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Section 709.3

709.3 Residential health care facility beds.

709.3(a) Notwithstanding the provisions of subdivisions (a), (b), and (c) of section 709.1 of this Part, the methodology and procedures in this section will be used in the evaluation of certificate of need applications involving the construction of new or replacement residential health care facility beds, the renovation of residential health care facilities, the sale or transfer of residential health care facility beds between facilities, or the establishment of residential health care facilities, including changes of ownership subject to review by the Public Health Council.

(b)(1) For purposes of this methodology, the base year shall be ~~2000~~ 2006 and the planning target year shall be ~~2007~~ 2016. The planning area shall be the county except as otherwise provided for in this section.

(2) Notwithstanding any other provision of this section, the estimates of public need for residential health care facility beds determined under this section for the planning target year shall continue to be the estimates of public need for such beds for years subsequent to the planning target year until a new bed need methodology is promulgated.

(c) The methodology uses the following steps to estimate the need for residential health care facility beds in the planning target year:

(1) The population age 0-64 is estimated by county for the base year and planning target year in paragraph (1) of subdivision (d) of this section.

(2) The number of functionally dependent individuals in the population age 65 and older is estimated by county for the base year and the planning target year in paragraph (2) of subdivision (d) of this section.

(3) The population age 0-64 and the number of functionally dependent individuals aged 65 and older in each county for the base year is summed in paragraph (3) of subdivision (d) of this section to derive the statewide totals for each age group.

(4) Statewide normative use rates for residential health care facilities, long term community based care and supportive housing are calculated in paragraphs (4), (5) and (6) of subdivision (d) of this section for the population age 0-64 and for the functionally dependent population age 65 and older.

(5) The statewide pattern need estimates for residential health care facility beds, long term community based services and supportive housing in the planning target year are calculated in paragraph (7) of subdivision (d) of this section by county by multiplying the statewide normative use rates by the appropriate population group.

(6) The need estimates for residential health care facility beds, long term community based services and supportive housing are summed to determine total long term care need for each county in paragraph (8) of subdivision (d) of this section.

(7) Local pattern need estimates for residential health care facility beds, long term community based services and supportive housing in the planning target year are calculated based on the local pattern distribution of long term care services in the base year in paragraph (9) of subdivision (d) of this section.

(8) The statewide pattern need estimates and the local pattern need estimates are averaged in paragraph (10) of subdivision (d) of this section to derive the blended need estimate for residential health care facility

beds, long term community based care and supportive housing.

(9) The blended need estimates for residential health care facility beds are adjusted to reflect a 99% occupancy rate in paragraph (11) of subdivision (d) of this section.

(10) The residential health care facility bed need estimates are adjusted to reflect migration between counties in the State, to facilities outside the State, to special facilities and for patients migrating from other states to New York in paragraph (12) of subdivision (d) of this section.

~~(11) The estimates of public need for residential health care facility beds for the planning target year in each county are provided in paragraph (13) of subdivision (d) of this section.~~

~~(12~~) (11) The relationship of the need estimates for residential health care facility beds to special populations is addressed in paragraphs (14) and (15) of subdivision (d) of this section.

~~(13) The requirement for the department to evaluate the residential health care facility bed need methodology and the appropriateness of certain assumptions set forth in this section is addressed in paragraph (16) of subdivision (d) of this section.~~

~~(14)(13~~)(12) The development of long term care plans by the health systems agencies and the types of adjustments to the need estimates that may be recommended in these plans is addressed in subdivision (e) of this section.

~~(15)(14)~~ (13)Subdivision (f) of this section provides that the bed need estimates for the planning target year shall constitute the public need for residential health care facility beds in the planning area.

~~(16)(15~~)(14) Remaining need for construction of additional residential health care facility beds is calculated by county in subdivision (g) of this section.

~~(17)(16)~~ (15)Factors which could be considered by the department to modify the need estimates developed in accordance with subdivision (d) of this section are described in subdivision (h) of this section.

(d) The methodology for determining the public need for residential health care facility beds and the estimates of projected need by county for the planning target year shall be as follows:

(1) The population age 0-64 shall be estimated by county for the base year and the planning target year using New York State Data Center projections ~~U.S. Census Bureau data and the planning target year using linear interpolation of the population projections for 2005 and 2010~~ and 2015 ~~developed by the Empire State Development.~~

(2)(i) The population age ~~65-69, 70-74, 75-79, 80-84 and 85~~ 65-74 and 75 and older shall be estimated by county for the base year using ~~U.S. Census Bureau data~~ New York State Data Center projections ~~and the planning target year using linear interpolation of the population projections developed by the Empire State Development and by population categories based on U.S. Census Bureau data.~~

(ii) The total number of functionally dependent individuals age 65 and older shall be estimated by county for the base year and planning target year based on the percentage of such individuals found in the population age 65 and older derived from U.S. Census Bureau data which ~~defined~~ identified those with a self-care limitation as those who resided in the community but report having a condition that makes activities of daily living difficult ~~functional dependents as those who resided in the community but receive or indicate the need to receive help or supervision with personal care, mobility or household activities~~ plus those who resided in residential health care facilities. Estimating the functionally dependent population age 65 and older identifies a sub-set of the population age 65 and older of which a further sub-set will need long term care services from the formal support system, such as residential health care facility beds,

supportive housing and long term community based services.

(3) The population estimates for those age 0-64 derived in accordance with paragraph (1) of this subdivision in each county and the population estimates of the functionally dependent individuals age 65 and older derived in accordance with paragraph (2) of this subdivision in each county for the base year shall be summed to derive the State total for each age group.

(4) The average daily census of persons served with long term care services in the base year shall be determined by age for the 0-64 age group and for those age 65 and older. Such data shall include the following long term care services:

(i) residential health care facility patients by county of origin including New York State residents served in out-of-state facilities;

(ii) persons served in the personal care program;

(iii) persons served in adult care facilities serving the frail elderly;

(iv) persons served by certified home health agencies with a length of stay of 90 days or longer;

(v) persons served by long term home health care programs;

(vi) persons served by managed long term care plans;

~~(vi)~~(vii) patients in general hospitals on alternate level of care status with a length of stay on such status of seven days or more.

(5) For purposes of calculating appropriate normative use rates, the number of long term care patients served in the base year shall be summed by age group for the three long term care categories of residential health care facilities, long term community based care (including long term home health care programs, certified home health agency services to long term care patients, managed long term care plans and personal care programs) and supportive housing (including adult homes and enriched housing, programs). The number of patients on alternate level of care status shall be allocated between long-term community based care services and residential health care facilities.

(6) Statewide normative use rates shall be calculated for residential health care facilities, long term community based care and supportive housing for the population age 0-64 and for the functionally dependent population age 65 and older. Such statewide normative use rates shall be calculated by dividing the total patient population for residential health care facilities, long term community based services and supportive housing determined in accordance with paragraph (5) of this subdivision by the estimated base year population age 0-64 and the number of the functionally dependent age 65 and older.

(7) The statewide normative use rates derived in paragraph (6) of this subdivision shall be multiplied by the estimated county level population age 0-64 and estimated number of the functionally dependent age 65 and older for the planning target year to derive county level estimates of the need for residential health care facility beds, persons to be served in supportive housing and long term community based services needs. These need estimates shall be referred to as the statewide pattern need estimates.

(8) The total long term care need for each county is calculated by summing the need for residential health care facility beds, long term community based care and supportive housing. This sum represents an estimate of the total number of people in need of long term care services on a daily basis as represented by the statewide normative use rates.

(9) The local pattern of distribution of long term care services shall be calculated by county using the percentage distribution of resources in the county for residential health care facility beds, supportive

housing and long term community based services in the base year. These percentages are multiplied by the total long term care need for the county derived in paragraph (8) of this subdivision to calculate the local pattern need estimates for residential health care facility beds, supportive housing and long term community based care.

(10) The need for residential health care facility beds calculated using the statewide pattern and the local pattern shall be averaged to estimate the blended need for each service category in the county for the planning target year.

(11) The residential health care facility beds in each county resulting from blending the statewide pattern need and the local pattern need in paragraph (10) of this subdivision shall be adjusted to reflect a 99% occupancy rate.

(12) The residential health care facility beds in each county resulting from the occupancy adjustment in paragraph (11) of this subdivision shall be adjusted to reflect migration between counties and to and from other states. In general, migration is estimated to be 50% voluntary and likely to continue regardless of the availability of resources in the county of origin and 50% involuntary resulting from the unavailability of resources in the county of origin. ~~In addition, some special facilities serve a population that is statewide in origin. Migration of all patients served in special facilities for purposes of migration adjustments is considered to be voluntary.~~ Migration adjustments shall be based on base year data and shall include:

(i) Migration from the county of origin to other New York State counties. Such migration adjustment shall be equal to 50% of the number of residential health care facility beds that would be required in the planning target year for residents who have migrated from another county for residential health care facility services calculated based on the proportion of county of origin patients migrating to the county of destination in the base year multiplied by the planning target year county of origin residential health care facility need.

(ii) Migration to facilities outside New York State. Such migration adjustment shall be equal to 50% of the Medicaid patients served outside New York State calculated based upon Medicaid claims data concerning out of state placements in the base year.

~~(iii) Migration to special facilities. Special facilities are defined as those residential health care facilities serving a statewide population or for which 50% or more of the patients originate from outside the health systems agency region in which the facility is located. Migration adjustments for such facilities shall be equal to 100% of the patients reported by these facilities in the base year.~~

~~(iv)~~(iii) Out-of-state migration to New York State facilities. Such migration adjustment shall be equal to 100% of the patients reported by residential health care facilities in the base year.

~~(13) The following are the projected estimates of public need by county for the planning target year for residential health care facility beds determined in accordance with paragraphs (1) through (12) of this subdivision:~~

~~Residential Health Care~~
~~County Facility Bed Need – 2007~~ ~~2016~~

~~ALBANY~~
~~ALLEGANY~~
~~BRONX~~
~~BROOME~~
~~CATTARAUGUS~~
~~CAYUGA~~
~~CHAUTAUQUA~~
~~CHEMUNG~~

~~CHENANGO~~
~~CLINTON~~
~~COLUMBIA~~
~~CORTLAND~~
~~DELAWARE~~
~~DUTCHESS~~
~~ERIE~~
~~ESSEX~~
~~FRANKLIN~~
~~FULTON~~
~~GENESEE~~
~~GREENE~~
~~HAMILTON~~
~~HERKIMER~~
~~JEFFERSON~~
~~KINGS~~
~~LEWIS~~
~~LIVINGSTON~~
~~MADISON~~
~~MONROE~~
~~MONTGOMERY~~
~~NASSAU~~
~~NEW YORK~~
~~NIAGARA~~
~~ONEIDA~~
~~ONONDAGA~~
~~ONTARIO~~
~~ORANGE~~
~~ORLEANS~~
~~OSWEGO~~
~~OTSEGO~~
~~PUTNAM~~
~~QUEENS~~
~~RENSSELAER~~
~~RICHMOND~~
~~ROCKLAND~~
~~SAINT LAWRENCE~~
~~SARATOGA~~
~~SCHENECTADY~~
~~SCHOHARIE~~
~~SCHUYLER~~
~~SENECA~~
~~STEUBEN~~
~~SUFFOLK~~
~~SULLIVAN~~
~~TIOGA~~
~~TOMPKINS~~
~~ULSTER~~
~~WARREN~~
~~WASHINGTON~~
~~WAYNE~~
~~WESTCHESTER~~
~~WYOMING~~
~~YATES~~

~~TOTAL~~

~~(14~~) (13) The estimates of need for residential health care facility beds ~~in paragraph (13) of~~ developed in accordance with this subdivision do not include estimates of need for residential health care facility beds for special pediatric beds, ventilator beds, patients with acquired immune deficiency syndrome or those in need of long term rehabilitation for head injury. Need for residential health care facility beds to serve such patients shall be in addition to the estimates of need ~~in paragraph (13) of~~ developed in accordance with this subdivision.

~~(15~~) (14) The estimates of need for residential health care facility beds ~~in paragraph (13) of~~ developed in accordance with this subdivision include beds needed for dementia patients, e.g. Alzheimers disease and related disorders, ~~and ventilator dependent patients.~~

~~(16) The department shall conduct an evaluation of the residential health care facility bed need methodology set forth in this section by December 31, 2007; provided that before December 31, 2005, the department shall evaluate the appropriateness of the 99% occupancy rate as set forth in subdivision (d) of this section and the 97% occupancy threshold criterion in subdivision (f) of this section, based on the most recent data available.~~

(e)(1) The estimates of need for residential health care facility beds, supportive housing and long term community based services developed in accordance with subdivision (d) of this section shall serve as the basis for development of long term care plans by the health systems agencies that are operational. These need estimates may be modified in accordance with paragraph (4) of this subdivision.

(2) The long term care plans shall describe the steps that will be taken on a regional basis to develop the long term care system to meet the needs for residential health care facilities, long term community based services and supportive housing. These plans should be developed by the health systems agency in consultation with providers, consumers, local governments and other entities within the health systems agency region having an interest in long term care services. To be used by the department in reviewing certificate of need applications, the long term care plan must be approved by the Commissioner of Health with the advice of the State Hospital Review and Planning Council, provided, however, that if a long term care plan has not been developed by the health systems agency and approved by the Commissioner of Health with the advice of the State Hospital Review and Planning Council at the time an application is considered by the department, the need estimates shall be determined in accordance with subdivision (d) of this section without a long term care plan adjustment.

(3) The long term care plans developed by the health systems agencies shall include but need not be limited to:

(i) designation of long term care planning areas. Long term care planning areas may include a single county or two or more counties grouped together but may not include portions of a county. The criteria for establishing long term care planning areas shall be reflective of at least the following:

(a) voluntary patient migration patterns;

(b) travel patterns including driving time.

(4) The health systems agency long term care plans may make recommendation for amending the need estimates developed in accordance with subdivision (d) of this section to reflect local characteristics. Factors that may be considered in this analysis include, but are not limited to, the following:

(i) Adjustments for additional migration between health systems agency regions that is documented and agreed upon in writing by the affected health systems agencies;

(ii) Adjustments to the allocation of long term care services between components of the long term care

service system - residential health care facilities, long term community based services and supportive housing. Factors that may be considered in reallocation of the need between components of the long term care service system may include issues related to geographic considerations or manpower availability. All such recommendations should clearly demonstrate why these adjustments are necessary and how they will benefit the planning area.

(f)(1) The bed need estimates developed pursuant to subdivision (d) of this section, together with any approved adjustments developed in accordance with subdivision (e) of this section, shall constitute the public need for residential health care facility beds in the planning areas defined subject to further adjustments in accordance with subdivision (h) of this section.

(2) For purposes of determining public need for residential health care facility beds in the City of New York, the public need estimates for each county in the City of New York, determined in accordance with this section, shall be summed. For the purposes of determining public need for residential health care facility beds in the counties in Nassau and Suffolk, the public need estimates for each of these two counties, determined in accordance with this section, shall be summed.

(3) Notwithstanding that there is an indication of need in a planning area for additional residential health care facility beds as determined in accordance with subdivisions (d) or (e) of this section, there shall be a rebuttable presumption that there is no need for any additional residential health care facility beds in such planning area if the overall occupancy rate for existing residential health care facility beds in such planning area is less than 97% based on the most recently available data. It shall be the responsibility of an applicant in such instances to demonstrate that there is a need for additional residential health care facility beds despite the less than 97% occupancy rate in the applicant's planning area utilizing the factors set forth in subdivision (h) of this section.

(g) The evaluative procedure for determining public need for residential health care facility beds in a planning area for the planning target year shall include, but not be limited to:

(1) identification of existing residential health care facility beds in the planning area;

(2) identification of residential health care facility beds that have been approved for construction but are not in operation in the planning area;

(3) identification of resulting total residential health care facility beds that will be available in the planning area;

(4) identification of remaining need in the planning area, based upon public need for residential health care facility beds in the planning area determined in accordance with subdivision (d) or (e) of this section or adjusted in accordance with subdivision (h) of this section.

(h) Notwithstanding any other provision of this section, when the estimates of need for residential health care facility beds developed in accordance with subdivision (d) or (e) of this section indicate the need for additional residential health care facility beds, such estimates of additional need may be modified, based on information and data gathered from relevant sources relating to significant local factors pertaining to an applicant’s service/planning area, or on statewide factors, where relevant, which factors may include, but not necessarily be limited to, those set forth in paragraphs (1) through (7) of this subdivision. When making recommendations to the State Hospital Review and Planning Council and Public Health Council concerning the impact of the factors set forth in this subdivision, the department shall, to the extent practicable, indicate the relative priority of such factors.

(1) the impact of requirements pertaining to placing persons with disabilities into the most integrated setting appropriate so as to enable persons with disabilities to interact with non-disabled persons to the fullest extent possible;

(2) the growth, availability and cost-effectiveness of long-term home and community-based services, other non-institutional residential programs and of other programs and services that may serve as a substitute for or prevent the need for residential health care facility placement;

(3) occupancy rates, and the trend of those rates of existing residential health care facilities in the planning area and in contiguous counties;

(4) patient migration patterns that vary from those included in the methodology set forth in subdivision (d) of this section;

(5) the health status of residents of the planning area or the state, as applicable;

(6) recommendations made by the local health systems agency, if applicable;

(7) documented evidence of the unduplicated number of patients on waiting lists who are appropriate for and desire admission to a residential health care facility who experience a long waiting time for placement and who cannot be served adequately in other settings.

(i) An applicant for residential health care facility beds should anticipate that the review of the certificate of need application will be on a competitive basis. Therefore, all information and factors that the applicant deems relevant to the Department's determination of public need must be included in the applicant's certificate of need submission. Review of the proposal as submitted by the applicant shall include:

(1) the proposal's responses to and consistency with priority considerations specified in any requests for proposals issued by the Department or the health systems agency;

(2) the relationship of the residential health care facility beds being proposed to any applicable regional or statewide plans;

(3) the proposal's consistency with the provisions of subdivision (d) of section 709.1 of this Part;

(4) the availability of less costly or more effective alternative methods of providing the residential health care facility beds being reviewed;

(5) whether the proposed residential health care facility beds would provide improvements or innovations in the financing and delivery of health services and serve to promote quality assurance and cost effectiveness;

(6) the quality of care provided by the residential health care facility in the past;

(7) in cases involving the reduction or elimination of residential health care facility beds including those cases involving the relocation of a facility or service, the extent to which need will be met adequately and the effect of the reduction, elimination, or relocation of the facility on the ability of low income persons, racial and ethnic minorities, and other underserved groups, to obtain needed long term care services;

(8) in cases involving a proposed service area which includes a neighboring planning area, the ability of residents of such neighboring planning area to access the residential health care facility beds proposed;

(9) the contribution the proposed residential health care facility would make in meeting the health needs of members of medically underserved groups which have traditionally experienced difficulties in obtaining equal access to residential health care facility beds (for example, low- income persons, racial and ethnic minorities, and patients on alternate level of care status in general hospitals). For the purpose of determining the extent to which the proposed facility will be accessible to such persons, the following shall be considered:

(i) the extent to which medically underserved populations currently use the applicant's services, where the applicant currently provides residential health care facility services, in comparison to the percentage of all users of the service in the applicant's planning area or to which they are found in the population in general, and the extent to which medically underserved populations are expected to use the proposed residential health care facility beds if approved;

(ii) the performance of the applicant, where the applicant currently provides residential health care facility services, in meeting its obligation under the applicable civil rights statutes prohibiting discrimination on the basis of race, color, national origin, handicap, sex and age; and

(iii) the extent to which Medicaid and medically indigent patients are or would be served by the applicant.

(10) When the remaining public need identified in subdivision (g) of this section is not sufficient to permit the approval of all applications for residential health care facility beds which are considered in the batch under consideration which otherwise meet all statutory and regulatory criteria specified under the Public Health Law, the proposals will be competitively reviewed. In the competitive review process consideration will be given to those proposals which meet any or all of the following:

(i) make a commitment to admit a percentage of patients who are Medicaid eligible or Medicare/Medicaid eligible in excess of that required under subdivision (m) of this section;

(ii) make a commitment to admit a percentage of patients who have been on alternate level of care status in a general hospital for more than 90 days. Additional consideration will be given to applications that:

(a) identify and agree to meet special program requirements for such patients; and

(b) demonstrate that they have written agreements with general hospitals for admission of alternate level of care patients;

(iii) agree in writing to participate in available local long term care case management programs. Existing written agreements with local case management programs should be documented in the application;

(iv) propose to establish or expand adult care facility beds or other supportive housing programs;

(v) provide an architectural design, as demonstrated through room-by-room single line drawings and project narrative, that offers innovative designs and other factors (such as interior finishes, lighting, decorating and furnishings) to enhance quality of life in the facility.

(j) Notwithstanding any inconsistent provision of this section, the applicant may propose a service area that includes a long term care planning area outside of that in which the facility or proposed facility is located. If any application is approved on this basis, the number of residential health care facility bed resources available in the external planning area determined in accordance with subdivision (g) of this section will be adjusted to reflect that portion of the facility's bed complement which will serve residents of the external planning area.

(k) Any application for construction wherein a determination of public need is made pursuant to this section shall be subject to he provisions of subdivision (e) of section 709.1 of this Part.

(l) Notwithstanding any other provision of this section to the contrary, up to 300 additional residential health care facility beds for the State as a whole may be approved, which shall be in addition to the total statewide number of residential health care facility beds otherwise estimated to be needed under this section. Such additional beds may be approved in response to applications to add a single bed or multiple beds to an existing facility, to add an extension unit to an existing facility or to construct a new facility. Such additional beds may be approved only to meet emergency situations or other unanticipated circumstances, which shall include, but not necessarily be limited to, the following:

(1) natural disasters, such as floods, fires and disease outbreaks,

(2) unanticipated changes in population migration patterns or census growth,

(3) unanticipated reduction in availability of alternative placement settings,

(4) unanticipated changes in population health or age group characteristics.

(m) Any residential health care facility or general hospital filing an application to add residential health care facility beds shall be subject to the following requirements which shall apply to all of the facility's existing and proposed certified residential health care beds:

(1) In determining the need for residential health care facilities, beds and services, consideration shall be given to the needs of persons who receive or are eligible to receive medical assistance benefits at the time of admission to a facility pursuant to title XIX of the Federal Social Security Act and title 11 of article 5 of the Social Services Law, hereafter referred to as Medicaid patients, and the extent to which the applicant serves or proposes to serve such persons, as reflected by factors including, but not necessarily limited to, the applicant's admissions policies and practices. An application by an applicant that is or will be a provider that participates in the medical assistance (Medicaid) program shall not be approved unless the applicant agrees to comply with the requirements of this subdivision. An applicant that, at the time of consideration of its application by the commissioner, proposes not to participate in the Medicaid program may be approved, provided all other review criteria have been met, upon the condition that if, in the future, it does participate in the Medicaid program, it would comply fully with the requirements of this subdivision.

(2) To ensure that the needs of Medicaid patients in an applicant's service area are met and that such patients have adequate access to appropriate residential health care facilities, beds and services, applicants shall be required to accept and admit at least a reasonable percentage of Medicaid patients as determined pursuant to this subdivision. Such reasonable percentage of Medicaid patient admissions, also referred to herein as the Medicaid patient admissions standard, shall be equal to 75 percent of the annual percentage of all residential health care facility admissions, in the long-term care planning area in which the applicant facility is located, that are Medicaid patients. The calculation of such planning area percentage shall not include admissions to residential health care facilities that have an average length of stay of 30 days or less. If there are four or fewer residential health care facilities in a planning area, the applicable Medicaid patient admissions standard for such planning area shall be equal to 75 percent of the planning area annual percentage of all residential health care facility admissions that are Medicaid patients or 75 percent of the annual percentage of all residential health care facility admissions, in the health systems agency area in which the facility is located, that are Medicaid patients, whichever is less. In calculating such percentages, the department will use the most current admissions data which have been received and analyzed by the department. An applicant will be required to make appropriate adjustments in its admissions policies and practices so that the proportion of its own annual Medicaid patient admissions is at least equal to 75 percent of the planning area percentage or health systems agency area percentage, whichever is applicable.

(3) The proportion of an applicant's admissions that must be Medicaid patients, as calculated under paragraph (2) of this subdivision, may be increased or decreased based on the following factors:

(i) the number of individuals within the planning area currently awaiting placement to a residential health care facility and the proportion of total individuals awaiting such placement that are Medicaid patients, provided that patients awaiting placement include, but need not be limited to, alternate level of care patients in general hospitals;

(ii) the proportion of the facility's total patient days that are Medicaid patient days and the length of time that the facility's patients who are admitted as private paying patients remain such before becoming

Medicaid eligible;

(iii) the proportion of the facility's admissions who are Medicare patients or patients whose services are paid for under provisions of the Federal Veterans' Benefit Law;

(iv) the facility's patient case mix based on the intensity of care required by the facility's patients or the extent to which the facility provides services to patients with unique or specialized needs; and

(v) the financial impact on the facility due to an increase in Medicaid patient admissions.

(4)(i) An applicant shall submit a written plan, subject to the approval of the department, for reaching the Medicaid patient admissions standard required by this subdivision. The plan shall provide for reaching the standard within no longer than a two-year period and the facility shall give preference, as necessary, to Medicaid patients in order to reach the admissions standard within the prescribed time period.

(ii) Once the Medicaid patient admissions standard is reached, the facility shall not reduce its proportion of Medicaid patient admissions so as to go below the standard unless and until the applicant, in writing, requests the approval of the department to adjust the standard and the department's written approval is obtained. In reviewing requests to adjust a facility's Medicaid patient admissions standard, the department shall consider factors which may include, but need not be limited to, those factors set forth in paragraphs (2) and (3) of this subdivision.

(iii) After a facility's initial Medicaid patient admissions standard has been reached, the department may increase such facility's Medicaid patient admissions standard, based on the criteria set forth in this subdivision, if the percentage of Medicaid patients admitted by residential health care facilities in the facility's planning area or health systems agency area, as appropriate, increases due to factors other than an increase in Medicaid patient admissions by the applicant.

(5)(i) Subject to the provisions of subparagraph (ii) of this paragraph, after the phase-in period provided for in paragraph (4) of this subdivision, a facility shall be prohibited from failing, refusing or neglecting to accept or admit a Medicaid patient for whom it is otherwise able to provide care, regardless of whether the level of reimbursement received for such patient is less than the rate the facility charges private pay patients, unless the facility has reached and is maintaining compliance with the Medicaid patient admissions standard imposed by this subdivision. Compliance with the requirements of this subdivision shall be determined on the basis of a facility's total annual admissions, so that a facility may exercise its discretion in determining when during a year it will admit a sufficient number of Medicaid patients to maintain its Medicaid patient admissions standard.

(ii) A facility may be exempt from the requirement of admitting a Medicaid patient in order to meet or maintain its Medicaid patient admissions standard if it can demonstrate in writing to the satisfaction of the commissioner that the Medicaid patient was denied admission solely in order to admit another patient who had a greater need of residential health care facility services, as determined by the intensity of care anticipated to be required by such patient, and that there was only one bed available in the facility at the time of the admission decision to accommodate a new admission. Facilities shall not be required to obtain prior department approval in order to accept a non-Medicaid patient in place of a Medicaid patient pursuant to this subparagraph, but shall maintain sufficient documentation including, but not necessarily limited to, a copy of the patient review instrument for the patient admitted and the Medicaid patient denied admission in order to justify the admission decision. Copies of such documentation shall be provided to the department upon request.

(6) If any provision of this subdivision or the application thereof is held invalid, the remainder of this subdivision and the application thereof to other circumstances shall not be affected by such holding and shall remain in full force and effect.