NEW YORK STATE | Department of Health

Medicaid Update

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Introducing Care Coordination Organization/Health Homes (CCO/HH) For Individuals with Intellectual and Developmental Disabilities (I/DD)

The New York State Department of Health (NYSDOH) and the New York State Office for People with Developmental Disabilities (OPWDD) are expanding the current Medicaid Health Home program to serve people with intellectual and/or developmental disabilities (I/DD). On April 9, 2018, the Centers for Medicare and Medicaid Services (CMS) approved the State Plan Amendment (SPA) #17-0025, *NYS Care Coordination Organization/Health Homes Serving Individuals with Intellectual/Developmental Disabilities (I/DD),* authorizing the enrollment of individuals with I/DD into Care Coordination Organizations (CCO) providing Health Home Care Management services. The expansion of Health Homes to serve the I/DD population is part of the State's Medicaid Redesign Plan to transition the OPWDD population into Medicaid Managed Care through the concurrent 1115/1915(c) OPWDD Comprehensive Waiver Authorities. The proposed concurrent 1915(c) and 1115 waiver amendments and timelines for implementation, are subject to CMS approval and therefore, may be subject to further modification.

SPA #17-0025 can be accessed via NYSDOH's *Health Homes Serving Individuals with Intellectual and/or Developmental Disabilities (CCO/HH)* website at: https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/idd/index.htm under: *State Plan Amendments (SPA),* Medicaid State Plan Amendment (#17–0025).

The 1115 Waiver Transition plan, *Individuals with Intellectual and/or Developmental Disabilities (I/DD),* can be accessed via the NYSDOH website at: https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/idd/draft_idd_1115_waiver.htm.

On July 1, 2018, OPWDD began the transition of both Medicaid Service Coordination (MSC) and Home and Community Based Services (HCBS) Waiver Plan of Care Support Services (PCSS) to Health Home Care Management. The CCO/HH model of care is designed to bring more choice and flexibility to the provision of comprehensive care management and assessment, and ultimately other services. This model provides the strong, stable, person-centered approach to service planning and delivery that supports the needs of individuals with I/DD. Enrollment into a CCO/HH is voluntary and individuals who elect not to enroll in a CCO/HH may instead choose to enroll in Basic HCBS Plan Support. Basic HCBS Plan Support provides individuals with the necessary assistance to conduct timely reviews and updates to their Life Plan and maintain documentation supporting their HCBS Waiver ICF Level of Care eligibility determination (ICF LCED).

Seven CCO/HHs have been designated and are now providing comprehensive care management to individuals with I/DD. CCO/HHs are required to develop robust networks by expanding partnerships with cross-system service providers including medical, developmental disability service providers, long-term supports and service providers, dentists, behavioral health care providers, regional Systemic, Therapeutic Assessment, Resources and Treatment (START) teams, community-based organizations, and social service providers. CCO/HH Care Managers are working with individuals and families to develop individualized, person-centered Life Plans. The Life Plan integrates all clinical and non-clinical health care related needs and services and identifies all providers directly involved in an individual's care.

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Andrew M. Cuomo
Governor
State of New York

Howard A. Zucker, M.D., J.D.
Commissioner
New York State
Department of Health

Donna Frescatore
Medicaid Director
Office of Health Insurance Programs
The Medicaid Update is a monthly publication of the New York State Department of Health.

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Introducing Care Coordination Organization/Health Homes (CCO/HH) For Individuals with Intellectual and Developmental Disabilities (I/DD) *(Continued)*

CCO/HH Care Managers are responsible for coordinating an individual's care and overseeing access to all services in the individual's Life Plan. With the individual's and/or their family/representative's signed consent, health records will be shared among providers to ensure the individual receives unduplicated supports and services in a comprehensive and integrated manner.
For additional information and/or if you have questions about the CCO/HH program, please email your questions to NYSDOH at: HHIDD@health.ny.gov
Providers are asked to watch for future editions of the *Medicaid Update* for additional information on CCO/HHs and the concurrent 1915(c) OPWDD Comprehensive and 1115 Waivers.

References:
For information on the seven CCO/HHs now providing comprehensive Care Management to individuals with I/DD, please visit: https://opwdd.ny.gov/opwdd_services_supports/care_coordination_organizations/CCOs. Additional information on CCO/HHs can also be found on the NYSDOH website at: https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/idd/index.htm. To access information about the NYS Medicaid Health Homes Program, please visit the NYSDOH website at: https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/index.htm.

The Care Coordination Organization/ Health Home (CCO/HH) Provider Policy Guidance and Manual - Version 2018-1 (July 2018) may be accessed via the eMedNY website at: https://www.emedny.org/ProviderManuals/HealthHomes/index.aspx.

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Clarification of Requirements for Ambulance Transports Originating from Hospitals

Non-Emergency Transport from One Hospital to Another Hospital, or to Any Other Destination
*Prior Authorization **is** required – **contact the Transportation Manager***

An ambulance may be requested to transfer a patient from one hospital to another admitting hospital, in **non-emergency** situations, for a variety of reasons. Examples include, but are not limited to: rehabilitation services, specialized medical procedures, or the "back-transfer" of a patient who was previously transferred from another hospital.

A "back-transfer" is when a patient who was originally transferred from one hospital to another hospital for a higher level of care in an emergency situation, no longer requires the specialized services of the higher level of care hospital, and is then safely "back-transferred" to the originating hospital.

An ambulance may also be requested to transfer a patient from a hospital to a non-hospital destination, such as a skilled nursing facility, long term care facility, or even the patient's residence. In compliance with Medicaid program rules, ambulance transportation will be approved **only** if it is the most medically appropriate, cost effective mode of transport.

These ambulance transports are not emergency transports; therefore, prior authorization is required.

Emergency Transport from One Hospital to Another Hospital, for a Higher Level of Care

*Prior authorization is **not** required – do **not** contact the Transportation Manager*

An ambulance may be requested to transfer a patient from one hospital to another hospital, in emergency situations, when the patient requires specialized medical services that are not available at the originating hospital. Examples of this include: but are not limited to: transfers to trauma, cardiac, burn, or stroke centers, or to another emergency room.

These ambulance transports are considered emergency transports; therefore, prior authorization is not required.

Emergency Transport from a Hospital to a Psychiatric Center

*Prior authorization is **not** required – do **not** contact the Transportation Manager*

An ambulance may be requested to transfer a patient undergoing an acute episode of mental illness from a hospital to a psychiatric center. These patients are in immediate need of acute psychiatric care that can only be provided by such a facility. For the safety of the patient, law enforcement and hospital officials, **must** use an ambulance to transport these patients; rather than non-emergency modes of transportation, such as an ambulette or taxi.

These ambulance transports are considered emergency transports; therefore, prior authorization is not required.

For Medicaid enrollees with county code 97 or 98 designation, **retroactive** prior authorization must be obtained from the Transportation Manager to submit an emergency claim. Do **not** delay the transportation of these enrollees in an emergency situation. Prior authorization may be obtained retroactively; after the services have been provided.

Non-Emergency Round-Trip Transportation of a Hospital Inpatient

*Prior authorization Is **not** required – do **not** contact the Transportation Manager*

When a Medicaid enrollee is admitted to a hospital, payments made to the hospital include reimbursement for any transportation services that may be necessary during the enrollee's inpatient stay.

If an admitting hospital sends an inpatient to another hospital or other healthcare facility for the purpose of obtaining a diagnostic test or other medical services, the admitting hospital is responsible for the provision of transportation services. Therefore, the admitting hospital is responsible for reimbursing the ambulance service for the cost of the transport. Medicaid will not make payment directly to the transportation providers in these instances.

Emergency Ambulance Transportation

*Prior authorization is **not** required – do **not** contact the Transportation Manager*

Emergency ambulance transportation is the transportation of a patient from the location of a medical emergency to a hospital emergency department. Requests for emergency ambulance transportation are typically generated by a "911" call, or by some similar request for an immediate response to a medical emergency.

Emergency ambulance transportation also includes the transportation of a patient from one hospital to another hospital, in situations when the patient requires specialized medical services that are not available at the originating hospital

Emergency ambulance transportation also includes the transportation of a patient from a hospital to a psychiatric center, in situations when the patient is in immediate need of acute psychiatric care.

Prior authorization is not required for emergency ambulance transports.

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Reminder to Sign Up for Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA) or PDF Remittances

Are you still receiving paper checks or remittance statements? If you are still receiving paper checks and/or paper remittance statements this is a reminder that all billing providers are required to register for EFT and either ERA or PDF remittances. Medicaid began phasing in this requirement beginning in September 2012.

The advantages of EFT over paper checks include:

- No lost checks.
- No delays caused by misdirected checks.
- Mail time is eliminated.
- Funds are secure.
- Trips to the bank to deposit Medicaid checks are eliminated.

Providers can sign up for paperless remittances through two different options:

Option 1: ERAs in the form of HIPAA compliant 835/820 formats. These will require software to interpret, but have advantages for systematic posting of payments.

Option 2: PDF version of the paper remittance delivered electronically through eMedNY's secure website. PDF remittances have many advantages over paper remittances such as:

- The PDF remittance will be immediately available every week on the Monday on which your Medicaid check is dated, and will not be subject to the two-week hold of your check or EFT release.
- You will know when the PDF is available in your eXchange account and not have to wait for the mail.
- The remittance can be downloaded and stored electronically for easy retrieval.
- The remittance can be word-searched to help locate specific claims.
- The PDF will look exactly like the paper remittance.
- Remittances can be printed with Adobe Reader® (6.0 release or higher required), available free of charge.

Both the EFT and ERA/PDF remittance applications are available online at https://www.emedny.org/info/ProviderEnrollment/allforms.aspx. Questions about either application or the process can be directed to the eMedNY Call Center at (800) 343-9000.

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Health Home Program Announces New Recipient Restriction/Exception Codes

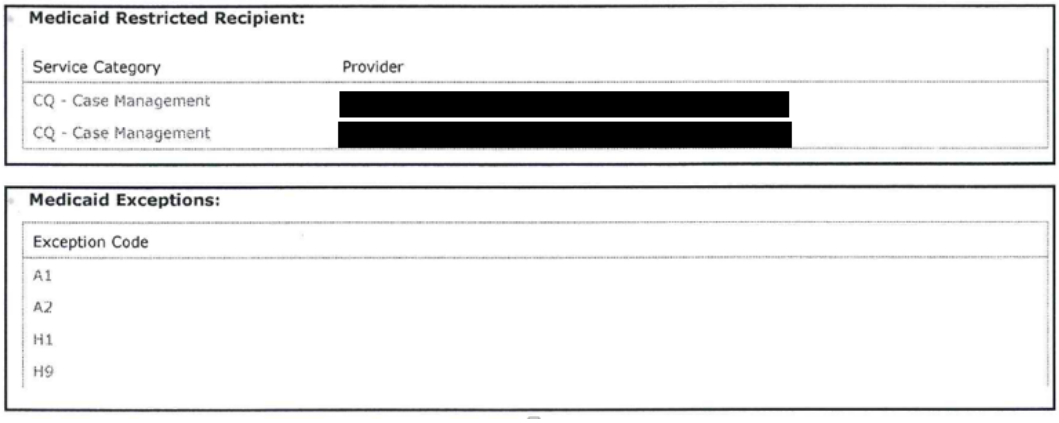
On July 16, 2018, two new Recipient Restriction/Exception (RR/E) codes went into effect for the Health Home Program. The purpose of these RR/E codes is to notify all Medicaid providers that these members are associated with the Health Home program.

A1 indicates the member is in outreach or enrolled with a Care Management Agency (CMA).
A2 indicates the member is in outreach or enrolled with a Health Home (HH).

Within ePACES, the actual A1/A2 codes are displayed within the “Medicaid Exceptions” field. This section does not include a description of the codes nor the member’s CMA/HH provider information. The CMA/HH NPI and Provider name associated with the corresponding Health Home program A1/A2 code are displayed in the “Medicaid Restricted Recipient” field with the Service Category “CQ – Case Management”. **This does not indicate that the health home members are in the Recipient Restriction Program (RRP). The codes do not restrict health home members to certain providers and do not limit the types of Medicaid services**

the member is eligible to receive. These members may change CMA/HH agencies, disenroll from the health home program, and may receive *any* other service(s) that the member is entitled to.

Below is how a member in the Health Home Program will appear within ePACES:



Medicaid Restricted Recipient:

Service Category	Provider
CQ - Case Management	[redacted]
CQ - Case Management	[redacted]

Medicaid Exceptions:

Exception Code
A1
A2
H1
H9

When a Medicaid Provider verifies eligibility using the Medicaid Eligibility Verification System (MEVS) and hears/sees the individual has these two codes, the provider should discuss with the individual their outreach or enrollment status in the Health Home Program. If the individual indicates that they are not enrolled, the provider may discuss with them the benefits of the Health Home Program and having a Care Manager. If the individual indicates they are enrolled in the Health Home Program, the provider is encouraged to consent to communicate with the Health Home and/or Care Management Agency. This will allow the Health Home Care Manager and the provider to discuss the individual's care and needs. If the individual appears to be Health Home eligible and does not have either code on their eligibility return, a provider should refer the individual to the Health Home Program. A provider may contact the individual's Medicaid Managed Care Plan to refer the individual into the Health Home program or may refer the member directly to a Health Home/Care Management Agency. Please see Health Home eligibility and Health Home contact information on our Health Home website at: https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/

Please note: Individuals who are enrolled in PACE, FIDA, or FIDA-IDD Plan are excluded from enrollment in the Health Home Program. However, individuals enrolled in either a mainstream or Managed Long-Term Care (MLTC) Plan are eligible to enroll. Health Home and MLTC Care Managers must work together to ensure there are no duplication of services.

For additional information or questions please contact the NYS Office of Health Insurance Programs, Health Home Policy Unit at 518-473-5569 or email the Health Home Bureau Mail Log at: https://apps.health.ny.gov/pubdoh/health_care/medicaid/program/medicaid_health_homes/emailHealthHome.action.

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Pharmacy Update on Dose Optimization Program

Effective August 30, 2018, the Medicaid fee-for-service (FFS) program will update the Dose Optimization initiative. Dose optimization can reduce prescription costs by reducing the number of pills a patient needs to take each day. The NYS Department of Health has identified drugs to be included in this program, the majority of which have FDA approval for once-a-day dosing, have multiple strengths available in correlating increments at similar costs, and are currently being utilized above the recommended dosing frequency. Prior authorization (PA) will be required to obtain the following medication beyond the following limits:

Dose Optimization Chart- New Additions

Cardiovascular			
Beta Blockers			
Drug name	**Dose Optimization Limitations**		
metoprolol succinate 25mg, 50mg, 100mg	1 daily	Tablet	
Central Nervous System			
Anticonvulsants			
Drug name	**Dose Optimization Limitations**		
Trokendi XR 100mg	1 daily	Capsule	Electronic bypass for diagnosis of seizure disorder identified in medical claims data. In case of dose titration for these medications, the Department will allow for multi-day dosing (up to 2 doses/daily) for titration purposes for three months
Antipsychotics- Second Generation			
Drug Name	**Dose Optimization Limitations**		
olanzapine 5mg, 10mg	1 daily	Tablet	In case of dose titration for these medications, the Department will allow for multi-day dosing (up to 2 doses/daily) for titration purposes for three months
olanzapine ODT 5mg, 10mg	1 daily	Tablet	
paliperidone ER 1.5mg, 3mg	1 daily	Tablet	
quetiapine fumarate ER 200mg	1 daily	Tablet	
Rexulti 0.25mg, 0.5mg, 1mg, 2mg	1 daily	Tablet	
Vraylar 1.5mg, 3mg	1 daily	Capsule	
Central Nervous System (CNS) Stimulants			
Drug Name	**Dose Optimization Limitations**		
dexmethylphenidate ER 10mg, 20mg (Focalin XR generic)	1 daily	Capsule	
methylphenidate ER 18mg (Concerta ER generic)	1 daily	Tablet	
methylphenidate LA 20mg (Ritalin LA generic)	1 daily	Capsule	
Miscellaneous Antidepressants			
Drug Name	**Dose Optimization Limitations**		
bupropion XL 150mg	1 daily	Tablet	In case of dose titration for these medications, the Department will allow for multi-day dosing (up to 2 doses/daily) for titration purposes for three months
mirtazapine 7.5mg	1 daily	Tablet	
Endocrine and Metabolic			
Biguanide			
Drug Name	**Dose Optimization Limitations**		
metformin ER 500mg (Glumetza ER, Fortamet ER generic)	1 daily	Tablet	
Gastrointestinal			
Proton Pump Inhibitors			
Drug Name	**Dose Optimization Limitations**		
Nexium 5mg	1 daily	Packet	

PA requirements are not dependent on the date a prescription is written. New prescriptions and refills on existing prescriptions require PA even if the prescription was written before the date the drug was determined to require PA.

To obtain a PA, please call the PA Clinical Call Center at 1-877-309-9493. The Clinical Call Center is available 24 hours per day, 7 days per week with pharmacy technicians and pharmacists who will work with you, or your agent, to quickly obtain PA.

Below is a link to the most up-to-date information on the Medicaid FFS Pharmacy PA Programs, including the Dose Optimization initiative. This document contains a full listing of drugs subject to the Medicaid FFS Pharmacy Programs: https://newyork.fhsc.com/downloads/providers/NYRx_PDP_PDL.pdf.

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All Providers

New Online Provider Directory: HIV, HCV, Buprenorphine, PEP, and PrEP Services

The New York State Department of Health (NYSDOH) AIDS Institute (AI) is pleased to announce the launch of a new online provider directory. This new online directory will allow providers and consumers easier access to information regarding human immunodeficiency virus (HIV), hepatitis C virus (HCV), Buprenorphine, post-exposure prophylaxis (PEP), and pre-exposure prophylaxis (PrEP) service providers across New York State. This new directory will replace the former HIV and HCV provider directories located on the NYSDOH Health Commerce System (HCS). It will also replace the former PrEP/PEP Provider Voluntary Directory. Inclusion in this directory is completely voluntary, and does not confer any endorsement by NYSDOH, nor does it establish NYSDOH credentialing or certification in a specialty.

If you are a provider and would like to be included in the provider directory, please follow this link: https://www.health.ny.gov/diseases/aids. Then select "Access the NEW AIDS Institute Provider Directory."

If you were previously registered in the Voluntary PrEP/PEP Provider Directory or the Provider Directories for HIV or HCV, your information has been included in the new directory. If you would like to update your information, follow the link above.

For more information, please contact ProviderDirectory@health.ny.gov.

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Optical Provider Notice: New Form "Disclosure of Other Business at Same Location"

Optical Business Providers (COS 0401 & 0402) enrolling, revalidating, reinstating, or changing ownership must now identify other **optical providers** at the same location. This form, "Disclosure of other Business at the same location" #436702, can be found on the Optical Business landing page at: https://www.emedny.org/info/ProviderEnrollment/optEst/index.aspx under the section "Additional forms/information which may be required to complete your enrollment."

Other optical providers include other Medicaid-enrolled Optical Establishments, Optometrists, Opticians and Ophthalmic Dispensers.
In addition, the following information must also be reported on the Business Application (eMedNY - 436701) upon initial enrollment, revalidation, reinstatement, or change of ownership:

- Disclosure of Ownership and Control, Section 1, For Corporations and Optical Establishment only: Providers are required to report all other business addresses.

- Disclosure of Ownership and Control, Section 2: Providers are required to complete Ownership in Other Disclosing Entities (ODE).

Optical applications that do not include this form will be rejected.

If you have questions regarding the information that must be reported, please call the eMedNY Call Center at 800-343-9000 and choose option 2, or email providerenrollment@health.ny.gov with the subject line "Optical Establishment Notice."

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Medicaid Provider Revalidation

The Affordable Care Act mandates that all Medicaid providers revalidate their enrollment in the program every five years. The Bureau of Provider Enrollment has sent providers Initial and Final revalidation letters to their correspondence address informing them of the revalidation requirement.

However, some providers who were sent revalidation letters have not responded. To promote provider compliance, the Bureau has sent out a **final revalidation letter.** The Bureau encourages providers who have not revalidated yet and wish to remain enrolled in NYS Medicaid to watch for this letter, then follow the instructions to revalidate their enrollment.

Providers who do not revalidate will receive a termination letter and will be terminated. Terminated providers will not be able to participate in Medicaid Managed Care (MMC) networks and Children's Health Insurance Program (CHIP), in addition to being unable to bill for fee-for-service (FFS) Medicaid.

Additionally, future revalidation notification letters will be automatically sent to providers. An Initial letter will be sent out and, if after 90 days the provider has not responded, a Second and Final letter will be sent out. Providers who do **not** revalidate within 45 days of the Final letter will receive a Termination letter.

Providers are encouraged to maintain their correspondence address to ensure the letters are sent to the correct address. If you have any questions about the revalidation process, or maintaining your provider file, please visit www.eMedNY.org, contact the eMedNY Call Center at 1-800-343-9000 or email providerenrollment@health.ny.gov.

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Maintaining and Updating Your Enrollment Records

Section 5006(a) of the 21st Century Cures Act requires all State Medicaid programs to develop and maintain a Provider Directory (see https://www.medicaid.gov/federal-policy-guidance/downloads/smd18007.pdf). Required elements of the directory include provider name, specialty, service addresses, and telephone number for each service address. The New York State Medicaid program has made a directory of providers enrolled in the fee-for-service program available at: https://health.data.ny.gov/Health/Medicaid-Fee-for-Service-Provider-Listing/keti-qx5t.

In addition, Medicaid providers agree, as a condition of continued enrollment, to notify the Department of Health immediately of any changes supplied in your enrollment agreement, including a change in service location and/or ownership. To keep your enrollment agreement up to date, use the maintenance forms found on the Provider Enrollment tab at www.eMedNY.org.

Provider Enrollment applications and forms (e.g., Change of Address) must include the required elements of provider name, specialty, service addresses, and telephone number for each service address. Any such applications and forms that do not include these required elements will be rejected.

Additionally, notification letters are continually sent to providers informing of the requirement to complete a periodic revalidation of enrollment. Completion of these forms is required for continued enrollment in the New York Medicaid Program. Failure to complete and submit these forms will result in termination of the provider's enrollment.

If you have any questions about the provider directory, maintaining your enrollment file, or the revalidation process, please contact CSRA at 800-343-9000 or e-mail providerenrollment@health.ny.gov.

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Medicaid Provider Enrollment and Maintenance Feedback Survey is Now Online

The Department of Health's Bureau of Provider Enrollment and eMedNY are always interested in improving the provider experience of enrolling in and maintaining their information with New York Medicaid. Providers are encouraged to complete the easy, ten question survey to provide feedback about the various processes that are currently followed.

To access the survey, visit here: https://www.surveymonkey.com/r/BPEeMedNYSurvey2018. If you have any questions, please contact the eMedNY Call Center at 1-800-343-9000. We will close this survey two weeks from the publication of this edition of the *Medicaid Update*.

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NY Medicaid EHR Incentive Program Update

The NY Medicaid Electronic Health Record (EHR) Incentive Program promotes the transition to EHRs by providing financial incentives to eligible professionals and hospitals. Providers who demonstrate Meaningful Use of their EHR systems are leading the way towards Interoperability, which is the ability of healthcare providers to exchange and use patient health records electronically. The ultimate goal is to increase patient involvement, reduce costs and improve health outcomes. Since December 2011, over **$926 million** in incentive funds have been distributed **through 35,472** payments to New York State Medicaid providers.

Since 2011, Eligible Professionals and Eligible Hospitals have received:	
Number of Payments	**Distributed Funds**
35,472	**$926,561,735**

Are You Getting Ready for Payment Year 2019 Certified EHR Technology (CEHRT)?

Question	Answer
Who?	Eligible Professionals (EP) are required to have a 2015 Certified EHR Technology (CEHRT) Edition to meet Meaningful Use (MU) criteria in the NY EHR Incentive Program for Payment Year 2019.
What?	The Centers for Medicare & Medicaid Services (CMS) and Office of the National Coordinator for Health Information Technology (ONC) have established the 2015 Certified EHR Technology (CEHRT) Edition standards and other criteria for structured data that EHRs must meet in order to qualify for use in Promoting Interoperability (PI) Programs.
When?	Eligible Professionals (EP) are required to have a 2015 Certified EHR Technology (CEHRT) Edition for Payment Year 2019 and beyond.
Where?	Contact the Vendor that you are currently working with to ensure the EHR System is upgraded to the 2015 Certified EHR Technology (CEHRT) Edition.
Why?	The 2015 Certified EHR Technology (CEHRT) Edition is required for Promoting Interoperability (PI) Programs including, Medicaid Stage 3 and Medicare Quality Payment Program (QPP) Promoting Interoperability (PI) Performance Category. 2015 Certified EHR Technology (CEHRT) is better equipped to support patient access and interoperable exchange. For additional information on other Federal and State programs, see Programs Referencing ONC Certified Health IT.

How?	To ensure proper upgrade to the 2015 Certified EHR Technology (CEHRT) Edition, please refer to the following steps: 1) ID should have 15E as the 3rd, 4th, and 5th characters (e.g. XX15EXXXXXXXXX) 2) Check Certified Health IT Product List (CHPL) 3) Contact Vendor • Upgrade process, timeline, and costs • Impact on historical data, functions, and audit trail The Office of the National Coordinator for Health Information Technology (ONC) resources for Eligible Professionals (EP).

Updated Webinar Schedule – August/September 2018

We've added a new Webinar! ***Modified Stage 2 for New Meaningful Users*** is intended for Eligible Professionals who are attesting to Meaningful Use for the first time or who have attested before but prior to 2016.

Webinar	Date	Time
Meaningful Use Modified Stage 2	September 12, 2018	10:00am-11:00am
Meaningful Use Stage 3	September 14, 2018	10:00am-11:00am
***New!* Modified Stage 2 for New Meaningful Users**	September 27, 2018	9:00am-10:00am
2018 MU Public Health Reporting	September 25, 2018	10:00am-11:00am

Listserv – Have program announcements sent right to your inbox!

The NY Medicaid EHR Incentive Program publishes listserv messages each month, and additional messages when there are important changes to the program that will impact eligible providers. In the listserv you will find:

- Updates regarding the NY Medicaid EHR Incentive Program Administration
- Attestation system (MEIPASS) announcements and updates
- Attestation dates and deadlines
- Current quarter webinar schedule
- Program requirements
- Links to training resources and tutorials
- CMS final rule releases and programmatic changes

Register

- To register for the NY Medicaid EHR Incentive Program listserv:
  - Send an email to: listserv@listserv.health.state.ny.us
  - In the body of the message enter: SUBSCRIBE EHR_INCENTIVE-L Your Name
  - For example: SUBSCRIBE EHR_INCENTIVE-L John Doe
- You can also register for the MU Public Health Reporting listserv for information on the Public Health Reporting Objective for the EHR Incentive Program:
  - Send an email to listserv@listserv.health.state.ny.us
  - In the body of the message enter: SUBSCRIBE PUBLIC_HEALTH-L your name
  - For example: SUBSCRIBE PUBLIC_HEALTH-L Jane Doe

Visit Our Website

Find the following information and much more:

- Payment Year 2017 and 2018 Requirements – Modified Stage 2 and Stage 3
- Eligible Hospital Requirements
- Public Health Reporting Objective Information
- Post-Payment Audit Guidance
- Frequently Asked Questions (FAQs)

- Materials and Information – Document Repository

Questions? We have a dedicated support team ready to assist.
Contact us at 877-646-5410, Option 2 or hit@health.ny.gov.

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Provider Directory

Office of the Medicaid Inspector General:
For suspected fraud or abuse complaints/allegations, call 1-877-87FRAUD, (877) 873-7283, or visit www.omig.ny.gov.

Provider Manuals/Companion Guides, Enrollment Information/Forms/Training Schedules:
Please visit the eMedNY website at https://www.emedny.org/.

Providers wishing to listen to the current week's check/EFT amounts:
Please call (866) 307-5549 (available Thursday PM for one week for the current week's amount).

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 https://www.emedny.org/training/index.aspx. For individual training requests, call (800) 343-9000.

Beneficiary Eligibility:
Call the Touchtone Telephone Verification System at (800) 997-1111.

Medicaid Prescriber Education Program:
For current information on best practices in pharmacotherapy, please visit the following websites:
http://www.health.ny.gov/health_care/medicaid/program/prescriber_education/presc-educationprog

http://nypep.nysdoh.suny.edu/home

Need to change your address? Does your enrollment file need to be updated because you have experienced a change in ownership? Do you want to enroll another NPI? Did you receive a letter advising you to revalidate your enrollment?
Visit https://www.emedny.org/info/ProviderEnrollment/index.aspx and choose the link appropriate for you (e.g., physician, nursing home, dental group, etc.).

Medicaid Electronic Health Record (EHR) Incentive Program questions?
Contact the New York Medicaid EHR Call Center at (877) 646-5410 for assistance.

Comments and Suggestions Regarding This Publication?
Please contact the editor, Chelsea Cox, at medicaidupdate@health.ny.gov