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Medicaid Update

THE OFFICIAL NEWSLETTER OF THE NEW YORK STATE MEDICAID PROGRAM

Primary Care Service Corps (PCSC) – Strengthening the Health Workforce in New York's Medically Underserved Communities

According to federal data, as of May 8, 2012, there were 252 Health Resources and Services Administration (HRSA) designated Health Professional Shortage Areas (HPSAs) across New York State for primary, dental, or mental health; only five counties had no HPSAs. The total shortage of health practitioners in the State is 495 FTEs. Over half of all counties (35 out of 62) have designated HPSAs for all three health disciplines – primary care, dental, and mental health. Demand is rising for primary care practitioners in light of federal health care reform, which may add one million additional people who would newly obtain health care coverage.

To respond to these issues, in March 2012, the New York State Legislature agreed to fund a new program in the 2012-13 NYS budget, the Primary Care Service Corps (PCSC). The 2012-13 NYS budget agreement provides $1 million in funding - $500,000 in state funding matched by an additional $500,000 in federal State Loan Repayment Program funding – for up to 33 loan repayment awards under this program. The program was recommended by the Medicaid Redesign Team's (MRT) Workforce Flexibility and Change of Scope of Practice Workgroup, and subsequently approved as a New York State budget item by the full MRT.

PCSC will increase the supply of non-physician clinicians practicing primary, oral health and mental health care in federally-designated underserved areas by offering financial incentives in the form of loan repayment funding for these clinicians if they agree to fulfill an obligation of a series of years in these underserved areas. By increasing access to primary care, the PCSC would reduce emergency room visits and potentially reduce the attendant costs to the Medicaid program.

Eligible clinicians include:

- *Dentists and dental hygienists;*
- *Nurse practitioners;*
- *Physician assistants;*
- *Midwives;*
- *Clinical psychologists;*
- *Licensed clinical social workers;*
- *Psychiatric nurse practitioners;*
- *Licensed marriage family therapists; and*
- *Licensed mental health counselors.*

Physicians were specifically excluded since they currently are able to access the similar Doctors Across New York (DANY) programs, which were also continued in the 2012-13 NYS budget agreement at about $6 million annually.

It is anticipated that qualifying clinicians would receive up to $60,000 for repayment of qualifying educational loans for the first two years of service ($30,000 for a part-time commitment). For additional years, they would receive up to $32,500 for years three and four; then $25,000 for any additional years for which qualifying educational loan amounts still exist and the obligated service is still eligible for awards. Payments would likely be tiered (i.e., annual amounts adjusted) based on the severity of the health professional shortages in the HPSAs. With the passage of the budget, it is anticipated that contracts for this program could be awarded as early as October 2012.

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MAY 2012 NEW YORK STATE MEDICAID UPDATE

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New York Medicaid Electronic Health Records Incentive Program Update

The NYS Department of Health (NYSDOH) is pleased to announce that as of May 21, 2012, the New York Medicaid Electronic Health Records (EHR) Incentive Program paid over $115 million in federal incentive funds to more than 1,000 New York State hospitals and healthcare practitioners.

The Department continues to review applications for Payment Year 2011 incentive payments that were submitted prior to the April 29, 2012 deadline, and applications for Payment Year 2012 are currently being accepted from providers who are new to the incentive program. Applications for providers' second incentive payment (Meaningful Use Attestation) will be accepted beginning in the fourth quarter of 2012.

If you have not yet registered for the NY Medicaid EHR Incentive Program, we encourage you to visit the eMedNY.org website (https://www.emedny.org/meipass/) or attend one of the informational webinars hosted by the NYSDOH throughout the month of June.

Tuesday, June 5	10:00–11:00AM	Eligible Professional Registration & Attestation
Wednesday, June 6	3:00–4:00PM	MEIPASS Prerequisites
Thursday, June 7	12:00–1:00PM	Meaningful Use, Stage 1 (Eligible Professionals)
Tuesday, June 12	12:00–1:00PM	Eligible Hospital Registration & Attestation
Thursday, June 14	12:00–1:00PM	Meaningful Use, Stage 1 (Eligible Hospitals)
Tuesday, June 19	10:00–11:00AM	Eligible Professional Registration & Attestation
Thursday, June 21	10:00–11:00AM	Eligible Hospital Calculation Workshop
Tuesday, June 26	12:00–1:00PM	MEIPASS Prerequisites
Wednesday, June 27	10:00–11:00AM	Meaningful Use, Stage 1 (Eligible Professionals)

The webinar schedule is subject to change based on interest levels. For the complete schedule or to register for one of the webinars, please view the webinar schedules posted on the eMedNY.org website at:

- Current Month: https://www.emedny.org/meipass/webinar/Webinar.pdf
- Next Month: https://www.emedny.org/meipass/webinar/NextMonth.pdf

Long Term Home Health Care Program (LTHHCP) 2012 Participant Expenditure Caps

The Long Term Home Health Care Program (LTHHCP) waiver is a coordinated plan of care and services for individuals who would otherwise be medically eligible for placement in a hospital or residential health care facility for an extended time. LTHHCP services can be provided when the total monthly Medicaid expenditures for health and medical services for an individual do not exceed seventy-five percent of the cost of care in either a skilled nursing facility (SNF) or a health-related facility (HRF) located within an individual's local district of fiscal responsibility. To be eligible for the LTHHCP waiver, Medicaid participants must be able to be served safely and effectively with a Plan of Care; the cost of which falls within the seventy-five percent budget cap.

LTHHCP expenditure caps are calculated in accordance with 10 NYCRR Part 86-5.10. Expenditure caps are based on the January 1, 1992, average Medicaid reimbursement rates for nursing facilities in a county trended forward to the current year. Due to a zero trend factor in 2012, the participant expenditure caps have not changed from the maximum allowed in 2011.

If you have questions regarding these expenditure caps, please contact Gary Crucetti at (518) 473-8910.

If you have questions regarding the LTHHCP, please contact Vicki Rockefeller at (518) 474-5271.

Mandatory Medicaid Managed Care Expanding to Tioga County

Effective June 2012, managed care enrollment will be required for most Medicaid beneficiaries residing in **Tioga** County. Once a mandatory managed care program is implemented in a county, it is expected that the enrollment of all eligible Medicaid beneficiaries will take up to twelve months to complete.

Providers should check the Medicaid Eligibility Verification System (MEVS) prior to rendering services to determine Medicaid eligibility and the conditions of Medicaid coverage. Providers are strongly encouraged to check eligibility at each visit as eligibility and enrollment status may change at any time. If the Medicaid beneficiary is enrolled in a Medicaid managed care plan, the first coverage message will indicate "Eligible PCP".

MEVS responses no longer include scope of benefits information so providers will need to contact the health plan to determine services covered by them. Service Type codes will be used to identify carved-out services where possible. **Medicaid will not reimburse a provider on a fee-for-service basis if a medical service is covered by the plan.**

For more information on MEVS messages, please see the February 2011 Special Edition Medicaid Update article at:

http://health.ny.gov/health_care/medicaid/program/update/2011/2011-2_special_edition.htm.

Providers may call the eMedNY Call Center at (800) 343-9000 with any Medicaid billing issues. Medicaid beneficiaries may call NY Medicaid Choice at (800) 505-5678 or contact their local department of social services (LDSS) to learn more about managed care. For additional information on managed care covered services and managed care plan types, please see the December 2010 Medicaid Update article entitled "Managed Care Covered Services" available online at:

http://health.ny.gov/health_care/medicaid/program/update/2010/2010-12.htm.

Medicare Providers May Not Bill QMBs for Medicare Cost-Sharing

This article provides guidance to Medicare providers to help them avoid inappropriately billing Qualified Medicare Beneficiaries (QMBs) for Medicare cost-sharing, including deductible, coinsurance, and copayments. This is known as "balance billing."

Balance Billing of QMBs Is Prohibited by Federal Law

Under current law, Medicare providers cannot balance bill a QMB. Section 1902(n)(3)(B) of the Social Security Acts prohibits Medicare providers from balance billing QMBs for Medicare cost-sharing. **PLEASE NOTE:** This section of the Act is available online at:

http://www.ssa.gov/OP Home/ssact/title19/1900.htm.

Specifically, the statute provides that the Medicare payment and any Medicaid payment are considered payment in full to the provider for services rendered to a QMB. QMBs have no legal obligation to make further payment to a provider or Medicare managed care plan for Part A or Part B cost sharing. Providers who balance bill QMB patients may be subject to sanctions based on Medicare provider requirements established in Sections 1902(n)(3)(C) and 1905(p)(3) of the Social Security Act. Medicare providers who violate these billing restrictions are violating their Medicare provider agreement.

QMBs and Benefits

QMBs are persons who are entitled to Medicare Part A and are eligible for Medicare Part B; have incomes below 100 percent of the Federal Poverty Level; and have been determined to be eligible for QMB status by their State Medicaid Agency.

- Medicaid pays the Medicare Part A and B premiums, deductibles, co-insurance and co-payments for QMBs.
- New York State Medicaid will pay the Part C Medicare Advantage premiums when it is determined cost effective to do so. These premiums may also be used to meet a Medicaid spend down or be used as an income deduction.
- Regardless of whether Medicaid opts to pay the Part C premium, the QMB is not liable for any co-insurance or deductibles for Part C benefits.

Medicare Crossover Billing

Providers must bill claims for Medicare/Medicaid beneficiaries to Medicare. Medicare will then reimburse its portion to the provider and the provider's Medicare remittance will indicate that the claim will be crossed over to Medicaid. Medicare will send the claim data to GHI and they will submit the data to New York State Medicaid for processing and payment of the deductible, coinsurance or co-pay amounts (also known as the Medicare Patient Responsibility). Medicaid will deny the claim if a claim is crossed over with no Patient Responsibility. Providers may call the eMedNY Call Center at (800) 343-9000 with any QMB billing issues. Questions regarding the QMB balance billing policy may be referred to the Third Party Liability Unit at (518) 473-5330.

Transportation Fees Change For Livery and Stretcher Van Services in New York City

Effective for dates of service on or after **May 1, 2012**, the following **one way** reimbursement fees are established for the transportation of NYC fee-for-service Medicaid enrollees traveling to and from necessary medical care via livery or stretcher van.

Livery	One Way Fee	Procedure Code	Modifier
Inside the Common Medical Marketing Area [1]	$20.00	A0100	
Outside the Common Medical Marketing Area [2]	$25.00	A0100	TN
Stretcher Van [3]	**One Way Fee**	**Procedure Code**	**Modifier**
7 AM to 7 PM Monday through Friday, except Certain Holidays [4]	$76.00	T2005	
Weeknights 7 PM to 7 AM, Weekends, and Holidays	$98.00	T2005	TU

[1] ***Inside the Common Medical Marketing Area Livery***

	Trips Originates in	Trip ends In
1.	Brooklyn	Brooklyn
2.	Brooklyn	Queens
3.	Bronx	Bronx
4.	Bronx	Upper Manhattan Above 110th Street
5.	Bronx	Westchester County
6.	Upper Manhattan Above 110th Street	Bronx
7.	Upper Manhattan Above 110th Street	Upper Manhattan Above 110th Street
8.	Upper Manhattan Above 110th Street	Westchester County
9.	Lower Manhattan Below 110th Street	Lower Manhattan Below 110th Street
10.	Queens	Brooklyn
10.	Queens	Queens
11.	Queens	Nassau County
12.	Staten Island	Staten Island

-continued-

[2] ***Outside the Common Medical Marketing Area Livery***

	Trips Originates in	Trip ends In
1.	Brooklyn	Bronx
2.	Brooklyn	Staten Island
3.	Brooklyn	Upper/Lower Manhattan
4.	Bronx	Brooklyn
5.	Bronx	Lower Manhattan Below110th Street
6.	Bronx	Queens
7.	Bronx	Staten Island
8.	Queens	Bronx
9.	Queens	Staten Island
10.	Queens	Upper/Lower Manhattan
11.	Staten Island	Brooklyn
12.	Staten Island	Bronx
13.	Staten Island	Queens
14.	Staten Island	Upper/Lower Manhattan
15.	Upper/Lower Manhattan	Brooklyn
16.	Upper/Lower Manhattan	Queens
17.	Upper/Lower Manhattan	Staten Island
18.	Lower Manhattan Below110th Street	Bronx
19.	Lower Manhattan Below110th Street	Upper Manhattan Above 110th Street
20.	Upper Manhattan Above 110th Street	Lower Manhattan Below110th Street

[3] **Stretcher Van**: Used when the enrollee cannot walk, is confined to bed, cannot sit up or sit in a wheelchair, ***and <u>does not</u> require medical attention during transport***.

[4] **Holidays**: New Year's Day, Memorial Day, Fourth of July, Labor Day, Thanksgiving, and Christmas

Questions regarding this fee schedule may be sent via e-mail to: MedTrans@health.state.ny.us, or contact the Transportation Unit at (518) 473-2160.

New York State Partnership for Long Term Care Insurance Update

This year brings some of the most sweeping improvements to the Partnership for Long Term Care Program (PLTC). These changes are designed to modernize the program.

The four major changes to the program are as follows:

A new plan option will be available offering a Total Asset Protection Plan with two years of nursing home coverage; or four years of home care or residential care (at half the nursing home rate). A Medicaid State Plan Amendment to include this option has already been approved by the Centers for Medicare & Medicaid Services (CMS). This offering (2-4-50) will be available upon final publication of a new Regulation #144 by the Department of Financial Services. These regulations will be final on June 1, 2012.

The second change is the decision by NYS to participate in Reciprocity as offered in the Federal Deficit Reduction Act of 2005. This change will allow New Yorkers who relocate to one of the forty other participating states to take advantage of both asset protection and Medicaid Extended Coverage in those states at a dollar-for-dollar level based on the amount of LTC insurance paid on their behalf. This provision will also allow PLTC participants from the other forty states who relocate to New York to achieve the same benefit. A Medicaid State Plan Amendment to include this option has already been approved by CMS. Reciprocity will be available upon final publication of a new Regulation #144 by the Department of Financial Services. As noted above, a final rule will be in place on June 1, 2012. A new disclosure statement explaining Reciprocity in detail will be attached to any new PLTC policy.

The third change relates to required inflation protections. Every PLTC policy sold must cover a minimum daily benefit amount, and this amount is increased annually by an inflation factor. Historically, this factor has been 5 percent, but research shows that a more accurate amount would be 3.5 percent. This new level will now be available, subject to the choice of the policyholder, upon final publication of a new Regulation #144 by the Department of Financial Services. As noted above, a final rule will be in place on June 1, 2012.

The final change relates to the way insurance agents are trained and certified to sell PLTC policies. In the past, NYSDOH staff has traveled around the state and agents have spent valuable time sitting in classrooms to receive this training. DOH has opened an all on-line training and certification program.

These changes are designed to make the PLTC policies more attractive as a benefit to policyholders and a savings to the Medicaid program. This program is one of the "win-win" activities that result when public-private partnerships are carefully planned and implemented for the benefit of all.

For more information regarding the Partnership for Long Term Care program, please visit: www.NYSPLTC.org.

Questions? Please contact the New York State Partnership for Long Term Care at 1-866-950-PLAN or via e-mail to: pltc@health.state.ny.us.

Ordering Non-Emergency Transportation in New York City New Form Used to Justify the Mode of Transport

Medicaid will cover the costs of transportation provided to an eligible beneficiary, when payment for transportation expenses is essential for an eligible enrollee to obtain necessary medical care and services which may be paid for under the Medicaid program.

In New York City, a new form has been developed to assist practitioners and/or facilities order the appropriate mode of transport. The form is available for download at:

http://www.nycmedicaidride.net/en-us/medicalpractitioners/downloads.aspx .

Questions regarding this article may be e-mailed to: MedTrans@health.state.ny.us, or contact the Transportation Unit at (518) 473-2160.

Brooklyn and Queens Medical Practitioners and Facilities:

Numbers to Call When Ordering Transportation

The NYS Department of Health (NYSDOH) and its contractor, LogistiCare Solutions, has implemented non-emergency medical transportation (NEMT) management services for New York City Medicaid **fee-for-service** enrollees *(i.e., those not in a managed care plan)* who are receiving Medicaid covered services **in Brooklyn**. Starting for dates of service July 1, 2012, **Queens based** practitioners and facilities will submit requests directly to LogistiCare *(those not in a managed care plan)*. All trips must be pre-arranged and confirmed by LogistiCare. Below is information to help you in the transition.

Key Terms and Telephone Numbers

- ✓ A **standing order** is a regularly reoccurring *(three or more times per week, for 3 or more months' duration)* reservation for transport to a Medicaid covered service. For example, Monday, Wednesday and Friday transport to and from dialysis.
- ✓ A **demand response** trip is a less frequent, episodic trip. For example, a trip to and from the doctor next Wednesday.

Facility Services Department	**877-585-8758**	**Monday – Friday 7a.m. – 6 p.m.**	**This is the number the medical provider (you) can call to speak to one of our specialists to request standing order or demand response transport for an enrollee.**
Facility Services Dept. fax	877-585-8758	24/7	Case managers or social workers fax the 2015 Medical Justification Form or the Standing Order Request forms to this number.
"Where's My Ride"	877-564-5923	24/7	Call this number if there is a service issue or complaint, or when the enrollee needs to be picked up.
Reservation Number for Enrollees	877-564-5922	Monday – Friday 7a.m. – 6 p.m.	This is the number a Medicaid fee-for-service enrollee can call to request transportation. Urgent & hospital discharges trips can be called in 24/7.

NYCMedicaidRide.net is the website with documents, webinar and more information regarding arranging non-emergency transportation services for fee-for-service Medicaid enrollees. Requests for routine NEMT services must be pre-arranged with LogistiCare 72 hours or 3 days in advance, as illustrated in the chart below. Requests for urgent, same day or next day NEMT are reserved pending confirmation from the medical provider that the enrollee needs to come in today or tomorrow, and that treatment cannot be delayed to another day.

Three (3) day's prior for routine non-emergency transportation:

Appointment is on:	**Contact LogistiCare the:**
Saturday	Wednesday before
Sunday	Thursday before
Monday	Friday before
Tuesday	Friday before
Wednesday	Friday before
Thursday	Monday before
Friday	Tuesday before

Hepatitis C Agents (Injectable Agents and Protease Inhibitors) Subject to Prior Authorization

As a result of Drug Utilization Review (DUR) Board recommendations, effective June 21, 2012, certain Hepatitis C agents (Injectable Agents and Protease Inhibitors) will be subject to prior authorization.

Prior authorization requirements are intended to ensure that utilization of Hepatitis C agents is appropriate and follows the most recent practice guidelines by the American Association for the Study of Liver Diseases (AASLD).

Prior authorizations for Hepatitis C Protease Inhibitors and Injectable Agents may be requested by completing the form found at: https://newyork.fhsc.com/providers/PDP_forms.asp . The completed form must then be faxed to the clinical call center at (800) 268-2990.

Key Points:

- The form must be completed if an injectable Hepatitis C Virus (HCV) agent and/or HCV Protease Inhibitor is being requested for a patient.
- Boceprevir (Victrelis®) and telaprevir (Incivek®) are new products that belong to the HCV Protease Inhibitor class and must be used concurrently with both peginterferon and ribavirin.
- HCV Protease Inhibitors are only approved for the treatment of HCV genotype 1 infection in adults. Patients' baseline HCV genotype must be established prior to use.
- Victrelis® treatment should only be initiated after a 4-week lead-in period of peginterferon and ribavirin.
- HCV-RNA viral load must be tested at baseline and also at critical points during treatment (treatment weeks 4, 8, 12 and 24). Laboratory test results and answers to additional questions must be documented on the fax form and resubmitted at each critical point.
- Duration of treatment is determined by the patient's response and previous treatment status.
- Patients who have previously failed on Incivek® or Victrelis®, should not be treated with the other HCV Protease Inhibitor due to the risk of cross resistance.

For additional clinical information on Hepatitis C, including an overview of the HCV Protease Inhibitors and interactive treatment algorithms, please visit: http://nypep.nysdoh.suny.edu/

The most up-to-date Preferred Drug List (PDL), with a full listing of preferred and non-preferred drugs for each of the drug classes currently subject to the PDP is available online at: https://newyork.fhsc.com/downloads/providers/NYRx_PDP_PDL.pdf.

For clinical concerns or PDP questions, please call (877) 309-9493. For billing questions, please call (800) 343-9000.

Pharmacy Update

The New York State Medicaid Prescriber Education Program Highlights New Drugs for Chronic Hepatitis C

The New York State Medicaid Prescriber Education Program (NYSMPEP) is a partnership between the New York State Department of Health (NYSDOH) and the State University of New York (SUNY), as approved by state legislation. This program was designed to provide prescribers with an evidence-based, non-commercial source of the latest objective information about pharmaceuticals.

In May of 2011, the Food and Drug Administration approved boceprevir (Victrelis®) and telaprevir (Incivek®), the first direct acting antivirals for the treatment of chronic hepatitis C virus (HCV) infection.[1,2] Both are oral agents designed to prevent a key step in viral replication by inhibiting HCV NS3/4A protease. These agents are only indicated for treatment of patients infected with HCV genotype 1 and must be used in combination with peginterferon and ribavirin. Combination treatment with either telaprevir or boceprevir has demonstrated significantly higher rates of sustained virologic response compared to peginterferon and ribavirin alone for the treatment of HCV genotype 1 in both treatment-naïve and those that have previously failed treatment with peginterferon and ribavirin. For this reason the American Association for the Study of Liver Diseases currently recommends combination of telaprevir or boceprevir with peginterferon and ribavirin as optimal treatment for genotype 1 chronic HCV infection.[3]

Prescribers must consider numerous patient-specific factors related to HCV infection, comorbid conditions, concomitant medications, and willingness to adhere to treatment when deciding to initiate therapy. Both boceprevir and telaprevir are associated with significant drug interactions and side effects that warrant serious consideration as well. Duration of treatment is determined based on previous exposure/response to treatment and by measuring viral response (HCV RNA) at key time points during therapy. In order to minimize the development and spread of viral resistance, it is also critical to stop treatment when response is inadequate.

New drug summaries highlighting efficacy data, safety precautions, and the place in therapy for boceprevir and telaprevir are available on the NYMPEP website. These printable documents contain treatment algorithms outlining response-guided therapy which are also available in interactive format and may be accessed at: http://nypep.nysdoh.suny.edu/hepatitis. Contact information for NYSMPEP academic educators in your area is available online at: http://nypep.nysdoh.suny.edu/contactus.

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1. Boceprevir (Victrelis®) prescribing information. Schering Corporation, a subsidiary of Merck & Co., Inc. Whitehouse Station, NJ; revised April 2012.
2. Telaprevir (Incivek®) prescribing information. Vertex Pharmaceuticals, Inc. Cambridge, MA; revised March 2012.
3. Ghany M, Nelson DR, Strader DB, Thomas DL, Seeff LB. An update on treatment of genotype 1 chronic hepatitis C virus infection: 2011 practice guidelines by the American Association for the Study of Liver Diseases. Hepatology 2011.

Reminder: Pharmacies Must Obtain an HCS Medical Professions Account for the Upcoming Average Acquisition Cost (AAC)/Cost of Dispensing (COD) Project

In accordance with legislation passed in April 2011, the NYS Department of Health (NYSDOH) is undertaking a comprehensive survey of Medicaid enrolled pharmacies to identify drug acquisition costs and associated costs of dispensing. The overall goal of this initiative is to create a pharmacy reimbursement benchmark that is valid, transparent, timely and sustainable.

NYSDOH will utilize the Health Commerce System (HCS) to collect data for the AAC/COD project. Data will be collected through a secure process and in a manner that ensures provider confidentiality. As a reminder, NYSDOH requires that Medicaid enrolled pharmacies that do not currently have accounts, obtain an HCS Medical Professions Account.

Your pharmacy may already exist on the HCS. To verify this information, please send an e-mail to: camuout@health.state.ny.us with the pharmacy name, NYSED registration number, and a phone number. If you do not have an account, an application will be sent to you.

PLEASE NOTE: An entity (pharmacy) cannot hold an account. An individual must apply to represent the entity. Chain pharmacies may apply for one account at the corporate level but it cannot be shared.

Attention: Fee-for-Service Pharmacy Providers

REVISED Drug Acquisition Costs and Associated Costs of Dispensing

In accordance with legislation passed in April 2011, the New York State Department of Health (NYSDOH) is undertaking a comprehensive survey of Medicaid enrolled pharmacies to identify drug acquisition costs and associated costs of dispensing. The overall goal of this Medicaid Redesign Team (MRT) initiative is to create a pharmacy reimbursement benchmark that is valid, transparent, timely and sustainable.

Average Acquisition Cost (AAC) and Cost of Dispensing (COD) Tentative Timeline*****:

- **Apply for HCS Medical Professional Accounts – March 1, 2012**
- **Verify Applications and Issue Accounts – March 2012**
- **Conduct Focus Groups – March 2012**
- **Issue Pilot Study – June 2012**
- **Issue AAC and COD Survey – July 2012**
- **Verify and Publish Rates – August 2012 and monthly thereafter**
- **Implementation – January 2013**

Questions related to this initiative may be sent via e-mail to: medpharmpricing@health.state.ny.us

eMedNY Provider Support

eMedNY offers a variety of support options for providers who may be experiencing problems or need assistance with successful submission of transactions and resolving outstanding billing issues. Support is available for the New York State Medicaid Program including but not limited to these major areas:

- *Provider Enrollment*
- *Billing*
- *Eligibility Verification*
- *Prior Approval Requests*
- *The Electronic Provider Assisted Claim Entry System (ePACES)*
- *Electronic Responses/Remittance and Claim Denial Interpretation*

PROVIDER SUPPORT AVAILABLE

The eMedNY Call Center can be reached by telephone at (800) 343-9000.

For provider inquiries pertaining to non-pharmacy billing or claims, or provider enrollment:
Monday through Friday: 7:30 a.m. - 6:00 p.m., Eastern Time (excluding holidays)

For provider inquiries pertaining to eligibility, service authorizations, DVS, and pharmacy claims:
Monday through Friday: 7:00 a.m. - 10:00 p.m., Eastern Time (excluding holidays) Weekends and Holidays: 8:30 a.m. - 5:30 p.m., Eastern Time

Additionally, the Call Center can refer a helpdesk ticket for technical inquiries about electronic file rejections and electronic HIPAA formatting of files to Computer Sciences Corporation (CSC).

CSC has Regional Representatives who can assist providers with individual requests for training. The Regional Representatives also offer seminars and webinars every month. Registration is available at www.emedny.org, click on Training.

Requests for individual training can be made through the Call Center number above or via e-mail to: eMedNYProviderRelations@csc.com.

The eMedNY website offers information on all aspects of the eMedNY claims processing system including, provider self-help documents, provider manuals and links to other websites.

We welcome your inquiries and thank you for your continued participation in the New York State Medicaid Program.

Medicaid to Require Electronic Funds Transfer (EFT) for Provider Payments and Electronic Remittance Advice (ERA) or PDF Version of Paper Remittances

Medicaid will soon require all billing providers to register for EFT and ERA or PDF remittances. This effort moves the Medicaid program in the direction of healthcare industry standards of practice. In addition to the cost savings associated with eliminating the production, processing and mailing of paper, this initiative is better for the environment and in line with the "GO GREEN" movement. The NYS Department of Health (NYSDOH) will begin phasing in this requirement effective September 2012; however, providers are urged to act now. The applications are available at www.emedny.org or click the "go green" icon above.

Providers who do not wish to purchase software to interpret the HIPAA-compliant ERA can elect to have remittances delivered in a PDF format to an eMedNY eXchange in-box. The PDF version is an exact copy of the paper remittance but delivered two weeks in advance of payment release. To establish an eXchange in-box providers need to be registered ePACES users. ePACES registration begins with a call to the eMedNY Call Center at (800) 343-9000.

Attention Submitters:

Provide Proper EDI Contact Information

The Submitter Name and Submitter EDI Contact Information contained in Loop 1000A of 837 transactions is an important part of troubleshooting problem files. This is the first source eMedNY uses to try and contact submitters who have files that require immediate intervention. Please ensure that this information is populated with valid information for someone who can assist with EDI troubleshooting. This will ensure that there is minimal delay if a problem is identified with the submitted file and an outbound call is necessary.

If your transactions are being submitted by a service provider, please share this information with them. Please submit your questions by e-mail to emednyproviderservices@csc.com or contact the eMedNY Call Center at (800) 343-9000.

Protected Health Information (PHI)Fact Sheet

What is Protected Health Information (PHI)?

HIPAA Privacy Rule defines PHI as individually identifiable health information about the past, present, or future physical or mental health or condition (including the provision of his/her health care, insurance, payment status, etc.) of an individual that is held or transmitted by a covered entity or its business associate, in any form.

PHI is information that is recorded electronically, on paper, or transmitted orally about an individual. Voicemail, prescription bottles, and conversations within earshot of other individuals are examples of PHI that may not be as obvious as paper documents, but are equally subject to the Rule.

PHI must be protected from unauthorized use or disclosure by the Covered Entity and its Business Associates under HIPAA regulations. Stricter enforcement and penalties for breaches, unauthorized use and unauthorized disclosure are enforced under the HITECH Act, enacted under the American Recovery and Reinvestment Act of 2009. Covered entities include: health care providers, health plans, and health care clearinghouses.

What is considered PHI?

- *Name*
- *Address*
- *Phone number*
- *Date of birth*
- *Date of service*
- *Gender*
- *Medical records number*
- *Health plan beneficiary number*
- *Client Identification number (CIN)*
- *License number*
- *Social Security Number*
- *Explanation of Benefits (EOB)*
- *Diagnosis and procedure codes or any other information that can be used to identify an individual*

Electronic PHI (EPHI)

The HITECH Act adds further protections for Electronic PHI, or EPHI. These include requirements that EPHI access be limited to the minimum amount required for healthcare operations, that clients have the ability to review any EPHI kept on file, and that clients have the ability to receive a list of those persons who may have accessed their EPHI. HITECH also adds substantial notification requirements and potential penalties for breaches of EPHI. The Federal Office for Civil Rights is expected to increase random audits of EPHI management by Covered Entities and their Business Associates beginning this year.

All Providers

What if I need to send PHI to eMedNY?

In order to safeguard the individually identifiable health information listed above, we must all implement reasonable and appropriate security measures. Sending data to CSC via the established communications methods (ePACES, eMedNY eXchange, FTP, SFTP, and SOAP) ensures the security of PHI during transmission.

If you need to submit PHI to eMedNY, please follow these simple guidelines:

- Always include a confidentiality statement in e-mails or fax cover letters.
- Make certain that any PHI that is being faxed or e-mailed is going to the proper receiver.
- Never send PHI through e-mail unless it is encrypted or in a password protected attachment.
- For mail that contains PHI, providers should follow the Return of Misdirected Communication process currently being used by the eMedNY Call Center. For more detail contact the Call Center at (800) 343-9000.

The US Department of Health and Human Services has fully defined what constitutes PHI.

For additional guidance on PHI, please see the Privacy Rule at:
http://www.hhs.gov/ocr/privacy/hipaa/administrative/privacyrule/index.html.

For more information on your HIPAA Privacy and Security Practices, contact your HIPAA Privacy and Security Officer.

HIPAA Version 5010 Discretionary Enforcement Period Ends June 30

Providers who still submit electronic transactions to Medicaid in the HIPAA Version 4010 format are reminded that the federal government's discretionary enforcement period for Version 5010 and NCPDP D.0 will expire on **June 30, 2012**. In keeping with this federal guideline, effective 12:01AM July 1, 2012, Medicaid will no longer be able to accept or process HIPAA Version 4010 and NCPDP Version 5.1 transactions. All such transactions will be denied. We urge all our trading partners to complete their 5010 transition well in advance of the July 1, 2012 deadline in order to minimize any adverse impact on their Medicaid payments.

It is highly recommended that providers who utilize the services of a software vendor or billing service work closely with that entity to make certain that the billing system is being upgraded in a timely manner and will be able to support the 5010 format in advance of the July 1, 2012 deadline. Providers should not assume that their vendor or billing service is proceeding with completing the required upgrades, proper testing with Medicaid and timely transition. It is the provider's responsibility to ensure their transactions comply with the mandated 5010 requirements.

eMedNY offers a Provider Testing Environment(PTE) to facilitate provider transition to Version 5010 that will accept and process 5010 HIPAA X12 and NCPDP D.0 transactions from trading partners who wish to test their program changes with eMedNY. It is strongly recommended that all providers and vendors submitting electronic transactions test their submissions using the PTE. Information about testing with eMedNY is available in the Standard Companion Guide – Trading Partner Information available on the eMedNY website at:

https://www.emedny.org/hipaa/5010/transactions/eMedNY_Trading_Partner_Information_CG.pdf

Providers experiencing difficulties transitioning their billing system to the Version 5010 format should consider converting to the Electronic Provider Assisted Claim Entry System (ePACES) software application. The ePACES application is fully Version 5010 compliant, is very simple to use and is offered free of charge by New York State Medicaid. Users only need a PC with an Internet browser with high speed access and an e-mail address. Extensive ePACES information is available at www.emedny.org under 'Self Help' or from the eMedNY Call Center at (800) 343-9000.

For additional information on Version 5010, please visit eMedNY HIPAA Support page at http://www.emedny.org/HIPAA/5010/index.html or e-mail any questions to: emednyproviderservices@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 web site at: www.emedny.org.

Providers wishing to hear 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: 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 (800) 997-1111.

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?

Rate Base/Institutional and Fee-for-Service providers, please call (518) 474-3575, Option 4.

Do you have comments and/or suggestions regarding this publication?
Please contact Kelli Kudlack at: medicaidupdate@health.state.ny.us.