volume of services attributable to each contracted agency. Such agencies shall submit to providers with which they contract written certifications attesting that such funds will be used solely for the purposes of recruitment and retention of non-supervisory home care services workers or any worker with direct patient care responsibility and shall maintain in their files expenditure plans specifying how such funds will be used for such purposes. The Commissioner is authorized to audit such agencies to ensure compliance with such certifications and expenditure plans and shall recoup any funds determined to have been used for purposes other than those set forth in this section.

The Commissioner of Health will additionally adjust rates of payment for AIDS home care service providers, for the purpose of improving recruitment and retention of home health aides or other non-supervisory personnel with direct patient care responsibility.

These additional adjustments to rates of payments shall be calculated by allocating the available funding proportionally based on each AIDS home care service provider's, home health aide or other direct care services total annual hours of service provided to Medicaid patients, as reported in each such agency's most recently available cost report as submitted to the Department [prior to November 1, 2005, to the total of such hours for all eligible AIDS home care service providers.] The total aggregate available funding for AIDS home care service providers is as follows:

For the period June 1, 2006 through December 31, 2006 - $540,000.
For the period January 1, 2007 through June 30, 2007 - $540,000.
For the period July 1, 2007 through March 31, 2008 - $1,080,000.
For the period April 1, 2008 through March 31, 2009 - $1,080,000
For the period April 1, 2009 through March 31, 2010 - $1,080,000.
For the period April 1, 2010 through March 31, 2011 - $1,080,000.
For the period April 1, 2011 through March 31, 2012 - $1,080,000.
For the period April 1, 2012 through March 31, 2013 - $1,080,000
For the period April 1, 2013 through March 31, 2014 - $1,080,000.

Payments made pursuant to this section shall not be subject to subsequent adjustment or reconciliation.

For providers established after November 1, 2005, the Department utilizes Medicaid data from the initial cost report submitted to the Department, which would allow the inclusion of those providers in the distribution.

OFFICIAL

Funds received through this program are to be used solely for the purposes of recruitment and retention of non-supervisory home care services workers or other personnel with direct patient care responsibility. Each agency receiving funds shall submit, at a time and in a manner determined by the Commissioner, a written certification attesting that such funds will be used solely for the purpose of recruitment and retention of non-supervisory home health aides or any personnel with direct patient care responsibility. The Commissioner is authorized to audit each such agency or program to ensure compliance with this written certification and may recoup any funds determined to have been used for purposes other than recruitment and retention of non-supervisory home health aides or other personnel with direct patient care responsibility. All government and non-government owned or operated providers are eligible for this adjustment pursuant to the same uniformly applied methodology.

[Accessibility, Quality, and, Efficiency of Home Care Services

The Commissioner of Health shall adjust rates of payment for services provided by AIDS home care service providers for the purpose of enhancing the provision, accessibility, quality, and/or efficiency of home care services. These rate adjustments shall be for the purposes of assisting such providers, located in social services districts that do not include a city with a population of over one million persons, in meeting the cost of:

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

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

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

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

The Commissioner shall increase the rates of payment for all eligible providers in an aggregate amount of $16,000,000 annually for the periods June 1, 2006 through March 31, 2007, July 1, 2007 through March 31, 2008, and June 1, 2008 through March 31, 2009.

Rates will be adjusted in the form of a uniform percentage add-on as calculated by the Department, based upon the proportion of total allocated dollars, to the total Medicaid expenditures for covered home care services provided in local social services districts that do not include a city with a population over one million. All government and non-government owned or operated providers are eligible for this adjustment pursuant to the same uniformly applied methodology.

Criminal Background Checks for AIDS Home Care Program Providers

Effective April 1, 2005, AIDS home care program providers must obtain a criminal history record check from the United States Attorney General for any prospective unlicensed direct care employee. This includes obtaining, as part of an application for employment, all information from a prospective employee necessary for initiating the criminal history record]

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

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

The Commissioner shall increase the rates of payment for all eligible providers in an aggregate of $16,000,000 annually for the period June 1, 2006 through March 31, 2007, July 1, 2007 through March 31, 2008, and June 1, 2008 through March 31, 2009.

Rates will be adjusted in the form of a uniform percentage add-on as calculated by the Department, based upon the proportion of total allocated dollars, to the total Medicaid expenditures for covered home care services provided in local social services districts that do not include a city with a population over one million. All government and non-government owned or operated providers are eligible for this adjustment pursuant to the same uniformly applied methodology.

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Recruitment and Retention of Direct Patient Care Personnel

The Commissioner of Health will additionally adjust rates of payment for certified home health agencies, for purposes of improving recruitment and retention of home health aides or other non-supervisory personnel with direct patient care responsibility.

These additional adjustments to rates of payments shall be calculated by allocating the available funding proportionally based on each certified home health agency's, home health aide or other direct care services total annual hours of service provided to Medicaid patients, as reported in each such agency's most recently available cost report as submitted to the Department [prior to November 1, 2005 to the total of such hours for all certified home health agency providers.] The total aggregate available funding for all eligible certified home health agency providers is as follows:

For the period June 1, 2006 through December 31, 2006 - $20,100,000.
For the period January 1, 2007 through June 30, 2007 - $20,100,000.
For the period July 1, 2007 through March 31, 2008 - $40,200,000.
For the period April 1, 2008 through March 31, 2009 - $40,200,000.
For the period April 1, 2009 through March 31, 2010 - $40,200,000.
For the period April 1, 2010 through March 31, 2011 - $40,200,000.
For the period April 1, 2011 through March 31, 2012 - $40,200,000.
For the period April 1, 2012 through March 31, 2013 - $40,200,000.
For the period April 1, 2013 through March 31, 2014 - $40,200,000.

Payments made pursuant to this section will not be subject to subsequent adjustment or reconciliation.

For providers established after November 1, 2005, the Department utilizes Medicaid data from the initial cost report submitted to the Department, which would allow the inclusion of those providers in the distribution.

OFFICIAL

Types of Service

Hospice Services: Routine Home Care, Continuous Home Care, Inpatient Respite Care, And General Inpatient Care

Medicaid payment for hospice care will be in amounts no lower than the Medicare rates for: general inpatient, inpatient respite, routine home care and continuous home care using the same methodology as used under Part A of Title XVIII. Annual adjustments shall be made to these rates commencing October 1, 1990, using inflation factors developed by the State.

The Commissioner of Health will increase medical assistance rates of payment by three percent for hospice services provided on and after December first, two thousand two, for purposes of improving recruitment and retention of non-supervisory workers or workers with direct patient care responsibility.

For hospice services provided on or after June 1, 2006 through March 31, 2011, rates of payment will be additionally adjusted for the purpose of further enhancing the provider's ability to recruit and retain non-supervisory workers or workers with direct patient care responsibility. These additional adjustments to rates of payment will be [calculated by allocating] allocated proportionally [the available funding proportionally] based on each hospice provider's non-supervisory workers' or [workers with] direct patient care [responsibility] workers' total annual hours of service provided to Medicaid patients as reported in each such provider's most recently available cost report as submitted to the Department[prior to November 1, 2005, to the total of such hours for all eligible hospice providers.] The total aggregate available funding for all eligible hospice providers is as follows:

For the period June 1, 2006 through December 31, 2006 - $730,000.
For the period January 1, 2007 through June 30, 2007 - $730,000.
For the period July 1, 2007 through March 31, 2008 - $1,460,000.
For the period April 1, 2008 through March 31, 2009 - $1,460,000.
For the period April 1, 2009 through March 31, 2010 - $1,460,000.
For the period April 1, 2010 through March 31, 2011 - $1,460,000.
For the period April 1, 2011 through March 31, 2012 - $1,460,000.
For the period April 1, 2012 through March 31, 2013 - $1,460,000.
For the period April 1, 2013 through March 31, 2014 - $1,460,000.

Hospice services providers that have their rates adjusted for this purpose shall use such funds solely for the purposes of recruitment and retention of non-supervisory workers or workers with direct patient care responsibility and are prohibited from using such funds for any other purposes. Each hospice provider receiving funds shall submit, at a time and in a manner determined by the Commissioner, a written certification attesting that such funds will be used solely for the purpose of recruitment and retention of non-supervisory workers or workers with

direct patient care responsibility. The Commissioner is authorized to audit each provider to ensure compliance with this purpose and shall recoup all funds determined to have been used for purposes other than recruitment and retention of non-supervisory workers or workers with direct patient care responsibility. Payments made pursuant to this section shall not be subject to subsequent adjustment or reconciliation. All government and non-government owned or operated providers are eligible for this adjustment pursuant to the same uniformly applied methodology.

Type of Service

For persons residing in nursing facilities who have elected hospice care, the Medicaid State agency will pay the hospice an amount sufficient to cover room and board as defined in Section 1905 (o) of the Social Security Act.

Special Needs Patients

Enhanced Medicaid rates for services to special need hospice patients are established for routine home care, continuous home care and general inpatient care using the following methodology: Use the percentages for each service component as promulgated by the CMS in the routine home care, continuous home care and general inpatient care rates, to determine service component dollar values; use documented cost data which supports specific service component enhancement to calculate amount to be added to rate as an enhancement; apportion each rate into its respective labor and non-labor component using the Medicare prescribed labor to non-labor ratios; adjust labor component of each enhanced rate to account for regional differences in wages using Medicare hospice wage indices; add adjusted labor component to the non-labor component to arrive at the regional enhanced rates.

Rehabilitative Services

The New York State Office of Alcoholism and Substance Abuse Services establishes rates of reimbursement for the provision of rehabilitative services to persons in freestanding chemical dependence residential facilities. Allowable base year costs are determined by the application of principles developed for determining reasonable cost payments under the Medicare program. To be allowable, costs must be reasonable and relate to patient care. Allowable costs may not include costs for services, which have not been approved by the Commissioner. Total allowable costs are classified as either treatment related costs or room and board related costs. Utilizing only allowable treatment related costs; a provider-specific Medicaid treatment rate shall be established. The treatment rate shall consist of an operating and a capital component.