to the application of trend factor adjustments attributable to the two thousand eight and two thousand nine calendar years, shall have their rates further adjusted such that such net reduction does not exceed such two percent.

(f) Eligible facilities as described in paragraph (d) of this subdivision which, as determined by the commissioner, have experienced a net reduction in their inpatient rates of more than six million dollars as a result of the application of the factor described in subparagraph (iii) of paragraph (b) of this subdivision shall after application of the provisions of paragraph (e) of this subdivision, have their rates further adjusted such that any such net reduction remaining after the application of the other provisions of this subdivision is reduced to zero.

(g) In computing net reductions of medicaid reimbursement pursuant to paragraph (b) of this subdivision the commissioner shall:

(i) disregard the impact of case mix adjustments as otherwise scheduled for July first, two thousand ten; and,

(ii) disregard the impact of any rate adjustments issued on or after January first, two thousand eleven, including adjustments to rate periods prior to January first, two thousand eleven.

(h) Payments made pursuant to this subdivision shall not be subject to subsequent adjustment or reconciliation and, further, the computation and application of limitations on medicaid rates of payment as described in section two of part D of chapter fifty-eight of the laws of two thousand nine, as amended, and as applicable to the rate periods described in paragraph (a) of this subdivision, shall disregard payments

made pursuant to this subdivision.

(i) Additional rate adjustments shall be made pursuant to this subdivision to eligible facilities in the form of rate add-ons for the period May first, two thousand eleven through May thirty-first, two thousand eleven which shall in aggregate be equal to twenty-five percent of the aggregate amount described in paragraph (a) of this subdivision and which shall be distributed to each eligible facility in the same proportion as the total distributions otherwise received by each facility pursuant to this subdivision.

(j) The commissioner may, with the approval of the director of the budget, and subject to the identification of sufficient nursing home related medicaid savings to offset the expenditures authorized by this paragraph, make additional rate adjustments pursuant to this subdivision to eligible facilities in the form of rate add-ons for the period December first, two thousand eleven through December thirty-first, two thousand eleven which shall in aggregate be equal to twelve and five-tenths percent of the aggregate amount described in paragraph (a) of this subdivision and which shall be distributed to each eligible facility in the same proportion as the total distributions otherwise received by each facility pursuant to this subdivision.

3. The commissioner, with the approval of the state hospital review and planning council, shall promulgate regulations to be effective the first day of January, nineteen hundred seventy-eight, which shall relate the rate of payment to the efficient operation and program management of the facility, as well as to the quality of patient care provided by the facility. Such regulations shall be consistent with the requirements of subdivision three of section twenty-eight hundred seven of this chapter and with federal laws and regulations.

4. The commissioner, in determining and certifying to the director of the budget the rates of payment to residential health care facilities, shall exclude the following costs: (a) contributions or other payments to political parties, candidates or organizations; (b) direct or indirect costs incurred for advertising or promotion except as allowed by the commissioner; (c) costs incurred for the promotion or opposition, directly or indirectly, of the passage of bills or resolutions pending

before or passed by a legislative body of any jurisdiction; (d) costs which principally afford diversion, entertainment or amusement to their owners, operators or employees not properly related to patient care or treatment; (e) any penalty imposed by governmental agencies or courts, and the costs of policies obtained solely to insure against the imposition of such a penalty; and (f) costs incurred by the residential health care facility to obtain the security required under the provisions of section twenty-eight hundred nine of this chapter.

5. (a) Any operator withdrawing equity or assets from a hospital operated for profit so as to create or increase a negative net worth or when the hospital is in a negative net worth position, calculated without regard to any surplus created by revaluation of assets, must obtain the prior approval of the commissioner in accordance with regulations promulgated by the commissioner with the approval of the state hospital review and planning council. The commissioner shall make a determination to approve or disapprove a request for withdrawal of equity or assets under this subdivision within sixty days of the date of the receipt of such a request. Requests shall be made in a form acceptable to the department by certified or registered mail. In addition to any other remedy or penalty available under this chapter, and after opportunity for a hearing, the commissioner may require replacement of the withdrawn equity or assets and may impose a penalty for violation of the provisions of this subdivision, relating to withdrawing equity or assets, or the regulations promulgated thereunder, in an amount not to exceed ten percent of any amount withdrawn without prior approval. No facility shall enter into a real property mortgage or lease transaction without thirty days prior notice in writing to the commissioner.

(b) On and after April first, two thousand ten, no non-public residential health care facility may withdraw equity or transfer assets which in the aggregate exceed:

(i) three percent of such facility's total reported annual revenue for patient care services, based on the facility's most recently available reported data, without prior written notification to the commissioner; or

(ii) in the case of a residential health care facility which (1) over

the two immediately preceding successive quarters for which relevant data is available to the department, has been compliant with the minimum staffing level requirements prescribed by section twenty-eight hundred ninety-five-b of this chapter; (2) is not in the special focus facility program operated by the centers for medicare and Medicaid services or subject to a denial of payment for new admissions imposed by the centers for medicare and Medicaid services; and (3) has not been the subject of an enforcement action brought by the department or the centers for medicare and Medicaid services in the previous eighteen months that resulted in a finding of deficiency, five percent of such facility's total reported annual revenue for patient care services, based on the facility's most recently available reported data, without prior written notification to the commissioner. Notification shall be made in a form acceptable to the department by certified or registered mail.

(c) Notwithstanding any inconsistent provision of this subdivision, on and after April first, two thousand ten, no non-public residential health care facility, whether operated as a for-profit facility or as a not-for-profit facility, may withdraw equity or transfer assets which in the aggregate exceed:

(i) three percent of such facility's total reported annual revenue for patient care services, based on the facility's most recently available reported data, without the prior written approval of the commissioner; or

(ii) in the case of a residential health care facility which (1) over the two immediately preceding successive quarters for which relevant data is available to the department, has been compliant with the minimum staffing level requirements prescribed by section twenty-eight hundred ninety-five-b of this chapter; (2) is not in the special focus facility program operated by the centers for medicare and Medicaid services or subject to a denial of payment for new admissions imposed by the centers for medicare and Medicaid services; and (3) has not been the subject of an enforcement action brought by the department or the centers for medicare and Medicaid services in the previous eighteen months that resulted in a finding of deficiency, five percent of such facility's total reported annual revenue for patient care services, based on the facility's most recently available reported data, without prior written notification to the commissioner. The commissioner shall make a

determination to approve or disapprove a request for withdrawal of equity or assets under this subdivision within sixty days of the date of the receipt of a written request from the facility. Requests shall be made in a form acceptable to the department by certified or registered mail. In reviewing such requests the commissioner shall consider the facility's overall financial condition, any indications of financial distress, whether the facility is delinquent in any payment owed to the department, whether the facility has been cited for immediate jeopardy or substandard quality of care, and such other factors as the commissioner deems appropriate. In addition to any other remedy or penalty available under this chapter, and after opportunity for a hearing, the commissioner may require replacement of the withdrawn equity or assets and may impose a penalty for violation of the provisions of this subdivision in an amount not to exceed ten percent of any amount withdrawn without prior approval.

* 6. Prior to the approval by the state hospital review and planning council of any regulations promulgated pursuant to this section, the commissioner shall convene a public hearing, upon at least seven days notice, to consider the proposed regulations. The commissioner shall include a summary of the comments made at such hearing in a report to the state hospital review and planning council at the meeting at which it considers the regulations for approval.

* NB Expired December 31, 1985

* 7. The commissioner may assess an annual fee on each residential health care facility to be used to reimburse any first instance appropriation for the purpose of making payments to receivers pursuant to subdivision three of section twenty-eight hundred ten of this article. Such fee shall not exceed thirty dollars per bed certified pursuant to this article, and shall be a reimbursable expense for the purposes of determining rates of payment made by government agencies. The reimbursement rate for a facility must reflect the cost of the annual fee prior to requiring that the facility pay the fee. The commissioner shall seek to obtain federal approval to include such fee as a reimbursable expense for purposes of computing reimbursement rates pursuant to title XVIII of the federal social security act.

* NB (Effective pending Federal Law - Expired December 31, 1983)

8. Every lease or lease renewal executed on or after September first, nineteen hundred eighty-six between a landlord and the operator of a residential health care facility shall contain a provision terminating any interest the operator of such facility may have in any lease of premises used for the operation of such facility after the public health council has approved the establishment of a new operator. Nothing herein shall be construed to affect any interest such operator may have in any movable equipment located on the premises of the facility. In the event any lease or lease renewal executed on or after September first, nineteen hundred eighty-six fails to contain the termination provision required by this subdivision, the lease or lease renewal shall be deemed to be terminated upon the public health council approval of a new operator. The commissioner, the landlord, or the new operator shall be entitled to maintain a summary proceeding to recover possession of the real property in any court of competent jurisdiction upon such termination.

9. Trend factors. (a) The commissioner, in accordance with the methodology developed by the consultants pursuant to paragraph (b) of this subdivision, shall establish trend factors to project for the effect of inflation. The factors shall be applied to the appropriate portion of reimbursable costs of residential health care facilities. The methodology for developing the trend factor shall include the appropriate external price indicators and shall also include the data from major collective bargaining agreements as reported quarterly by the federal department of labor, bureau of labor statistics, for nonsupervisory employees.

(b) The methodology shall be developed by four independent consultants with expertise in health economics appointed by the commissioner pursuant to paragraph (b) of subdivision ten of section twenty-eight hundred seven-c of this chapter. On or about September first of each year following the effective date of this subdivision, the consultants shall provide to the commissioner and the council the methodology to be used to determine the trend factors for subsequent rate periods only, beginning with the nine month period commencing April first, nineteen hundred ninety-one and for subsequent twelve month periods commencing January first, nineteen hundred ninety-two and thereafter. The

commissioner shall monitor the actual price movements during these periods of the external price indicators used in the methodology, shall report the results of the monitoring to the consultants and shall implement the recommendations of the consultants for one prospective interim annual adjustment to the trend factors to reflect such price movements and to be effective on January first, one year after the initial trend factor was established and one prospective final annual adjustment to the trend factors to reflect such price movements and to be effective on January first, two years after the initial trend factor was established.

11. Residential health care facility reimbursement rate promulgation. With regard to a residential health care facility, the provisions of subdivision seven of section twenty-eight hundred seven of this article relating to advance notification of rates shall not apply to prospective or retroactive adjustments to rates that are based on rate appeals filed by such facility, audits, changes in patient conditions or acuity levels, the correction of errors or omissions of data or errors in the computations of such rates, the submission of cost report data from facilities without an established cost basis, the judicial annulment or invalidation of existing rates or changes in the methodology used to compute rates which changes are promulgated following the judicial annulment or invalidation of existing rates or as otherwise authorized by law. Notwithstanding any inconsistent provision of law or regulation, as of April first, two thousand nine, with regard to administrative rate appeals, the department will only review such appeals for (a) the correction of computational errors or omissions of data by the department in determining the operating rate based upon the information provided to the department prior to the computation of the rate, (b) capital cost reimbursement, or (c) such reasons as the commissioner determines are appropriate. The department will not consider any revisions made to a facility's annual cost report for operating rate adjustment purpose later than the due date established by the commissioner.

12. (a) Notwithstanding any inconsistent provision of law or regulation, the commissioner shall increase rates of payment established

pursuant to this article for non-state operated public residential health care facilities in an aggregate amount not to exceed one hundred million dollars in additional reimbursement for payments for services provided during the period July first, nineteen hundred ninety-five through March thirty-first, nineteen hundred ninety-six. The commissioner may adopt rules and regulations necessary to implement this paragraph.

(b) Notwithstanding any inconsistent provision of law or regulation, the commissioner shall provide, in addition to payments established pursuant to this article prior to application of this section, additional payments under the medical assistance program pursuant to title eleven of article five of the social services law for non-state operated public residential health care facilities, excluding public residential health care facilities operated by a town or city within a county, in an aggregate amount of two hundred fifty-seven million dollars in additional payments in the period August first, nineteen hundred ninety-six through March thirty-first, nineteen hundred ninety-seven.

(c) Notwithstanding any inconsistent provision of law or regulation, the commissioner shall provide, in addition to payments established pursuant to this article prior to application of this section, additional payments under the medical assistance program pursuant to title eleven of article five of the social services law for non-state operated public residential health care facilities, including public residential health care facilities located in the county of Nassau and the county of Westchester, but excluding public residential health care facilities operated by a town or city within a county, in an aggregate amount of $631.1 million in additional payments in the period April first, nineteen hundred ninety-seven through March thirty-first, nineteen hundred ninety-eight, and a like amount in the period April first, nineteen hundred ninety-eight through March thirty-first, nineteen hundred ninety-nine.

(d) Notwithstanding any inconsistent provision of law or regulation, the commissioner shall provide, in addition to payments established pursuant to this article prior to application of this section, additional payments under the medical assistance program pursuant to title eleven of article five of the social services law for non-state

operated public residential health care facilities, including public residential health care facilities located in the county of Nassau and the county of Westchester, but excluding public residential health care facilities operated by a town or city within a county, in an aggregate amount of $914.5 million in additional payments in the period April first, nineteen hundred ninety-nine through March thirty-first, two thousand.

(e) Notwithstanding any inconsistent provision of law or regulation, the commissioner shall provide, in addition to payments established pursuant to this article prior to application of this section, additional payments under the medical assistance program pursuant to title eleven of article five of the social services law for non-state operated public residential health care facilities, including public residential health care facilities located in the county of Nassau and the county of Westchester, but excluding public residential health care facilities operated by a town or city within a county, in an aggregate amount of up to $991.5 million in additional payments each state fiscal year for the period beginning April first, two thousand through March thirty-first, two thousand five.

(e-1) Notwithstanding any inconsistent provision of law or regulation, the commissioner shall provide, in addition to payments established pursuant to this article prior to application of this section, additional payments under the medical assistance program pursuant to title eleven of article five of the social services law for non-state operated public residential health care facilities, including public residential health care facilities located in the county of Nassau, the county of Westchester and the county of Erie, but excluding public residential health care facilities operated by a town or city within a county, in aggregate annual amounts of up to one hundred fifty million dollars in additional payments for the state fiscal year beginning April first, two thousand six and for the state fiscal year beginning April first, two thousand seven and for the state fiscal year beginning April first, two thousand eight and of up to three hundred million dollars in such aggregate annual additional payments for the state fiscal year beginning April first, two thousand nine, and for the state fiscal year beginning April first, two thousand ten and for the state fiscal year beginning April first, two thousand eleven, and for the state fiscal

years beginning April first, two thousand twelve and April first, two thousand thirteen, and of up to five hundred million dollars in such aggregate annual additional payments for the state fiscal years beginning April first, two thousand fourteen, April first, two thousand fifteen and April first, two thousand sixteen and of up to five hundred million dollars in such aggregate annual additional payments for the state fiscal years beginning April first, two thousand seventeen, April first, two thousand eighteen, and April first, two thousand nineteen, and of up to five hundred million dollars in such aggregate annual additional payments for the state fiscal years beginning April first, two thousand twenty, April first, two thousand twenty-one, and April first, two thousand twenty-two, and of up to five hundred million dollars in such aggregate annual additional payments for the state fiscal years beginning April first, two thousand twenty-three, and from April first, two thousand twenty-four until December thirty-first, two thousand twenty-four, and for the calendar year January first, two thousand twenty-five through December thirty-first, two thousand twenty-five, and for each calendar year thereafter. The amount allocated to each eligible public residential health care facility for this period shall be computed in accordance with the provisions of paragraph (f) of this subdivision, provided, however, that patient days shall be utilized for such computation reflecting actual reported data for two thousand three and each representative succeeding year as applicable, and provided further, however, that, in consultation with impacted providers, of the funds allocated for distribution in the state fiscal year beginning April first, two thousand thirteen, up to thirty-two million dollars may be allocated in accordance with paragraph (f-1) of this subdivision.

(f) The amount allocated to each eligible public residential health care facility for each period shall be calculated as the result of (A) the total payment for each period multiplied by (B) the ratio of patient days for patients eligible for medical assistance pursuant to title eleven of article five of the social services law provided by the public residential health care facility, divided by the total of such patient days summed for all eligible public residential health care facilities. For the period August first, nineteen hundred ninety-six through March thirty-first, nineteen hundred ninety-seven, nineteen hundred

ninety-four patient days shall be utilized; for the period April first, nineteen hundred ninety-seven through March thirty-first, nineteen hundred ninety-eight, nineteen hundred ninety-five patient days shall be utilized; for the period April first, nineteen hundred ninety-eight through March thirty-first, nineteen hundred ninety-nine, nineteen hundred ninety-six patient days shall be utilized; for the period April first, nineteen hundred ninety-nine through March thirty-first, two thousand, nineteen hundred ninety-seven patient days shall be utilized; for the period April first, two thousand through March thirty-first, two thousand one, nineteen hundred ninety-eight patient days shall be utilized; for the period April first, two thousand one through March thirty-first, two thousand two, nineteen hundred ninety-nine patient days shall be utilized; for the period April first, two thousand two through March thirty-first, two thousand three, two thousand patient days shall be utilized; for the period April first, two thousand three through March thirty-first, two thousand four, two thousand one patient days shall be utilized; for the period April first, two thousand four through March thirty-first, two thousand five, two thousand two patient days shall be utilized.

(f-1) Funds allocated by the provisions of paragraph (e-1) of this subdivision for distribution pursuant to this paragraph, shall be allocated proportionally to those public residential health care facilities which were subject to retroactive reductions in payments made pursuant to this subdivision for state fiscal year periods beginning April first, two thousand six.

(g) Payments may be made based on adjustments to rates of payment for services provided during the applicable period or as lump sum payments to an eligible residential health care facility.

13. Notwithstanding any inconsistent provision of law or regulation to the contrary, residential health care facility rates of payment determined pursuant to this article for governmental agencies for services provided on or after July first, nineteen hundred ninety-five through March thirty-first, nineteen hundred ninety-six shall be reduced by the commissioner, to reflect the elimination of operational requirements previously mandated by law or, consistent with the standards specified in subparagraph (v) of paragraph (a) of subdivision

two of section twenty-eight hundred three of this article, regulation or the commissioner or other governmental agency, by a factor determined as follows:

(i) an aggregate reduction shall be calculated for each residential health care facility as the result of (A) fifty-six million dollars on an annualized basis for nineteen hundred ninety-five, trended to the rate year by the trend factor for projection of reimbursable costs to the rate year, multiplied by (B) the ratio of patient days for patients eligible for payments made by governmental agencies provided in a base year two years prior to the rate year by a residential health care facility, divided by the total of such patient days summed for all residential health care facilities; and

(ii) the result for each residential health care facility shall be divided by such patient days provided in the residential health care facility, for a per diem reduction in rates of payment for such residential health care facility for patients eligible for payments made by governmental agencies.

14. (a) Notwithstanding any inconsistent provision of law or regulation to the contrary, for purposes of establishing rates of payment by governmental agencies for residential health care facilities for services provided on or after April first, nineteen hundred ninety-five through March thirty-first, nineteen hundred ninety-nine and for services provided on or after July first, nineteen hundred ninety-nine through March thirty-first, two thousand and on and after April first, two thousand through March thirty-first, two thousand three and on and after April first, two thousand three through March thirty-first, two thousand six and on and after April first, two thousand six through December thirty-first, two thousand six, the reimbursable base year administrative services and fiscal services costs, as defined in the New York state residential health care facility accounting and reporting manual, of a residential health care facility, excluding a provider of services reimbursed on an initial budget basis, shall, except as otherwise provided in this subdivision, not exceed the statewide average of total reimbursable base year administrative and fiscal services costs of residential health care facilities. For the purposes of this subdivision, reimbursable base year administrative and

fiscal services costs shall mean those base year administrative and fiscal services costs remaining after application of all other efficiency standards, including but not limited to, peer group cost ceilings or guidelines.

(b) A separate statewide average of total reimbursable base year administrative and fiscal services costs shall be determined for each of those facilities wherein eighty percent or more of its patients are classified with a patient acuity equal to or less than .83 which is used as the basis for a facility's case mix adjustment. For the period July first, two thousand through March thirty-first, two thousand one, the total reimbursable base year administrative and fiscal services costs of such facilities shall not exceed such separate statewide average plus one and one-half percentage points. For annual periods thereafter through December thirty-first, two thousand six, the total reimbursable base year administrative and fiscal services costs of such facilities shall not exceed such separate statewide average. In no event shall the calculation of such separate statewide average result in a change in the statewide average determined under paragraph (a) of this subdivision.

(c) The limitation on reimbursement for provider administrative and fiscal expenses provided by this subdivision shall be expressed as a percentage reduction of the operating cost component of the rate promulgated by the commissioner for each residential health care facility.

15. Notwithstanding any inconsistent provision of law or regulation to the contrary, for services provided by residential health care facilities for the period April first, nineteen hundred ninety-five through March thirty-first, nineteen hundred ninety-six, the commissioner shall not be required to revise a certified rate of payment established pursuant to this article based on consideration of rate appeals filed by a residential health care facility. In cases where the commissioner determines that a significant financial hardship exists, he or she may, subject to the approval of the director of the budget, consider an exemption to this subdivision. Beginning April first, nineteen hundred ninety-six and thereafter, the commissioner shall consider such rate appeals within a reasonable period. After April first, nineteen hundred ninety-six, through March thirty-first, nineteen

hundred ninety-seven, the commissioner shall revise certified rates of payment not to exceed an aggregate payment of forty-seven million dollars, state share medical assistance.

16. Notwithstanding any inconsistent provision of law or regulation to the contrary, residential health care facility rates of payment determined pursuant to this article for governmental agencies for services provided on or after April first, nineteen hundred ninety-six through March thirty-first, nineteen hundred ninety-nine and on or after July first, nineteen hundred ninety-nine through March thirty-first, two thousand and on and after April first, two thousand through March thirty-first, two thousand three and on and after April first, two thousand three through March thirty-first, two thousand six and on and after April first, two thousand six through December thirty-first, two thousand six, shall be further reduced by the commissioner to encourage improved productivity and efficiency by providers by a factor determined as follows:

(a) an aggregate reduction shall be calculated for each residential health care facility commencing April first, nineteen hundred ninety-six through March thirty-first, nineteen hundred ninety-nine and on or after July first, nineteen hundred ninety-nine through March thirty-first, two thousand and on and after April first, two thousand through March thirty-first, two thousand three and on and after April first, two thousand three through March thirty-first, two thousand six and on and after April first, two thousand six through December thirty-first, two thousand six as the result of (i) fifty-six million dollars on an annualized basis multiplied by (ii) the ratio of patient days for patients eligible for payments made by governmental agencies provided in a base year two years prior to the rate year by a residential health care facility, or for residential health care facility beds not fully in operation in such base year by an estimate of projected utilization for the rate year, divided by the total of such patient days summed for all residential health care facilities; and

(b) the result for each residential health care facility shall be divided by such patient days provided in the residential health care facility, for a per diem reduction in rates of payment for such residential health care facility for patients eligible for payments made

by governmental agencies.

17. (a) Notwithstanding any inconsistent provision of law or regulation to the contrary, for the period April first, nineteen hundred ninety-seven through March thirty-first, nineteen hundred ninety-eight, the commissioner shall not be required to revise a certified rate of payment established pursuant to this article based on consideration of rate appeals filed by a residential health care facility or based upon adjustments to capital cost reimbursement as a result of approval by the commissioner of an application for construction under section twenty-eight hundred two of this article. For the period April first, nineteen hundred ninety-eight, through March thirty-first, nineteen hundred ninety-nine, the commissioner shall revise certified rates of payment in an aggregate amount not to exceed twenty million dollars, state share medical assistance. In cases where the commissioner determines that a significant financial hardship exists, he or she may, subject to the approval of the director of the budget, consider an exemption to this subdivision. Beginning April first, nineteen hundred ninety-nine and thereafter, the commissioner shall consider such rate appeals within a reasonable period.

(b) Notwithstanding any inconsistent provision of law or regulation to the contrary, for the state fiscal years beginning April first, two thousand ten and ending March thirty-first, two thousand twenty-nine, the commissioner shall not be required to revise certified rates of payment established pursuant to this article for rate periods prior to April first, two thousand twenty-nine, based on consideration of rate appeals filed by residential health care facilities or based upon adjustments to capital cost reimbursement as a result of approval by the commissioner of an application for construction under section twenty-eight hundred two of this article, in excess of an aggregate annual amount of eighty million dollars for each such state fiscal year provided, however, that for the period April first, two thousand eleven through March thirty-first, two thousand twelve such aggregate annual amount shall be fifty million dollars. In revising such rates within such fiscal limit, the commissioner shall, in prioritizing such rate appeals, include consideration of which facilities the commissioner determines are facing significant financial hardship as well as such

other considerations as the commissioner deems appropriate and, further, the commissioner is authorized to enter into agreements with such facilities or any other facility to resolve multiple pending rate appeals based upon a negotiated aggregate amount and may offset such negotiated aggregate amounts against any amounts owed by the facility to the department, including, but not limited to, amounts owed pursuant to section twenty-eight hundred seven-d of this article; provided, however, that the commissioner's authority to negotiate such agreements resolving multiple pending rate appeals as hereinbefore described shall continue on and after April first, two thousand twenty-nine. Rate adjustments made pursuant to this paragraph remain fully subject to approval by the director of the budget in accordance with the provisions of subdivision two of section twenty-eight hundred seven of this article.

(c) Notwithstanding any other contrary provision of law, rule or regulation, for periods on and after April first, two thousand eleven the commissioner shall promulgate regulations, and may promulgate emergency regulations, establishing priorities and time frames for processing rate appeals, including rate appeals filed prior to April first, two thousand eleven, within available administrative resources; provided, however, that such regulations shall not be inconsistent with the provisions of paragraph (b) of this subdivision.

17-a. Notwithstanding any inconsistent provision of law or regulation to the contrary, for purposes of establishing rates of payment by governmental agencies for residential health care facilities for services provided on and after January first, nineteen hundred ninety-eight, the regional direct and indirect input price adjustment factors to be applied to any such facility's rate calculation shall be based upon the utilization of either nineteen hundred eighty-three, nineteen hundred eighty-seven or nineteen hundred ninety-three calendar year financial and statistical data and for periods beginning April first, two thousand four through March thirty-first, two thousand nine based on either nineteen hundred eighty-three, nineteen hundred eighty-seven, nineteen hundred ninety-three or two thousand one calendar year financial and statistical data; provided, however, the state share amount for the utilization of two thousand one calendar year data shall be no more than twenty-two million dollars on a pro rata basis per

calendar year. The determination of which calendar year's data to utilize shall be based upon a methodology that ensures that the particular year chosen by each facility results in a factor that yields no less reimbursement to the facility than would result from the use of any of the other three years' data. Such methodology shall utilize the nineteen hundred eighty-three and nineteen hundred eighty-seven regional direct and indirect input price adjustment factor corridor percentages in existence on January first, nineteen hundred ninety-seven as well as nineteen hundred ninety-three regional direct and indirect input price adjustment factor corridor percentage in existence on January first, two thousand four as well as a two thousand one regional direct and indirect input price adjustment factor corridor percentage calculated in the same manner as the nineteen hundred ninety-three direct and indirect input price adjustment factor corridor percentages in existence on January first, two thousand four; provided, however, for rate periods on and after April first, two thousand nine, the regional input price adjustment factors shall be based on the case mix predicted staffing for registered nurses, licensed practical nurses, nurses' aides, licensed therapists and therapist aides. For the rate period beginning April first, two thousand nine through the day immediately prior to the day the provisions of subdivision two-c of this section take effect, the regional direct and indirect input price adjustment factors to be applied to a facility's rate calculation shall be based upon the utilization of two thousand two calendar year financial and statistical data. Such methodology shall utilize two thousand two regional direct and indirect input price adjustment factor corridor percentages calculated in the same manner as the two thousand one regional direct and indirect input price adjustment factor corridor percentages in existence on December thirty-first, two thousand six except that every region shall receive a corridor to reflect the region's actual variation subject to a maximum statewide average variable corridor percentage of ten percent.

18. Residential health care facility recruitment and retention of health care workers. Notwithstanding any inconsistent provision of law, rule or regulation and subject to the availability of federal financial participation:

(a) (i) The commissioner shall adjust inpatient medical assistance rates of payment established pursuant to this article for non-public residential health care facilities in accordance with subparagraph (ii) of this paragraph for purposes of recruitment and retention of health care workers in the following aggregate amounts for the following periods:

(A) fifty-three million five hundred thousand dollars on an annualized basis for the period April first, two thousand two through December thirty-first, two thousand two; eighty-three million three hundred thousand dollars on an annualized basis for the period January first, two thousand three through December thirty-first, two thousand three; one hundred fifteen million eight hundred thousand dollars on an annualized basis for the period January first, two thousand four through December thirty-first, two thousand six; fifty-seven million nine hundred thousand dollars for the period January first, two thousand seven through June thirtieth, two thousand seven, fifty-seven million nine hundred thousand dollars for the period July first, two thousand seven through March thirty-first, two thousand eight, and fifty-nine million four hundred thousand dollars for the period April first, two thousand eight through March thirty-first, two thousand nine.

(ii) Such increases shall be allocated proportionally based on each non-public residential health care facility's reported total gross salary and fringe benefit costs on exhibit H of the 1999 RHCF - 4 cost report or exhibit 11 of the 1999 institutional cost report submitted as of November first, two thousand one, where applicable, to the total of such reported costs for all non-public residential health care facilities, provided, however, that for periods on and after July first, two thousand seven, fifty percent of such increases shall be allocated proportionally, based on each non-public residential health care facility's reported total gross salary and fringe benefit costs on exhibit H of the nineteen hundred ninety-nine RHFC - 4 cost report or exhibit 11 of the nineteen hundred ninety-nine institutional cost report submitted to the department prior to November first, two thousand one, where applicable, to the total of such reported costs for all non-public residential health care facilities, and fifty percent of such increases shall be allocated proportionately, based on each such non-public facility's reported Medicaid revenue, as reported in the applicable two

thousand five cost report as submitted to the department prior to November first, two thousand six, to the total of such Medicaid revenue reported by all such non-public facilities. These amounts shall be included as a reimbursable cost add-on to medical assistance inpatient rates of payment established pursuant to this article for non-public residential health care facilities, based on medical assistance utilization data in each facility's annual cost report submitted two years prior to the rate year. Such amounts shall not be reconciled to reflect changes in medical assistance utilization between the year two years prior to the rate year and the rate year.

(b) (i) Notwithstanding sections one hundred twelve and one hundred sixty-three of the state finance law and any other inconsistent provision of law, the commissioner shall make grants to public residential health care facilities without a competitive bid or request for proposal process for purposes of recruitment and retention of health care workers in the following aggregate amounts for the following periods:

(A) seven million five hundred thousand dollars on an annualized basis for the period April first, two thousand two through December thirty-first, two thousand two; eleven million seven hundred thousand dollars on an annualized basis for the period January first, two thousand three through December thirty-first, two thousand three; sixteen million two hundred thousand dollars on an annualized basis for the period January first, two thousand four through December thirty-first, two thousand six; and eight million one hundred thousand dollars for the period January first, two thousand seven through June thirtieth, two thousand seven, eight million one hundred thousand dollars for the period July first, two thousand seven through March thirty-first, two thousand eight, six million six hundred ninety thousand dollars for the period April first, two thousand eight through March thirty-first, two thousand nine.

(ii) Such grants shall be allocated proportionally based on each public residential health care facility's reported total gross salary and fringe benefit costs on exhibit H of the 1999 RHCF - 4 cost report or exhibit 11 of the 1999 institutional cost report submitted as of November first, two thousand one, where applicable, to the total of such reported costs for all public residential health care facilities.

(c) (i) Non-public and public residential health care facilities in operation as of the effective date of this paragraph which have not submitted 1999 RHCF-4 cost reports or 1999 institutional cost reports but which have submitted such reports for cost years subsequent to 1999, shall have distributions authorized in subparagraph (i) of paragraph (a) of this subdivision or in subparagraph (i) of paragraph (b) of this subdivision allocated based on total gross salary and fringe benefit costs on exhibit H of the earliest subsequently submitted RHCF-4 cost report or exhibit 11 of the earliest subsequently submitted institutional cost report, as trended downward to 1999 using trend factors authorized in accordance with the provisions of section twenty-one of chapter one of the laws of nineteen hundred ninety-nine.

(ii) Non-public and public residential health care facilities in operation as of the effective date of this paragraph which have not submitted 1999 or subsequent RHCF-4 cost reports or institutional cost reports, shall have distributions authorized in subparagraph (i) of paragraph (a) of this subdivision or in subparagraph (i) of paragraph (b) of this subdivision allocated based on imputed total gross salary and fringe benefit costs reflecting the average of such costs in the region in which each such facility is located, provided, however, that for periods on and after July first, two thousand seven, facilities that have not submitted two thousand five cost reports shall have distributions allocated based on imputed days of care to patients eligible for medical assistance, reflecting the average of such medicaid days of care in the region in which such facilities are located.

(iii) Non-public and public residential health care facilities which received allocations pursuant to subparagraph (ii) of this paragraph and which subsequently submit RHCF-4 cost reports or institutional cost reports shall, for the purpose of setting medical assistance rates of payment, have such allocations adjusted to reflect costs which were incurred in connection with such allocations and which are contained in such cost reports.

(d) Residential health care facilities which have their rates adjusted or receive grants pursuant to paragraphs (a), (b) and (c) of this subdivision, respectively, shall use such funds for the purpose of recruitment and retention of non-supervisory workers at health care facilities or any worker with direct patient care responsibility and are

prohibited from using such funds for any other purpose. Funds under this subdivision are not intended to supplant support provided by a local government. Each such residential health care facility shall submit, at a time and in a manner to be 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 workers at health care facilities or any worker with direct patient care responsibility. The commissioner is authorized to audit each residential health care facility to ensure compliance with the written certification required by this paragraph and shall recoup any funds determined to have been used for purposes other than recruitment and retention of non-supervisory workers at health care facilities or any worker with direct patient care responsibility. Such recoupment shall be in addition to applicable penalties under sections twelve and twelve-b of this chapter.

(e) Residential health care facilities which have their rates adjusted or receive grants pursuant to paragraphs (a), (b) and (c) of this subdivision, respectively, shall use such funds for the purpose of recruitment and retention of non-supervisory workers at health care facilities or any worker with direct patient care responsibility and are prohibited from using such funds for any other purpose. Funds under this subdivision are not intended to supplant support provided by a local government. Each such residential health care facility shall submit, at a time and in a manner to be 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 workers at health care facilities or any worker with direct patient care responsibility. The commissioner is authorized to audit each residential health care facility to ensure compliance with the written certification required by this paragraph and shall recoup any funds determined to have been used for purposes other than recruitment and retention of non-supervisory workers at health care facilities or any worker with direct patient care responsibility. Such recoupment shall be in addition to applicable penalties under sections twelve and twelve-b of this chapter.

19. Notwithstanding any law, rule or regulation to the contrary, the

commissioner shall within amounts allocated pursuant to paragraph (hh) of subdivision one of section twenty-eight hundred seven-v of this article, make adjustments to the medical assistance rates of payment to residential health care facilities to assist certain financially disadvantaged nursing homes, in order to promote financial stability and quality improvement. Such adjustments shall be made pursuant to subdivision twenty-one of this section.

20. a. The commissioner shall timely develop and implement a standardized process for assessing the feasibility of capital mortgage re-financings, including a standard formula for determining the net cost benefit of re-financing, inclusive of all transaction and closing costs. On or before September first, two thousand three or thirty days after the commissioner makes the standard formula available to facilities, each residential health care facility established under this article and certified as a provider pursuant to title XIX of the federal social security act (Medicaid), except for those facilities established under the nursing home companies law or the hospital loan construction law, shall review its existing capital debt structure using the standard formula to evaluate whether or not a material cost benefit could be derived by re-financing its capital mortgage or mortgages, and shall forward the results of such review to the commissioner. The commissioner may request and such facilities shall submit descriptions of existing mortgage arrangements and debt service reserve funds as needed to implement paragraph b of this subdivision. Facilities established under the nursing home companies law or the hospital loan construction law shall submit to the dormitory authority, the housing finance agency and/or the state of New York mortgage agency such information as is required by such agency to evaluate potential re-financing of such capital mortgages.

b. the commissioner shall review each facility's submission and make a written determination as to whether or not the facility should re-finance its capital mortgage or mortgages, and if so, for what amount, within sixty days of the date of the facility's submission based on the following parameters:

(i) the mortgage re-financing must result in a present value cost

benefit that "materially exceeds", as such term is defined by the commissioner, the amount of all transaction and closing costs associated with the re-financing, including any pre-payment penalties associated with the current mortgage or mortgages. The commissioner shall do such calculations in a manner consistent with comparable calculations in the state finance law;

(ii) mortgages may be re-financed for a term greater than the remaining term of the existing debt within certain limits, if doing so would result in the present value cost benefit specified in subparagraph (i) of this paragraph;

(iii) mortgages may be re-financed utilizing variable rate mortgage loans, if doing so would result in the present value cost benefit specified in subparagraph (i) of this paragraph. In such cases, for purposes of determining the reimbursable capital interest expense included in the capital cost component of rates of payment determined pursuant to this article, the average interest rate over the life of the re-financed mortgage shall not exceed the interest rate in effect on the previous mortgage debt immediately prior to the re-financing;

(iv) not-for-profit and governmental residential health care facilities may utilize taxable mortgage loans to re-finance their existing debts, if doing so would result in the present value cost benefit specified in subparagraph (i) of this paragraph;

(v) moneys contained in facility debt service reserve funds may be considered in the evaluation of amounts necessary to be re-financed, but only to the extent such moneys total more than the debt service reserves needed to establish the successor capital mortgage financing;

(vi) in no event shall funded depreciation accounts, or building funds accumulated through donor-restricted contributions or unrestricted contributions, gifts, bequests, or legacies, be considered in the evaluation of amounts necessary to be re-financed; and

(vii) notwithstanding any inconsistent provision of law or regulation to the contrary, the principal amount, including all transaction and closing costs and any pre-payment penalties associated with the previous mortgage or mortgages, that is thereby deemed necessary to be re-financed by the commissioner, as approved by the public authorities control board and the United States department of housing and urban development where appropriate, shall be considered the final, approved

mortgage amount for capital cost reimbursement under the relevant provisions of this article.

c. Notwithstanding any inconsistent provision of law or regulation to the contrary, the capital cost component of rates of payment for services provided for the period beginning October first, two thousand three or one hundred eighty days after the effective date of this subdivision, whichever is later, through March thirty-first, two thousand four for residential health care facilities established under this article and certified as providers pursuant to title XIX of the federal social security act (Medicaid), except for those facilities established under the nursing home companies law or the hospital loan construction law, that have been identified by the commissioner as refinancing candidates pursuant to paragraph b of this subdivision shall reflect capital interest costs equivalent to the lower of the prevailing market borrowing rates available on or about July first, two thousand three or ninety days after the effective date of this subdivision, whichever is later, for refinancing capital mortgages for their remaining term plus two hundred basis points, or the existing rate being paid by the facility on its capital mortgage or mortgages as of that date. The commissioner shall determine, in consultation with mortgage financing experts, the prevailing market borrowing rates available to not-for-profit and governmental residential health care facilities to re-finance capital mortgages on a tax-exempt fixed rate basis, and to proprietary residential health care facilities to re-finance capital mortgages on a tax-exempt fixed rate basis, and to proprietary residential health care facilities to re-finance capital mortgages on a taxable fixed rate basis, for this purpose. Exceptions to this policy shall be provided by the commissioner to each such facility that demonstrates, prior to October first, two thousand three or thirty days after receipt of the commissioner's written determination specified in paragraph (b) of this subdivision, whichever occurs later, that:

(i) it has initiated or completed the process of re-financing the mortgage or mortgages in question, in which case the capital cost component of rates of payment shall be timely revised to reflect capital interest costs associated with a re-financed mortgage that conforms to the standards in paragraph (b) of this subdivision. For this purpose, a

facility that has applied for approval by the commissioner, the state hospital review and planning council and/or the public health council to re-finance its existing mortgage debt as part of a larger project involving facility replacement, expansion, renovation or change of ownership is considered to have initiated the process of re-financing; or

(ii) it can not re-finance its capital mortgage or mortgages to achieve the relevant present value cost benefit specified in subparagraphs (i) and (ii) of paragraph (b) of this subdivision due to a "lock out" or similar provision in its current mortgage agreement that prevents re-financing; due to some other type of genuine re-financing obstacle, such as an inability of the facility to obtain credit approval from a lender or mortgage insurer, or due to an intervening change in credit market conditions or other relevant circumstances, in which case the capital cost component of rates of payment shall continue to reflect capital interest costs associated with the existing mortgage or mortgages, together with reasonable costs incurred in connection with the facility's attempt to re-finance its existing mortgage debt.

d. Notwithstanding any contrary provision of law, rule or regulation, for rate periods on and after April first, two thousand eleven, the commissioner may reduce or eliminate the payment factor for return on or return of equity in the capital cost component of Medicaid rates of payment for services provided by residential health care facilities, and for rate periods on and after April first, two thousand twenty, there shall be no payment factor for residual equity reimbursement in the capital cost component of Medicaid rates of payment for services provided by residential health care facilities.

e. Notwithstanding any other provision of law or regulation to the contrary, the commissioner shall adopt or amend on an emergency basis any regulation the commissioner determines necessary to implement any provision of this subdivision.

21. (a) Notwithstanding any inconsistent provision of law or regulation to the contrary, for the purposes specified in subdivision nineteen of this section, the commissioner shall adjust medical

assistance rates of payment established pursuant to this article for services provided on and after October first, two thousand four through December thirty-first, two thousand four and annually thereafter for services provided on and after January first, two thousand five through April thirtieth, two thousand eleven and on and after May first, two thousand twelve, to include a rate adjustment to assist qualifying facilities pursuant to this subdivision, provided, however, that public residential health care facilities shall not be eligible for rate adjustments pursuant to this subdivision for rate periods on and after April first, two thousand nine, provided further, however, that notwithstanding any contrary provision of law and subject to the availability of federal financial participation, each facility that receives a rate adjustment pursuant to this subdivision for the period May first, two thousand ten through April thirtieth, two thousand eleven shall have its medicaid rates reduced for the rate period December first, two thousand eleven through December thirty-first, two thousand eleven by an amount equal in aggregate to the aggregate amount of the funds such facility received pursuant to this subdivision for the period May first, two thousand ten through April thirtieth, two thousand eleven.

(b) Eligibility for such rate adjustments shall be determined on the basis of each residential health care facility's operating margin over the most recent three-year period for which financial data are available from the RHCF-4 cost report or the institutional cost report. For purposes of the adjustments made for the period October first, two thousand four through December thirty-first, two thousand four, financial information for the calendar years two thousand through two thousand two shall be utilized. For each subsequent rate year, the financial data for the three-year period ending two years prior to the applicable rate year shall be utilized for this purpose.

(c) Each facility's operating margin for the three-year period shall be calculated by subtracting total operating expenses for the three-year period from total operating revenues for the three-year period, and dividing the result by the total operating revenues for the three-year period, with the result expressed as a percentage. For hospital-based residential health care facilities for which an operating margin cannot be calculated on the basis of the submitted cost reports, the sponsoring

hospital's overall three-year operating margin, as reported in the institutional cost report, shall be utilized for this purpose. All facilities with negative operating margins calculated in this way over the three-year period shall be arrayed into quartiles based on the magnitude of the operating margin. Any facility with a positive operating margin for the most recent three-year period, a negative operating margin that places the facility in the quartile of facilities with the smallest negative operating margins, a positive total margin in the most recent year of the three year period, or an average Medicaid utilization percentage of fifty percent or less during the most recent year of the three-year period shall be disqualified from receiving an adjustment pursuant to this subdivision, provided, however, that for rate periods on and after April first, two thousand nine, such disqualification:

(i) shall not be applied solely on the basis of a facility's having a positive total margin in the most recent year of such three-year period;

(ii) shall be extended to those facilities in the quartile of facilities with the second smallest negative operating margins; and

(iii) shall also be extended to those facilities with an average Medicaid utilization percentage of less than seventy percent during the most recent year of the three-year period.

(d) For each facility remaining after the exclusions made pursuant to paragraph (c) of this subdivision, the commissioner shall calculate the average annual operating loss for the three-year period by subtracting total operating expenses for the three-year period from total operating revenues for the three-year period, and dividing the result by three, provided, however, that for periods on and after April first, two thousand nine, the amount of such average annual operating loss shall be reduced by an amount equal to the amount received by such facility pursuant to subparagraph (ii) of paragraph (a) of subdivision two-b of this section. For this purpose, for hospital-based residential health care facilities for which the average annual operating loss cannot be calculated on the basis of the submitted cost reports, the sponsoring hospital's overall average annual operating loss for the three-year period shall be apportioned to the residential health care facility based on the proportion the residential health care facility's total revenues for the period bears to the total revenues reported by the

sponsoring hospital, and such apportioned average annual operating loss shall then be reduced by an amount equal to the amount received by such facility pursuant to subparagraph (ii) of paragraph (a) of subdivision two-b of this section.

(e) For periods prior to April first, two thousand nine, each such facility's qualifying operating loss shall be determined by multiplying the facility's average annual operating loss for the three-year period as calculated pursuant to paragraph (d) of this subdivision by the applicable percentage shown in the tables below for the quartile within which the facility's negative operating margin for the three-year period is assigned.

i. For a facility located in a county with a total population of two hundred thousand or more as determined by the two thousand U.S. Census:
First Quartile (lowest operating margins): 30 percent
Second Quartile: 15 percent
Third Quartile: 7.5 percent
ii. For a facility located in a county with a total population of fewer than two hundred thousand as determined by the two thousand U.S. Census:
First Quartile (lowest operating margins): 35 percent
Second Quartile: 20 percent
Third Quartile: 12.5 percent
(f) The amount of any facility's financially disadvantaged residential health care facility distribution calculated in accordance with this subdivision shall be reduced by the facility's estimated rate year benefit of the two thousand one update to the regional input price adjustment factors authorized pursuant to former subdivision seventeen of this section as amended by section 24 of part C of chapter 58 of the laws of 2004, or as authorized by subdivision seventeen-a of this section, as added by section 56 of part C of chapter 58 of the laws of 2007, if any, provided, however, that such reduction shall not be applied with regard to rate periods on and after April first, two thousand nine. After all other adjustments to a facility's financially disadvantaged residential health care facility distribution have been made in accordance with this subdivision, the amount of each facility's distribution shall be limited to no more than four hundred thousand dollars during the period October first, two thousand four through

December thirty-first, two thousand four and, on an annualized basis, for rate periods through March thirty-first, two thousand nine, and no more than one million dollars for the period April first, two thousand nine through December thirty-first, two thousand nine and for each annual rate period thereafter.

(g) The adjustment made to each qualifying facility's medical assistance rate of payment determined pursuant to this article shall be calculated by dividing the facility's financially disadvantaged residential health care facility distribution calculated in accordance with this subdivision by the facility's total medical assistance patient days reported in the cost report submitted two years prior to the rate year, provided however, that such rate adjustments for the period October first, two thousand four through December thirty-first, two thousand four shall be calculated based on twenty-five percent of each facility's reported total medical assistance patient days as reported in the applicable two thousand two cost report. Such amounts shall not be reconciled to reflect changes in medical assistance utilization between the year two years prior to the rate year and the rate year.

(h) The total amount of funds to be allocated and distributed as medical assistance for financially disadvantaged residential health care facility rate adjustments to eligible facilities for a rate period in accordance with this subdivision shall be thirty million dollars for the period October first, two thousand four through December thirty-first, two thousand four and thirty million dollars on an annualized basis for rate periods on and after January first, two thousand five through December thirty-first, two thousand eight and thirty million dollars on an annualized basis on and after January first, two thousand nine, provided that, subject to all necessary federal approvals, on and after January first, two thousand thirteen funds allocated under this paragraph shall be distributed pursuant to 10 NYCRR 86-2.39. The nonfederal share of such rate adjustments shall be paid by the state, with no local share, from allocations made pursuant to paragraph (hh) of subdivision one of section twenty-eight hundred seven-v of this article. In the event the statewide total of the annual rate adjustments determined pursuant to paragraph (g) of this subdivision varies from the amounts set forth in this paragraph, each qualifying facility's rate adjustment shall be proportionately increased or decreased such that the

total of the annual rate adjustments made pursuant to this subdivision is equal to the amounts set forth in this paragraph on a statewide basis.

(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 for the rate adjustments determined in accordance with this subdivision.

(j) For periods on and after April first, two thousand nine, residential health care facilities which are otherwise eligible for rate adjustments pursuant to this subdivision shall also, as a condition for receipt of such rate adjustments, submit to the commissioner a written restructuring plan that is acceptable to the commissioner and which is in accord with the following:

(i) such an acceptable plan shall be submitted to the commissioner within sixty days of the facility's receipt of rate adjustments pursuant to this subdivision for a rate period subsequent to March thirty-first, two thousand eight, provided, however, that facilities which are allocated four hundred thousand dollars or less on an annualized basis shall be required to submit such plans within one hundred twenty days, and further provided that these periods may be extended by the commissioner by no more than thirty days, for good cause shown; and

(ii) such plan shall provide a detailed description of the steps the facility will take to improve operational efficiency and align its expenditures with its revenues, and shall include a projected schedule of quantifiable benchmarks to be achieved in the implementation of the plan; and

(iii) such plan shall require periodic reports to the commissioner, in accordance with a schedule acceptable to the commissioner, setting forth the progress the facility has made in implementing its plan; and

(iv) such plan may include the facility's retention of a qualified chief restructuring officer to assist in the implementation of the plan, provided, however, that this requirement may be waived by the commissioner, for good cause shown, upon written application by the facility.

(k) If a residential health care facility fails to submit an acceptable restructuring plan in accordance with the provisions of

paragraph (j) of this subdivision, the facility shall, from that time forward, be precluded from receipt of all further rate adjustments made pursuant to this subdivision and shall be deemed ineligible from any future re-application for such adjustments. Further, if the commissioner determines that a facility has failed to make substantial progress in implementing its plan or in achieving the benchmarks set forth in such plan, then the commissioner may, upon thirty days notice to that facility, disqualify the facility from further participation in the rate adjustments authorized by this subdivision and the commissioner may require the facility to repay some or all of the previous rate adjustments.

22. Nursing home incentives for improved performance in patient care. Pursuant to such program, and within amounts as are appropriated therefor, the commissioner shall investigate adjusted quality indicators and quality measures including those defined by the federal centers for medicare and medicaid service (CMS) with respect to nursing home quality and quality benchmarks. The commissioner shall award rate enhancements to those residential health care facilities who demonstrate to the satisfaction of the commissioner, they can meet or exceed such defined quality measures. Such quality measures may include, but not be limited to, outcomes from state survey data, performance measures, and resident outcomes based upon Minimum Data Sets as defined by CMS. The commissioner shall consult with associations representing residential health care facilities and associations representing nursing home residents, and shall by July first, two thousand seven, adopt rules and regulations that incorporate payment incentives, related to such quality indicators and measures, including, but not limited to programs to improve patient care outcomes and performance outcomes. Such programs may include but not be limited to, clinician-centric electronic medical records implementation, automation of assessments and care plans, improved data collection, and the provision of accessible consumer information as well as patient satisfaction, into rates of payment.

22-a. Modifications. (a) Notwithstanding any inconsistent provision of law or regulation to the contrary, effective April first, two thousand six and thereafter, residential health care facility rates of payment

determined pursuant to this section for payments made by governmental agencies shall not contain a payment factor for interest on current indebtedness if the residential health care facility cost report utilized to determine such payment factor also shows a withdrawal of equity, a transfer of assets, or a positive net income.

(b) Notwithstanding any inconsistent provision of law or regulation to the contrary, for residential health care facility rates of payment determined pursuant to this article for services provided on and after April first, two thousand six, the annual cost report filed by each residential health care facility for two thousand five and for each year thereafter shall be examined and in the event the operating costs reported by each such facility in any such cost report is less than ninety percent of the operating costs reported in the cost report which is being utilized to set such facility's existing rates of payment trended to two thousand five and each year thereafter, then such rates of payment shall be recalculated utilizing the more recent reported operating cost data.

(c) Notwithstanding any inconsistent provision of law or regulation to the contrary, effective on and after April first, two thousand six, for purposes of establishing rates of payment by governmental agencies for residential health care facilities licensed pursuant to this article, the operating component of the rate for any residential health care facility that did not or does not achieve ninety percent or greater occupancy for any year within five calendar years from the date of commencing operation, shall be recalculated utilizing the facility's most recently available reported allowable costs divided by patient days imputed at ninety percent occupancy. Such recalculated rates of payment shall be effective January first of the sixth calendar year following the date the facility commenced operations or April first, two thousand six, whichever is later.

(d) (i) Notwithstanding any inconsistent provisions of subdivisions two-b or two-c of this section or any other contrary provision of law, and subject to the availability of federal financial participation, for inpatient services provided by residential health care facilities on and after April first, two thousand eleven, the commissioner may, subject to the approval of the director of the budget, grant approval of a temporary adjustment to Medicaid rates for eligible facilities, as

determined in accordance with this paragraph.

(ii) Eligible facilities shall be those residential health care facilities which, as determined by the commissioner, require short-term assistance to accommodate additional patient services requirements stemming from the closure of other facilities in the area, including, but not limited to, additional staff, service reconfiguration and enhanced information technology capability.

(iii) Eligible facilities shall submit written proposals demonstrating the need for additional short-term resources and how such additional resources will result in improvements to:

(A) the cost effectiveness of service delivery;

(B) quality of care; and

(C) other factors deemed appropriate by the commissioner.

(iv) Such written proposals shall be submitted to the department at least sixty days prior to the requested effective date of the temporary rate adjustment. The temporary rate adjustment shall be in effect for a specified period of time as determined by the commissioner. At the end of the specified timeframe, the facility will be reimbursed in accordance with otherwise applicable rate-setting methodologies. The commissioner may establish, as a condition of receiving such a temporary rate adjustment, benchmarks and goals to be achieved in accordance with the facility's approved proposals and may also require that the facility submit such periodic reports concerning the achievement of such benchmarks and goals as the commissioner deems necessary. Failure to achieve satisfactory progress, as determined by the commissioner, in accomplishing such benchmarks and goals shall be a basis for ending the facility's temporary rate adjustment prior to the end of the specified timeframe.

23. Notwithstanding any inconsistent provision of law or regulation to the contrary:

(a) (i) For adult day health care services provided by residential health care facilities, effective April first, two thousand seven and thereafter, the operating component of the rate of payment established pursuant to this article for an adult day health care program which has achieved an occupancy percentage of ninety percent or greater for a calendar year prior to April first, two thousand seven, shall be

calculated utilizing allowable costs reported in the two thousand four, two thousand five, or two thousand six calendar year residential health care facility cost report filed by the sponsoring residential health care facility, whichever is the earliest of such calendar year cost reports in which the program has achieved an occupancy percentage of ninety percent or greater, except that programs receiving rates of payment based on allowable costs for a period prior to April first, two thousand seven shall continue to receive rates of payment based on such period.

(ii) For such programs which achieved an occupancy percentage of ninety percent or greater prior to calendar year two thousand four, so long as approved capacity in that year is the same as in calendar year two thousand four, but which did not maintain occupancy of ninety percent or greater in calendar years two thousand four, two thousand five, or two thousand six, the operating component of the rate of payment established pursuant to this article shall be calculated utilizing allowable costs reported in the two thousand four calendar year cost report divided by visits imputed at ninety percent occupancy.

(iii) For such programs which have not achieved an occupancy percentage of ninety percent or greater for a calendar year prior to April first, two thousand seven, the operating component of the rate of payment established pursuant to this article shall be calculated utilizing allowable costs reported in the first calendar year after two thousand six in which such a program achieves an occupancy percentage of ninety percent or greater effective January first of such calendar year except for calendar year two thousand seven, effective no earlier than April first of such year, provided, however, that effective January first, two thousand nine, for programs that have not achieved an occupancy percentage of ninety percent or greater for a calendar year prior to January first, two thousand nine, the operating component of the rate of payment established pursuant to this article shall be calculated utilizing allowable costs reported in the two thousand nine cost report filed by the sponsoring residential health care facility divided by visits imputed at actual or ninety percent occupancy, whichever is greater. This subparagraph shall also apply to programs which achieved an occupancy percentage of ninety percent or greater prior to calendar year two thousand four but in such year had an

approved capacity that was not the same as in calendar year two thousand four.

(b) For a residential health care facility approved to operate an adult day health care program on or after April first, two thousand seven, rates of payment for such programs shall be computed based upon annual budgeted allowable costs, as submitted by the residential health care facility, and total estimated annual visits by adult day health care registrants of not less than ninety percent of licensed occupancy, and in accordance with the following:

(i) Each program shall be required to submit an individual budget. Multiple programs operated by the same residential health care facility shall submit a separate budget for each program. Multiple programs operated by the same residential health care facility shall have separate rates of payment.

(ii) Rates developed based upon budgets shall remain in effect for no longer than two calendar years from the earlier of:

(A) the date the program commences operations; or

(B) the date the sponsoring residential health care facility submits a full calendar year residential health care facility cost report in which the program has achieved ninety percent or greater occupancy. If a sponsoring residential health care facility submits such a cost report within two years of the date the program commences operation, rates shall then be computed utilizing such cost report.

(iii) If a program fails to achieve ninety percent or greater occupancy within two calendar years of the date of its commencing operations, rates shall be calculated utilizing allowable costs reported in such second calendar year residential health care facility's cost report for the applicable sponsoring residential health care facility divided by visits imputed at ninety percent occupancy.

(c) Effective January first, two thousand eight, allowable costs shall not include the costs of transportation.

(d) All rates of payment established pursuant to this subdivision are subject to the maximum daily rate provided by law. Such maximum daily rate of payment for adult day health care programs operated by residential health care facilities that undergo a change of ownership subsequent to nineteen hundred ninety shall be determined by utilizing the inpatient rate of payment of the prior operator as in effect on

January first, nineteen hundred ninety. In the event a residential health care facility establishes an off-site adult day health care program outside the regional input price adjustment region in which it is located, the computation of the maximum daily rate of payment for such program shall utilize the weighted average of the inpatient rates of payments for residential health care facilities in the region in which the program is located, as in effect on January first, nineteen hundred ninety, in place of the sponsoring residential health care facility's inpatient rate of payment.

(e) Notwithstanding any inconsistent provision of the state administrative procedure act or any other law or regulation to the contrary, the commissioner shall adopt or amend on an emergency basis any regulations the commissioner shall determine necessary to implement any provision of this subdivision.

24. Notwithstanding any other provisions of this section and any other law, rule or regulation to the contrary, for periods on and after July first, two thousand seven, the operating component of all rates of payment made by governmental agencies for services to individuals eligible for medical assistance pursuant to title eleven of article five of the social services law and provided by a residential health care facility with fewer than sixty beds as of July first, two thousand seven, which provides services primarily to neurologically impaired individuals and is located in a county with a population between two hundred ninety thousand and three hundred ten thousand as of July first, two thousand seven shall be based solely on the methodology used to establish rates for facilities which provide extensive nursing, medical, psychological and counseling support services solely to children; provided, however, this subdivision shall not apply if the application would result in a lesser rate of payment than otherwise provided for under this section. Nothing in this subdivision shall be construed to limit the application to such facility of rate adjustments applied to other residential health care facilities.

25. Reserved bed days. (a) For purposes of this subdivision, a "reserved bed day" is a day for which a governmental agency pays a residential health care facility to reserve a bed for a person eligible

for medical assistance pursuant to title eleven of article five of the social services law while he or she is on therapeutic leave of absence from the facility.

(b) Notwithstanding any other provisions of this section or any other law or regulation to the contrary, for reserved bed days provided on behalf of persons twenty-one years of age or older:

(i) payments for reserved bed days shall be made at ninety-five percent of the Medicaid rate otherwise payable to the facility for services provided on behalf of such person; and

(ii) payment to a facility for reserved bed days provided on behalf of such person for therapeutic leaves of absence may not exceed ten days in any twelve month period.

25-a. Reserved bed days for state veterans' homes. (a) For purposes of this subdivision, a "reserved bed day" is a day for which the state pays New York State Veterans' Home at Oxford, the New York State Veterans' Home at St. Albans, the New York State Veterans' Home at Batavia, the New York State Veterans' Home at Montrose or the Long Island State Veterans' Home to reserve a bed for a person eligible for medical assistance pursuant to title eleven of article five of the social services law while he or she is temporarily hospitalized.

(b) (i) Payments for reserved bed days shall be made at fifty percent of the Medicaid rate otherwise payable to the facility for services provided on behalf of the person.

(ii) Payment to a facility for reserved bed days provided on behalf of the person for temporary hospitalizations may not exceed fourteen days in any twelve-month period.

(iii) The person must have resided in the applicable State Veterans' home for at least thirty days since the date of his or her initial admission.

(iv) Unless medically contraindicated, the applicable State Veterans' home shall reserve the same bed and room the person occupied before being hospitalized or placed on a therapeutic leave of absence.

(v) Reserved bed days under this subdivision are in addition to reserve bed days for therapeutic leave of absence under subdivision twenty-five of this section.

(vi) This subdivision shall apply subject to the availability of

federal financial participation.

26. Notwithstanding any inconsistent provision of law, for rate periods on and after April first, two thousand ten, residential health care facility Medicaid rates of payment shall not include reimbursement for the cost of prescription drugs. Such reimbursement shall be in accordance with otherwise applicable provisions of section three hundred sixty-seven-a of the social services law.

* 27. The commissioner is authorized to conduct an energy audit and/or disaster preparedness review of residential health care facilities. Such audit or review shall explore the energy efficiency and/or disaster preparedness of the real property capital aspects of each facility and develop a cost/benefit analysis of potential modifications for each facility. Such audit or review shall serve as the basis for an energy efficiency and/or disaster preparedness program to be developed by the department in regulations. Participation in such audit or review shall be a condition to participation in any such program developed as a result thereof, and shall also be a condition to receipt of any funding available under such program. Such program shall only be implemented if it is in the best financial interests of the state, as determined by the commissioner. At least forty-five days prior to implementing such program, the department shall report to the senate and assembly health committees, the assembly ways and means committee and the senate finance committee the results of the energy audit authorized herein and the proposed eligibility criteria, funding sources, the manner in which savings may be shared between the state and facilities and any other information requested by such committees about such program prior to the transmittal of the report.

* NB Repealed July 1, 2027