

New York
2(c)(ii)

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**Attachment 4.19-B
(10/08)**

Transitional Supplemental Payments

For the periods February 1, 2002 through March 31, 2002, October 1, 2002 through December 31, 2002, October 1, 2003 through December 31, 2003, April 1, 2005 through June 30, 2005, October 1, 2006 through December 31, 2006, and October 1, 2007 through December 31, 2007, the Commissioner of Health shall make supplemental medical assistance payments to qualified voluntary not-for-profit health care providers that are: freestanding diagnostic and treatment centers (D&TCs) that qualify for distributions under the state's comprehensive diagnostic and treatment centers indigent care program or indicate on the cost reports submitted to the state that they receive funding under section three hundred thirty-three of the Federal Public Health Services Act for health care for the homeless, freestanding diagnostic and treatment centers that operate approved programs under the state Prenatal Care Assistance Program, or licensed freestanding family planning clinics. These supplemental payments reflect additional costs associated with the transition to Managed Care and are for services rendered to Medicaid beneficiaries for the effective period. Payments made, as adjustments to fee for service rates, shall not be subject to subsequent adjustment or reconciliation. These providers will be eligible to receive a supplemental payment if the following criteria are met. The provider's number of Medicaid visits in the base year (2000) equals or exceeds 25 percent of its total number of visits and its number of visits for Medicaid Managed Care enrollees equals or exceeds three percent of its total number of Medicaid visits during the base year. Providers meeting these criteria shall receive a supplemental payment equal to a proportional share of the total funds available not to exceed fourteen million dollars for the period February 1, 2002 through March 31, 2002, nine million eight hundred twenty-four thousand dollars for the period October 1, 2002 through December 31, 2002, nine million eight hundred twenty-four thousand dollars (\$9,824,000) for the period October 1, 2003 through December 31, 2003, nine million eight hundred twenty-four thousand dollars (\$9,824,000) for the period April 1, 2005 through June 30, 2005, twenty nine million four hundred seventy-two thousand dollars (\$29,472,000) for the period October 1, 2006 through December 31, 2006, and nine million eight hundred twenty-four thousand dollars (\$9,824,000) for the period October 1, 2007 through December 31, 2007. This share shall be based upon the ratio of a provider's visits from medical assistance recipients enrolled in Managed Care during the 2000 base year to the total number of visits to all such qualified providers by medical assistance recipients enrolled in managed care during the base year. These amounts shall be divided by the medical assistance utilization data reported in each provider's annual cost report for the period two years prior to the rate period. The resulting amount will represent the per visit add-on to each eligible provider's fee for service medical assistance rates of payment.

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Electronic Health Record Systems Supplemental Payments

For the period October 1, 2008 through December 31, 2008, seven million three hundred eighty eight thousand dollars (\$7,388,000) shall be available to eligible covered providers as medical assistance payments for services provided to Medicaid beneficiaries to reflect additional costs associated with the development, training, maintenance, and support of electronic health record systems that meet such standards no later than January 1, 2008, as established by the Commissioner of Health. The State will conduct a survey and perform independent verification. Electronic health records standards are: the exchanging of health information with other computer systems according to national standards; be certified by the Certification Commission for Health Information Technology; be capable of and used for supporting electronic prescribing; and be capable of and used for providing relevant information to the clinicians to assist with decision making. Providers will be eligible to receive a supplemental payment for the period October 1, 2008 through December 31, 2008, if this criterion is met. In addition to meeting the electronic record standards criterion, a provider's number of Medicaid visits for patient care services during the base year must equal or exceed twenty-five percent of its total number of visits for patient care services in the base year or its number of Medicaid visits combined with its number of uninsured visits for patient care services in the base year equals or exceeds thirty percent of its total number of visits for patient care services during the base year. Each qualified provider shall receive a supplemental payment equal to such provider's proportional share of the total funds allocated, based upon the ratio of its visits from Medicaid recipients during the base year to the total number of Medicaid visits to all such qualified providers during the base year. The base year will be two years prior to the rate year, and the Commissioner of Health shall utilize data to determine Medicaid and uninsured visits reported by covered providers on certified 2006 AHCF-1 cost reports submitted to the Department of Health for such base year.

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Supplemental Payments - Dental Clinic - February 1, 2002 through March 31, 2002

Notwithstanding the provisions of the preceding section, for the period February 1, 2002 through March 31, 2002, facilities licensed under article twenty-eight of the public health law that are sponsored by a university or a dental school which has been granted an operating certificate and which provides dental services as its principal mission, shall receive up to five hundred thousand dollars, in the aggregate, for use as supplemental payments pursuant to the preceding section. These funds shall be allocated for distribution to such facilities pursuant to the statutorily defined methodology contained in §364-j-2 of the Social Services Law. Payments may be added to rates of payment or made as aggregate payments to eligible facilities for services rendered to Medicaid beneficiaries for the effective period. Payments made, as adjustments to fee for service rates, shall not be subject to subsequent adjustment or reconciliation.

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Supplemental Payments - Dental Clinic - October 1, 2002 through December 31, 2002, October 1, 2003 through December 31, 2003, April 1, 2005 through June 30, 2005, October 1, 2006 through December 31, 2006, and October 1, 2007 through December 31, 2007, and October 1, 2008 through December 31, 2008.

Notwithstanding the provisions of the first paragraph of this section titled Transitional Supplemental Payments, for the periods October 1, 2002 through December 31, 2002, October 1, 2003 through December 31, 2003, April 1, 2005 through June 30, 2005, October 1, 2006 through December 31, 2006, and October 1, 2007 through December 31, 2007, facilities licensed under article twenty-eight of the Public Health Law that are sponsored by a university or a dental school which has been granted an operating certificate and which provides dental services as its principal mission, shall receive up to two hundred twenty-five thousand dollars in the aggregate for the period October 1, 2002 through December 31, 2002, for the period October 1, 2003 through December 31, 2003, up to two hundred twenty-four thousand dollars in the aggregate, for the period April 1, 2005 through June 30, 2005, up to two hundred twenty-four thousand dollars in the aggregate, for the period October 1, 2006 through December 31, 2006, up to six hundred seventy-two thousand dollars (\$672,000) in the aggregate, and for the period October 1, 2007 through December 31, 2007, up to two hundred twenty-four thousand dollars (\$224,000) in the aggregate; and for the period October 1, 2008 through December 31, 2008, up to two hundred twenty-four thousand dollars (\$224,000) in the aggregate; for use as supplemental payments pursuant to the first paragraph of this section titled Transitional Supplemental Payments. Forty percent of these funds shall be allocated for equal distribution based upon the facilities losses reported from self-pay and free visits multiplied by the facility specific Medicaid payment rate for the applicable year. This amount shall be offset by any payments received from such patients during the applicable period. Sixty percent, plus any funds allocated but not distributed under provisions of the previous sentence, shall be allocated according to the following scale.

% of eligible BD&CC visits to total visits	% of nominal financial loss coverage
up to 15%	50%
15 - 30%	75%
30%+	100%

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The allocated amounts will be added to rates of payment [s] for eligible facilities for services rendered to Medicaid beneficiaries for the effective periods. These amounts shall be divided by the medical assistance utilization data reported in each provider's annual cost report for the period two years prior to the rate period. The resulting amount will represent the per visit add-on to each eligible provider's fee for service medical assistance rates of payment. Payments made, as adjustments to fee for service rates, shall not be subject to subsequent adjustment or reconciliation.

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