

New York State

Medicaid Update

THE OFFICIAL NEWSLETTER OF THE NEW YORK STATE MEDICAID PROGRAM

Medicaid Spending Below Target for Current Year as Health Care Reform Initiatives Improve Quality and Control Costs

Medicaid spending is below target in the current fiscal year and adopted initiatives have already saved the state nearly \$600 million, according to information released by the New York State Medicaid Redesign Team (MRT). The MRT was created in January by Governor Andrew M. Cuomo to conduct a comprehensive examination of New York State's Medicaid program.



Seventy-eight recommendations of the MRT were enacted in the state budget in April. These initiatives will cap Medicaid spending growth in state law, begin a three-year phase-in to managed care for all Medicaid members, and reduce Medicaid spending by \$2.2 billion in the current fiscal year. Spending for the current year, which is reported on a monthly basis, totaled \$6.8 billion -- \$173 million or 2.5 percent below the target for August.

"Governor Cuomo's initiative to reform Medicaid represents an unprecedented effort to bring the public into the process of improving health care, controlling health care costs, and reforming health care in New York State," said Health Commissioner Nirav R. Shah, M.D., M.P.H. "With the hard work and dedication of the legislature, the industry, and the public, New York is becoming a model for the nation in improving health outcomes while controlling growth."

"Although spending remains on target, enrollment growth influenced by the weak economy may impact savings in the current year. We will continue to closely monitor spending and operational trends to ensure that the state remains within the Global Medicaid Cap," Shah said.

The enacted state budget set a Global State Medicaid spending cap for the Department of Health at \$15.3 billion for 2011-12 and \$15.9 billion for 2012-13. The cap represents Governor Cuomo's goal to limit total Medicaid spending growth to no greater than the rate of inflation for health care (currently 4 percent).

There are currently 10 MRT work groups developing reform proposals and working to address implementation issues in all areas of Medicaid, including managed long-term care implementation, behavioral health reform, program streamlining, payment reforms, health disparities, basic benefit reviews, medical malpractice, and others. All meetings of these work groups are open to the public.



OCTOBER 2011 NEW YORK STATE MEDICAID UPDATE

IN THIS ISSUE ...

POLICY AND BILLING GUIDANCE

Medicaid Spending Below Target for Current Year as Health Care Reform Initiatives Improve Quality and Control Costs.....	cover
Prior Authorization for Admission to Out-of-State Non-Specialized Skilled Nursing Facilities	page 3
Article Correction: Limits on Therapy Benefits for Managed Care Enrollees	page 4

PHARMACY UPDATES

Important EPIC Notice	page 5-6
Fee-For-Service Pharmacy Providers	page 7
Prescribers Eligibility Transaction Update	page 7
Attention: Medicaid Managed Care and Family Health Plus Members FAQs (Providers Please Post in your Practice)	page 8-9

ALL PROVIDERS

Provider Seminar Schedule for October-December 2011 Now Available	page 10
Secondary Claims Cannot be Billed to Medicaid Before the Primary Payer's Remittance is Received.....	page 11
eMedNY dashboard Helps Users Track Submitted Files	page 11
Provider Directory	page 12



POLICY AND BILLING GUIDANCE

Prior Authorization for Admission to Out-of-State Non-Specialized Skilled Nursing Facilities

Effective October 1, 2011, the Office of Health Insurance Programs (OHIP) will review prior authorization (PA) requests for all initial admissions for Medicaid fee-for-service beneficiaries to out-of-state non-specialized skilled nursing facilities (OOS N/S SNFs). The PA requirement for admission will help ensure that New York State Medicaid beneficiaries are provided every opportunity to remain in and receive health care services from providers within the borders of New York State. This supports the Medicaid Redesign Team's efforts to repatriate beneficiaries in OOS SNF placements by preventing unnecessary initial OOS admissions (see MRT #68 http://nyhealth.gov/health_care/medicaid/redesign/docs/redesign_proposals.pdf).

As with all SNF admissions, the discharge planner/case manager must complete an H/C PRI and SCREEN form. If the screener's recommendation is for SNF level of care, a Level I Evaluation must be completed. If the individual is identified as having serious mental illness and/or mental retardation, the discharge planner/case manager should continue with the PASRR process as defined in federal regulations. If the individual requires SNF level of care, admission to an OOS N/S SNF will be authorized for up to 120 days only under the following conditions:

- **the individual has been denied admission to all in-state SNFs within 50-75 miles of their residence; or**
- **the individual will be temporarily absent from the State and residents of the individual's district customarily obtain care at the proposed facility.**

The discharge planner/case manager must maintain the above documentation and provide it upon request.

A new PA form and submission instructions are posted on the eMedNY website at: <https://www.emedny.org/ProviderManuals/ResidentialHealth/>. This process does not apply to admissions for OOS short term acute rehabilitation or OOS High/Specialized Level of Care. Requirements and instructions for OOS High/Specialized Level of Care SNF admissions are also available on the website.

Additionally, a new post authorization process has been developed to monitor the necessity for continued payment to the OOS facility for Medicaid beneficiaries who received prior authorization on their initial admission. Within 120 days of the admission, the OOS N/S SNF must evaluate the individual's potential for repatriation to New York State. The facility must provide documentation to the local district that the recipient has been declined admission to all New York State facilities within 50–75 miles of the beneficiary's New York State residence. Denial must be based on a recently completed, not to exceed fourteen days, PRI and SCREEN. This information is required for the local district to extend authorization for payment through the principal provider file.

For questions on prior authorization of non-specialized out-of-state SNF initial admissions, please call OHIP Medical Prior Approval at (800) 342-3005, option #1.



Article Correction

Limits on Therapy Benefits for Managed Care Enrollees

The August 2011 Medicaid Update article entitled, *Limitation on Rehabilitation Visits: Medicaid Redesign Team Proposal #34 (MRT #34)*, stated that Medicaid managed care and Family Health Plus (FHPlus) plans “may choose to count therapy visits between April 1 and September 30 toward the twenty visit limit, or they may choose to begin counting visits as of October 1, 2011.”

► **Correction:** For Medicaid managed care and Family Health Plus (FHPlus) enrollees, the twelve-month benefit year is a calendar year, beginning January 1 of each year and running through December 31 of the same year. For calendar year 2011, *Medicaid managed care and FHPlus plans should begin counting visits as of October 1, 2011.* Plans may not begin limiting visits until October 1, 2011.

During the period between October 1 and December 31, 2011, Medicaid managed care enrollees are entitled to twenty visits of each therapy type and FHPlus enrollees are entitled to twenty speech therapy visits, regardless of how many visits the enrollee had prior to October 1. A new benefit year begins January 1, 2012.

PHARMACY UPDATE



Attention Prescribers IMPORTANT NOTICE

Effective January 1, 2012, the Elderly Pharmaceutical Insurance Coverage (EPIC) program will change as follows:

- EPIC will be free. There will be no fees or deductibles.
- EPIC will only be available to those who have Medicare Part D as their primary drug coverage.
- EPIC will only cover Part D covered drugs that are purchased while in the Medicare coverage gap (donut hole).
- Before reaching the coverage gap, members will be responsible for paying the price charged by their Part D plan.
- EPIC co-payments for covered claims paid in the coverage gap will be \$3 - \$20, depending on the cost of the drug.
- EPIC will no longer cover drugs that were denied by the Part D plan after two levels of appeal.
- EPIC will continue to cover Medicare Part D "excluded drugs", such as benzodiazepines and barbiturates, while in the coverage gap.

If your patients are currently receiving drugs that are not on their Part D formularies, please discuss alternative drug therapies that will be covered by their Part D plans in 2012. Prescribing drugs on the Medicare Part D formulary will maximize coverage and reduce your patients' out of pocket expenses.

EPIC sent a letter to members explaining these program changes. If you have patients who have questions about how these changes will affect them, please have them contact the **EPIC Participant Helpline at (800) 332-3742**.

If you have any questions or require further assistance please contact the **EPIC Provider Helpline at (800) 634-1340**.



Attention Supervising Pharmacists IMPORTANT NOTICE

EPIC Will Only Cover Medicare Part D Coverage Gap Claims

Beginning on January 1, 2012, the Elderly Pharmaceutical Insurance Coverage (EPIC) program will **only cover** Medicare Part D covered drugs purchased while in the Medicare coverage gap (donut hole) and Medicare Part D-excluded drugs such as benzodiazepines and barbiturates, purchased during the coverage gap. During this period, EPIC co-payments will be the same (\$3, \$7, \$15, or \$20) depending upon the cost of the drug. Before reaching the coverage gap, members will need to pay the price charged by their Part D plan including any Part D deductible, co-payment or coinsurance. EPIC will not provide secondary coverage for any claims covered by insurers other than Medicare Part D drug plans.

Pharmacy Software Upgrade to National Council of Prescription Drug Programs (NCPDP) Version D.0

EPIC will transition from NCPDP version 5.1 to NCPDP version D.0 on January 1, 2012. This change brings EPIC in compliance with the latest NCPDP standards. All claims must be submitted to EPIC using D.0 beginning January 1, 2012. For more information regarding version D.0 please visit the Centers for Medicare and Medicaid Services (CMS) - Educational Resources Website at: http://www.cms.gov/Versions5010andD0/40_Educational_Resources.asp

The link to the EPIC payer specifications for NCPDP version D.0 is: available at: http://www.nyhealth.gov/health_care/epic/pharmacy_prescriber.htm

If you require a paper copy of the payer specifications please contact the EPIC Provider Helpline at (800) 634-1340 and one will be faxed to your pharmacy.

How to Bill EPIC claims after January 1, 2012

EPIC will only reimburse pharmacies for Medicare Part D coverage gap claims; however claims submitted during other Part D phases should be billed and will be accepted. EPIC continues to require that each participating pharmacy **submit all members' claims to EPIC**. This will ensure that

accumulations and patient records are up to date and accurate. A letter amendment to your provider agreement was sent to your pharmacy that explains this change in detail.

EPIC will return a 100% participant co-payment for Medicare Part D-covered drugs in non-coverage gap Part D phases. In order to receive a paid response the claim must be paid by the primary Part D plan and submitted with an Other Coverage Code (OCC) of 8 (Field 308-C8). The OCC values of Blank, 0, 1, 2, and 4 will no longer be accepted by EPIC, and will reject for 13 - M/I Other Coverage Code. In addition to the OCC, the following fields must be submitted to EPIC:

- **353-NR OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT COUNT**
- **351-NP OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT QUALIFIER**
- **352-NQ OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT**
- **392-MUBENEFIT STAGE COUNT**
- **393-MVBENEFIT STAGE QUALIFIER**
- **394-MWBENEFIT STAGE AMOUNT**

The fields above should be returned to your system from the primary Medicare Part D insurance once a paid response is received. Based on the values in these fields EPIC can determine whether the member is in the coverage gap. The claim will be priced accordingly with the co-payment that the participant is responsible to pay.

Medicare Part D excluded drugs that are not covered by Part D can be submitted to EPIC with OCC of 3 (Other Coverage Billed - Claim Not Covered) and Other Payer Reject Code of 70 (Product/Service Not Covered - Field 472-6E). Medicare excluded drugs will only be reimbursed during the Part D coverage gap.

If you have any questions or require further assistance please contact the **EPIC Provider Helpline at (800) 634-1340**.

PHARMACY UPDATE

Attention: Fee-For-Service Pharmacy Providers

The Centers for Medicaid and Medicare Services (CMS) recently granted the New York State Department of Health (NYSDOH) approval to move forward with fee-for-service pharmacy reimbursement changes that were enacted in the 2011-2012 New York State Executive Budget. Per previous e-mail notification to pharmacy providers, effective August 25, 2011:

- **Reimbursement rates for brand name drugs changed from AWP less 16.25 percent to AWP less 17 percent;**
- **Dispensing fees paid for generic drugs were reduced from \$4.50 to \$3.50; and**
- **The specialized HIV pharmacy reimbursement rate was discontinued.**

All changes are retroactive to April 1, 2011.

Adjustments will be spread out, beginning with checks dated October 10, 2011, and ending March 31, 2012, using the following process:

- **Data has been pulled for enrolled pharmacies with claims for service dates April 1, 2011 through August 24, 2011;**
- **Claims for brand drugs that were paid at AWP-16.25 percent have been recalculated at AWP-17 percent;**
- **Dispensing fees paid for generic prescriptions have been recalculated to \$3.50;**
- **A total amount to be recouped has been identified for each pharmacy; and**
- **That amount has been divided evenly by the number of remittances through the end of the State fiscal year.**

Providers can identify the total adjustment by multiplying the amount withheld from the October 10, 2011 checks by the number of remaining payments in SFY 11/12. The amount will be identified by the code AWP (long description: pharmacy reimbursement).

Questions? Please contact the eMedNY Call Center at (800) 343-9000.

ATTENTION: PHARMACIES AND PRESCRIBERS ELIGIBILITY TRANSACTION UPDATE

Effective October 1, 2011, members enrolled in Medicaid Managed Care and Family Health Plus plans began receiving pharmacy benefits directly through their plans. Unfortunately, due to timing constraints the service type code "88-pharmacy" could not be suppressed from the provider's response. Providers performing eligibility transactions will continue to see the "88-pharmacy" as a carved-out service in their response until February 23, 2012, even though pharmacy benefits are included in the Managed Care rate.

**ATTENTION:
MEDICAID MANAGED CARE AND
FAMILY HEALTH PLUS MEMBERS
PHARMACY BENEFITS ARE NOW PROVIDED BY YOUR HEALTH PLAN**

Frequently Asked Questions (FAQ)

Q1. What has changed about the Medicaid Pharmacy benefit?

ANSWER: Beginning October 1, 2011, members enrolled with Medicaid and Family Health Plus managed care plans will have their pharmacy benefit paid for by their health plans instead of the Medicaid program directly. This means that members will need to work with their physicians and health plans to make certain the drugs they use are covered.

Q2. How do I know if the medications I am currently taking will be covered by my health plan?

ANSWER: You should have received a letter from your plan with information about which drugs are included on its formulary (list of covered drugs). If you did not receive this letter or have questions, please contact your health plan. You may also contact the NYS Medicaid helpline at (800) 541-2831 for assistance.

Q3. How can I obtain a list of the medications my plan covers?

ANSWER: You should contact your health plan directly to obtain its formulary or list of covered drugs. You may also contact the NYS Medicaid helpline at (800) 541-2831 for assistance.

Q4. Which card do I need to use at the pharmacy?

ANSWER: Effective October 1, 2011, Medicaid managed care and Family Health Plus beneficiaries must use their health plan card (not their Medicaid/CBIC card) at the pharmacy.

Q5. What if I do not have a health plan card?

ANSWER: You must contact your managed care plan and ask them to issue a new health plan card. All plans have help lines. Please visit your plan's Website or contact the NYS Medicaid helpline at (800) 541-2831 to obtain your plan's number.

Q6. What if I do not know what health plan I have chosen?

ANSWER: To find out what plan you currently have, please contact the New York State Medicaid helpline at (800) 541-2831.

Q7. Will my co-payment change?

ANSWER: Co-payments for drugs will remain the same in both Medicaid and Family Health Plus with one exception; there will be no co-payments for supplies if you are in a Medicaid Managed Care Plan.

Q8. I do not see my drug on my plan's formulary or list of covered drugs and I've been on this drug for a while; can I stay on it?

ANSWER: If you've been on the drug for a while, you may be able to stay on that drug. For example, many plans will continue to cover antipsychotics, immunosuppressants, antiretroviral therapy, anticonvulsant and antidepressant drugs for their members that are already on these drugs. You should contact your plan to find out if the drug you are on is one that your plan will continue to cover for you, even though it may not be on their list of covered drugs.

Q9. My drug is not covered by my plan; can I get a temporary supply?

ANSWER: Between October 1, 2011 and December 31, 2011, you can get a **one-time** temporary fill of up to 30 days for each drug you are currently taking that is not available through your plan.

If you have been on a drug for a while and it's not on your plan's list of covered drugs, you may be able to stay on that drug. See question #8 for details.

Frequently Asked Questions (FAQ)

Q10. I received a one-time fill and I need my medication again. What should I do?

ANSWER: You need to contact your doctor. The doctor may decide to change to a drug covered by your health plan or your doctor can ask the plan to make an exception to their formulary rules.

Q11. What if my drug is not covered and no other medication will work for me?

ANSWER: Your doctor needs to contact your plan and ask them to make an exception to their formulary rules and let you continue taking the drug.

Q12. What if the plan still won't pay for my medication after my doctor asks for an exception?

ANSWER: You can appeal your plan's denial to internal and external reviewers. Contact your plan for information about their appeal process. You can also call the Community Health Advocates Hotline at (888) 614-5400 for assistance, or the NYS Medicaid helpline at (800) 541-2831 for help with contacting your plan.

Q13. Can I also ask for a fair hearing?

ANSWER: Yes, you can ask for a fair hearing with aid continuing so that you can continue to receive the drug while you wait for the hearing. For help in requesting a fair hearing, you can call the Fair Hearings Hotline at (800) 342-3334 or call the Community Health Advocates Hotline at (888) 614-5400.

Q14. Will I be able to use the same pharmacy and doctor?

ANSWER: You can continue with the same pharmacy and doctor, as long as they participate with your managed care plan. Ask your pharmacy and doctor to check to make sure they are participating.

Q15. I cannot find a pharmacy in my neighborhood that accepts my health plan. What do I do?

ANSWER: You should contact your health plan for assistance in locating a neighborhood pharmacy that accepts your health plan.

Q16. I have Hemophilia (Bleeding disorder), how will I get my blood products (clotting factor)?

ANSWER: Clotting factor products will continue to be covered by Medicaid fee-for-service benefit for a limited period of time. When billing for these items the pharmacy can use your Client Identification Number (CIN) on the health plan card to bill Medicaid.

Q17. My managed care or Family Health Plus plan is Fidelis Care New York. How will I get my family planning prescriptions after the October 1 change?

ANSWER: You will continue to get your family planning items from Medicaid. Your pharmacy should bill Medicaid for these services using the alpha numeric Client Identification Number (CIN) on your Fidelis card.

Q18. When I used my Medicaid to get medications, I had no problems. Why can't I just continue to use my Medicaid card?

ANSWER: A new state law requires that these changes be made to your Medicaid benefit. The law and/or regulation(s) that allow us to do this are Social Services Law (SSL) Sections 365-i and 369-dd, as repealed by L. 2011, ch. 59, Pt. H, Section 5 (Medicaid managed care pharmacy benefit change); SSL Section 369-ee(1)(e)(v) and 369-ee(2-b) (FHP pharmacy benefit change).

Q19. Can I switch managed care plans if I do not like the pharmacy benefits?

ANSWER: If you are within the first 90 days of joining the health plan, then you may leave and join another plan. However, once the first 90 days are over, you are "locked in" to that plan for the rest of the year (the next nine months). After the 9 month "lock-in" you may switch plans at any time. However, the lock-in applies after the first 90 days of enrollment every time you switch plans. For help making a decision about which plan to join, you can call the State's Enrollment hotline at (800) 505-5678.

ALL PROVIDERS

Provider Seminar Schedule for October-December 2011 Now Available

ePACES is the Electronic Provider Assisted Claim Entry System and allows enrolled providers to submit the following type of transactions:

- **Claims**
- **Eligibility Verifications**
- **Claim Status Requests**
- **Prior Approval/DVS Requests**

Computer Sciences Corporation (CSC) Regional Representatives have scheduled educational sessions to demonstrate the new ePACES screens and functionality. In addition, updates for New Provider, Medicaid Managed Care and eMedNY website training sessions are also available.

Physician, Nurse Practitioner, Durable Medical Equipment (DME) and Private Duty Nursing claims can even be submitted in "REAL-TIME" via **ePACES**.

Real-time means that the claim is processed within seconds and professional providers can get the status of a real-time claim, including the paid amount without waiting for the remittance advice.

Fast and easy seminar registration, locations, and dates are available on the eMedNY website at:

<http://www.emedny.org/training/index.aspx>.

CSC Regional Representatives look forward to meeting with you at upcoming seminars!

If you are unable to access the Internet to register or have questions about registration, please contact the eMedNY Call Center at (800) 343-9000.



ALL PROVIDERS

Secondary Claims Cannot be Billed to Medicaid Before the Primary Payer's Remittance is Received

A recent analysis of secondary claims submitted to New York State Medicaid has identified a common practice that violates both Medicaid billing guidelines and national billing standards developed by the X12 and National Council for Prescription Drug Programs (NCPDP) Designated Standards Maintenance Organizations.

The practice involves the submission of secondary claims with payment and adjustment amounts reported as if they had been received in a remittance advice from a Coordination of Benefits (COB) payer, but in actuality are based on anticipated adjudication results.

Providers who submit secondary claims to Medicaid prior to receiving remittance advice from their primary payer must discontinue the practice immediately. Unless a COB claim is being submitted under the Cost Avoidance policy (aka OFill), it must be submitted with actual prior payer's adjudication information, including the prior payer's adjudication date. Providers who do not adhere to this requirement may be subject to future audits and corrective action.

eMedNY Dashboard Helps Users Track Submitted Files

On July 21, 2011, eMedNY implemented a submitter dashboard that allows users to track submitted files to acceptance. The dashboard is available on the eMedNY homepage at: www.emedny.org. Only the submitter of information may track the files. Submitters access the dashboard with their User ID and Password. When tracking files, submitters will notice a series of green check marks that show the files have moved to acceptance.

Please note that "acceptance" does not imply that all claims have been accepted for processing to a remittance statement. A number of edits called "pre-adjudication" check certain submitted information for validity and if not valid will reject the claim. Rejected claims will not appear on the provider's remittance statement. Submitters will receive notification of any rejected claims in a 277 Claim Acknowledgment response file.

The 277 Claim Acknowledgment provides the rejection codes and submitters can view the description of the codes at: [https://www.emedny.org/HIPAA/5010/transactions/crosswalks/eMedNY%20Pre-Adjudication%20Crosswalk%20\(837%20Health%20Care%20Claims\).pdf](https://www.emedny.org/HIPAA/5010/transactions/crosswalks/eMedNY%20Pre-Adjudication%20Crosswalk%20(837%20Health%20Care%20Claims).pdf).

Submitters may also review the 277 file status on the dashboard to determine if any of the claims have failed a pre-adjudication edit. The dashboard interprets the 277 error codes into a more easily understood form for submitters. More information is available in the eMedNY Submitter Dashboard User Manual by clicking on Dashboard Information on the www.emedny.org home page.

Questions? Please contact the eMedNY Call Center at (800) 343-9000 or via e-mail to: emednyhipaasupport@csc.com.

PROVIDER DIRECTORY

Office of the Medicaid Inspector General:

For general inquiries or provider self-disclosures, please call (518) 473-3782.

For suspected fraud complaints/allegations, call 1-877-87FRAUD (1-877-873-7283), or visit www.omig.ny.gov.

Provider Manuals/Companion Guides, Enrollment Information/Forms/

Training Schedules: Please visit the eMedNY website at: www.emedny.org.

Do you have questions about billing and performing MEVS transactions?

Please call the eMedNY Call Center at (800) 343-9000.

Provider Training:

To sign up for a provider seminar in your area, please enroll online at:

<http://www.emedny.org/training/index.aspx>. For individual training requests, call (800) 343-9000 or e-mail: emednyproviderrelations@csc.com.

Enrollee Eligibility:

Call the Touchtone Telephone Verification System at any of the following numbers: (800) 997-1111, (800) 225-3040, or (800) 394-1234.

Address Change?

Address changes should be directed to the eMedNY Call Center at (800) 343-9000.

Fee-for-Service Providers: A change of address form is available at:

<http://www.emedny.org/info/ProviderEnrollment/allforms.html>.

Rate-Based/Institutional Providers: A change of address form is available at:

<http://www.emedny.org/info/ProviderEnrollment/allforms.html>.

Does your enrollment file need to be updated because you've experienced a change in ownership? Fee-for-service providers please call (518) 402-7032.

Rate-Based/Institutional providers please call (518) 474-3575.

Do you have comments and/or suggestions regarding this publication?

Please contact Kelli Kudlack at: medicaidupdate@health.state.ny.us.

Do you suspect that a Medicaid provider or beneficiary has engaged in fraudulent activities?

PLEASE CALL: 1-877-87FRAUD

Your call will remain confidential. You may also complete a complaint form online at: www.omig.ny.gov.

