



Medicaid Update

The Official Newsletter of the New York State Medicaid Program

May 2019

Volume 35 | Number 6

New System Edit on Fee-for-Service Pharmacy Claims for the Vaccines for Children Program

The Vaccines for Children (VFC) Program is a federally-funded program that provides vaccines at no cost to eligible children. The vaccines are distributed to private physicians' offices, pharmacies, and public health clinics enrolled as VFC providers. VFC providers administer the vaccines to VFC-eligible children. A child is eligible for VFC vaccine if he or she is younger than 19 years of age and Medicaid-enrolled, which includes both fee-for-service (FFS) and Medicaid Managed Care (MMC).

Note: The VFC program is currently enrolling pharmacies to receive influenza vaccine only. Pharmacies immunizing patients 18 years of age with pneumococcal, meningococcal, tetanus, diphtheria and pertussis vaccines **may not** bill Medicaid for the costs of these vaccines. Patients 18 years of age who are enrolled in Medicaid are VFC-eligible and may receive these vaccines through a VFC healthcare practice or clinic.

New York State (NYS) Medicaid should **never** be billed for the cost of any vaccine for persons under 19 years of age when it is available through the VFC Program. This applies to both FFS and MMC. Pharmacies that are **not** enrolled in the VFC Program and choose to provide vaccines for members under 19 years of age at no charge to the member or Medicaid program, can be reimbursed an immunization fee of \$17.85 by NYS Medicaid.

Additional guidance can be found within the *NYS Medicaid FFS Program Pharmacist as Immunizers Fact Sheet* available at: https://www.health.ny.gov/health_care/medicaid/program/docs/phar_immun_fact.pdf. Information related to pharmacists as immunizers scope of practice, including a list of vaccines that pharmacists can administer, can be found at: <http://www.op.nysed.gov/prof/pharm/pharmimmunizationfaq.htm>.

VFC program guidance can be found on the **New York State VFC Program** web site at: https://www.health.ny.gov/prevention/immunization/vaccines_for_children. Providers located in New York City may visit the New York City VFC Program website at: <https://www1.nyc.gov/site/doh/providers/health-topics/immunizations.page>.

Effective May 23, 2019, a new edit will enforce the above policy for Medicaid FFS. The new edit will ensure that when there is an incoming claim for the administrative fee (procedure code "90460"), there also is a claim in the history for a VFC-eligible vaccine procedure code reimbursed at zero-dollar amount. If no history claim is found, then the claim will be denied for the new edit **02291**.

Claims Edit 02291

For National Council for Prescription Drug Programs (NCPDP) claims transactions that are denied for edit 02291, the corresponding Medicaid Eligibility Verification System (MEVS) Denial Reason Code "738" will be returned "History Not Found for Administrative Vaccine Claim" and NCPDP Reject Code "85" "Claim Not Processed."

Billing questions regarding this policy should be directed to the eMedNY Call Center at 1-800-343-9000.

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The Medicaid Update is a monthly publication of the New York State Department of Health.

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Behavioral Health Transition to Medicaid Managed Care for Children Under 21 Years of Age

Effective July 1, 2019, the Medicaid Managed Care (MMC) benefit package is aligning the MMC behavioral health benefit for all eligible enrollees under 21 years of age. This provision applies to all MMC plans and Human Immunodeficiency Virus Special Needs Plans (HIV SNPs). Some of these services may already be covered by MMC plans and HIV SNPs for certain eligible enrolled children under 21 years of age. Beginning July 1, 2019, these services will no longer be covered by New York State Medicaid fee-for-service (FFS) for any child under 21 years of age enrolled in an MMC plan or HIV SNP. Providers are required to bill the MMC plan or HIV SNP for these services if provided on or after July 1, 2019. **Note:** For children under 21 years of age **not** enrolled in an MMC plan or HIV SNP, these services will remain covered by Medicaid FFS.

Behavioral Health Services

MMC plans and HIV SNPs will manage access to the following services under the category **Medicaid State Plan Services**:

- Office of Alcoholism and Substance Abuse Services (OASAS) Outpatient – Clinic
- OASAS Outpatient – Rehabilitation Programs
- OASAS Opioid Treatment Program Services
- OASAS Chemical Dependence Inpatient Rehabilitative Services
- OASAS Residential Services
- Children and Family Treatment and Support Services (CFTSS), including:
 - Other Licensed Practitioner (OLP)
 - Psychosocial Rehabilitation (PSR)
 - Community Psychiatric Supports and Treatment (CPST)
 - Family Peer Support Services (FPSS)
- Office of Mental Health (OMH) Outpatient Services
- OMH-designated Serious Emotional Disturbance (SED) Clinic Services
- Assertive Community Treatment (ACT)
- Continuing Day Treatment
- Personalized Recovery Oriented Services (PROS)
- Partial Hospitalization
- Physician Services: Psychiatry
- Clinical Psychological Services
- Comprehensive Psychiatric Emergency Program (CPEP) including Extended Observation Bed
- Inpatient Psychiatric Services

Providers should contact the MMC plan to confirm notification, prior authorization, and billing requirements for these services. **Note:** Chapter 57 of the Laws of 2019 requires MMC plans and HIV SNPs to reimburse providers licensed pursuant to Article 28 of the Public Health Law or Article 31 or 32 of the Mental Hygiene Law for behavioral health services (except for inpatient services) provided to enrollees at State-mandated rates through 2023.

Additional information is available on the Department of Health's web site at: https://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health/.

Pharmacy Changes for Children’s Behavioral Health Services

Effective July 1, 2019, MMC plans and HIV SNPs will begin covering second-generation long-acting injectable antipsychotics and naltrexone extended release suspension under both the pharmacy and medical benefit for all eligible children under 21 years of age.

Current drugs affected include:

- aripiprazole (Abilify Maintena, Aristada, Aristada Initio),
- paliperidone palmitate (Invega Sustenna, Invega Trinza),
- risperidone microspheres (Risperdal Consta, Perseris),
- olanzapine (Zyprexa Relprevv), and
- naltrexone (Vivitrol).

These drugs will no longer be covered by New York State Medicaid FFS for children under 21 years of age, enrolled in an MMC plan or HIV SNP; providers are required to bill the MMC plan or HIV SNP for these services if provided on or after July 1, 2019. Previous guidance on this topic can be found in the [June 2016 Medicaid Update](#) article titled *Behavioral Health Transition to Managed Care (Outside of New York City) – What Providers Need to Know*. Please note the July 1, 2019 change affects enrollees referenced in the 2016 chart, row 3, with an “**Age**” category listed as “**20 or younger**”.

MMC general coverage questions should be directed to Office of Health Insurance Programs, Division of Health Plan Contracting and Oversight at (518) 473–1134 or at covques@health.ny.gov. Questions regarding MMC reimbursement and/or documentation requirements should be directed to the enrollees’ MMC plan.

Attention All Hospital Providers: Medicaid Fee-for-Service and Medicaid Managed Care Billing Guidance for Diagnosis of Malnutrition

Billing Guidance

It has recently come to the New York State Department of Health’s attention that some hospitals may be reporting an inaccurate diagnosis code on inpatient claims for members with a diagnosis of malnutrition. This has resulted in potential overpayments to hospital facilities. Providers need to make certain that the level of malnutrition, e.g., mild, moderate, or severe, is accurately reflected in the “**ICD-10**” diagnosis code reported on the inpatient claim. The medical record must include a clinical assessment that supports the member’s diagnosis. Proper documentation of a diagnosis of malnutrition **and** level of malnutrition must be included in the patient’s medical record and is subject to audit.

Malnutrition can result from the treatment of another condition; for example, inadequate treatment or neglect, or general deterioration of an individual’s health. In 2012, the American Society for Parenteral and Enteral Nutrition (ASPEN) published guidelines to diagnose and document malnutrition and its severity (mild, moderate, or severe) using six clinical characteristics, of which at least two should be met. Hospitals are not required to use ASPEN guidelines; however, the guidelines provide consistency in diagnosing malnutrition. The ASPEN guidelines related to malnutrition can be found at: https://www.nutritioncare.org/Guidelines_and_Clinical_Resources/Toolkits/Malnutrition_Toolkit/Definitions/.

Questions:

- Medicaid fee-for-service (FFS) coverage and policy questions should be directed to the Office of Health Insurance Programs (OHIP) Division of Program Development and Management at (518) 473–2160.
- Medicaid Managed Care (MMC) general coverage questions should be directed to the OHIP Division of Health Plan Contracting and Oversight at: covques@health.ny.gov or (518) 473–1134.
- MMC reimbursement and/or billing requirement questions should be directed to the enrollee’s MMC plan.
- FFS claim questions should be directed to the eMedNY call center at (800) 343–9000.
- Clarification on self-disclosing an overpayment may be obtained by visiting the OMIG website at: <https://omig.ny.gov/self-disclosure/submission-information-and-instructions> or by contacting OMIG’s Self-Disclosure Unit by email at: selfdisclosures@omig.ny.gov or by phone at: 518-402-7030.

Pharmacy

Reminder: 340B Providers, Covered Entities, and Contract Pharmacies

A review of 340B claims submitted via the National Council for Prescription Drug Programs (NCPDP) D.0 format indicates confusion as to which field should contain the ingredient cost and which should contain the Usual and Customary (U&C). 340B drug claims need to be properly identified as 340B as well as submitted at costs in the appropriate fields. **Claims submitted with incorrect data, including cost in the wrong field, are subject to audit and recovery.**

The following fields are required on each Medicaid 340B drug claim submitted NCPDP format:

Field	Medicaid Primary Claim	Medicaid Secondary Claim (Primary: Medicare; Commercial)
420-DK, Submission Clarification Code (SCC)	20	20
423-DN, Basis of Cost Determination (BCD)	08	Not applicable
409-D9, Ingredient Cost Submitted *	340B Acquisition Cost	Not applicable
426-DQ, Usual and Customary Cost (U&C) *	Lowest Net Charge to Cash Customers	Lowest Net Charge to Cash Customers

*MMC plans should be consulted on their requirements for this field.

Description of Costs:

- Ingredient Cost:** Cost of the 340B drug purchased by the entity, i.e., acquisition cost, no other costs, such as shipment charges may be added. Enter this cost in Ingredient Cost Submitted field (409-D9) for FFS NCPDP claims.
- Usual and Customary Cost (U&C):** Defined as the lowest price charged to the general public, including all applicable discounts, such as promotional discounts, and discounted prices associated with loyalty programs. Enter this cost in the Usual and Customary field (426-DQ).

Editing has been placed to ensure a pharmacy submits all required fields when identifying an NCPDP pharmacy drug claim as 340B.

Reminder: Substance Use Disorder Drug Treatment, Medicaid Managed Care and Fee-for-Service Coverage

Social Services Law §364-j and Public Health Law §273 prohibits prior authorization under Medicaid fee-for-service (FFS) and Medicaid Managed Care (MMC) for initial or renewal prescriptions for preferred or formulary forms of buprenorphine or injectable naltrexone when used for detoxification or maintenance treatment of opioid addiction. The Food and Drug Administration (FDA) and Compendia-supported frequency quantity and/or duration limits may continue to be applied.

The New York State (NYS) MMC Pharmacy Benefit Information Center

The NYS MMC Pharmacy Benefit Information Center is a website that assists providers in identifying which medications are included on the NYS MMC formularies, and can be found at: <https://mmcdruginformation.nysdoh.suny.edu/>. This includes a comprehensive listing of “Drugs to Treat Chemical Dependence” showing formulary coverage by plan. To find this list, select “DRUG QUICKLISTS” from the page headings, then select the “Therapeutic Classes, Other” tab whereupon a report can be customized to show coverage by all or only select plans. The list can be downloaded and printed. NYS MMC Pharmacy Benefit Information Center formulary coverage is updated quarterly.

This website also includes a link to each individual plans' website, contact information, and formulary to access more in-depth information about each plan. For information on substance use disorder drug coverage in FFS see the NYS Medicaid FFS Preferred Drug List (PDL) which is available at: https://newyork.fhsc.com/downloads/providers/NYRx_PDP_PDL.pdf.

Previous Medicaid Update Articles on Substance Abuse Disorder Medications

Several *Medicaid Update* articles have been published since 2016 which educate plans and providers about expanded access to substance use disorder medications. These include:

- [June 2017](#) *Update on System Editing for: Limiting Initial Opioid Prescribing to a Seven Day Supply for Acute Pain and Emergency 5-Day Supply of Drugs used to Treat Substance Use Disorders in Medicaid Fee-for-Service*
- [December 2016](#) *New Legislation Regarding Emergency 5-Day Supply of Drugs used to Treat Substance Use Disorders in Medicaid Fee-for-Service (FFS) & Medicaid Managed Care*
- [August 2016](#) *New Legislation Enacted for Drugs Used for Detoxification or Maintenance Treatment of Opioid Addiction for Medicaid Fee-for-Service & Medicaid Managed Care Beneficiaries*

Tightened Editing - Pharmacy Claims Override Should Not Be Used for Licensed *Non-Enrolled* Prescribers

Effective May 23, 2019, updated editing was put in place to ensure appropriate use of the override that enables claims payment for **non-enrolled** prescribers who are unlicensed residents, interns, or foreign physicians in training programs. The only option available when a pharmacy is presented with a prescription or fiscal order written by a **licensed, non-enrolled prescriber** for a Medicaid member is to obtain a **new prescription from an enrolled provider**.

The following guidance applies *only* to prescriptions written by unlicensed residents, interns, or foreign physicians in training programs:

- Pharmacy claims will initially reject for National Council for Prescription Drug Programs (NCPDP) Reject code **"56"** (*Non-Matched Prescriber ID*). This means the prescriber is **not** enrolled in Medicaid.
- To override above rejection for unlicensed residents, interns, or foreign physicians in training programs:
 - Field 439-E4 (Reason for Service Code): enter **"PN"** (*Prescriber Consultation*)
 - Field 441-E6 (Result of Service Code): enter applicable value (**"1A"**, **"1B"**, **"1C"**, **"1D"**, **"1E"**, **"1F"**, **"1G"**, **"1H"**, **"1J"**, **"1K"**, **"2A"**, **"2B"**, **"3A"**, **"3B"**, **"3C"**, **"3D"**, **"3E"**, **"3F"**, **"3G"**, **"3H"**, **"3J"**, **"3K"**, **"3M"**, **"3N"**, **"4A"**)
 - Field 420-DK (Submission Clarification Code): enter **"02"** (*Other Override*)

If the above override is attempted for licensed providers, the claim will continue to be denied. As mentioned above, a new prescription from an enrolled provider will need to be obtained.

Questions regarding billing should be directed to the eMedNY Call Center at (800) 343-9000. Providers with policy-related questions should e-mail the pharmacy mailbox at: ppno@health.ny.gov, or call (518) 486-3209.

All Providers

New York State Offers Free Extensive Training on Person-Centered Planning

In January 2019, the New York State Department of Health (Department) launched the *Person-Centered Planning Comprehensive System Transformation Statewide Training Initiative*, a series of free trainings designed to share best practices on person-centered planning and support the comprehensive system transformation required by the federal Home and Community-Based Services (HCBS) Final Rule.

New York State provides HCBS for individuals with a wide range of disabilities and disabling conditions in a variety of settings. **Regardless of condition or setting, all HCBS recipients must have a Person-Centered Service Plan that provides an informed choice of services, supports, and residences in compliance with HCBS Final Rule standards.**

The Department has partnered with Public Consulting Group (PCG), Support Development Associates, and the New York Alliance for Inclusion and Innovation to offer an extensive series of full- and half-day Regional Trainings and multi-day Learning Institutes on person-centered planning at no cost to participants in all regions of New York State.

Full- and Half-day Regional Trainings

These trainings are led by instructors certified by The Learning Community for Person-Centered Practices (TLCPCP), on the following topics:

- Person-Centered Plan Development
- Person-Centered Plan Implementation
- Person-Centered Practice for Managers
- Person-Centered Thinking Train-the-Trainer

Multi-day Learning Institutes

Multi-day Learning Institutes offer participants the opportunity to learn from one another, create new opportunities for change, test ideas through implementation, generate new collective wisdom for the larger provider community, and become leaders of change who can bring these ideas back to recipients, staff, families, and communities. Each multi-day Learning Institute includes:

- An in-person, 2.5 day opening session
- A webinar series
- Virtual office hours, coaching circles, and an online discussion board
- Both mentoring and self-directed learning
- An in-person, 1.5 day closing session

These training opportunities are intended for a variety of audiences including, but not limited to:

- Agency and plan managers
- Professional and para-professional staff involved in service planning, service delivery, and direct care
- Care managers, case managers, service coordinators, care coordinators
- Individuals receiving Medicaid-funded HCBS, their families, and their circles of support

For more information and to register for either Regional Trainings or Learning Institutes, please visit the training registration web page at: <http://nydohpcptraining.com/events>. Questions related to the Person-Centered Planning Comprehensive System Transformation Statewide Training Initiative should be addressed to: NYDOHPCPTraining@pcgus.com or PCSPTraining@health.ny.gov.

Opioid Treatment Plan Follow Up

This is a follow up to the “Opioid Treatment Plan” article published in the [March 2019 Medicaid Update](#). New York State Medicaid and the Bureau of Narcotic Enforcement (BNE) collaborated on legislation outlined in Public Health Law §3331 as well as the clinical criteria of that opioid treatment plan. An Opioid Treatment Plan Notification Letter was sent to providers in February 2019 outlining the legislation and treatment plan requirements. This letter can be found on the BNE web page at: <https://www.health.ny.gov/professionals/narcotic/>.

The treatment plan must follow generally accepted national professional or governmental guidelines, and shall include (but not be limited to) the documentation and discussion of the following clinical criteria within the medical record:

- goals for pain management and functional improvement based on diagnosis, and a discussion on how opioid therapy would be **tapered to lower dosages or tapered and discontinued*** if benefits do not outweigh risks;
- a review with the patient of the risks of and alternatives to opioid treatment; and
- an evaluation of risk factors for opioid-related harms.

Such documentation and discussion of the above clinical criteria shall be done, at a minimum, on an annual basis.

All Medicaid fee-for-service (FFS) and Medicaid Managed Care (MMC) providers who prescribe opioids to patients initiating or being maintained on opioid treatment for pain that has lasted more than three months, or past the time of normal tissue healing (with some exceptions), must have a written opioid treatment plan in the patients’ medical record that shall include the criteria set forth in the letter. This must be in place no later than **January 1, 2020**. Failure to comply with this date will be subject to audit.

*Center for Disease Control (CDC) *Pocket Guide: Tapering Opioids for Chronic Pain* can be found at: https://www.cdc.gov/drugoverdose/pdf/Clinical_Pocket_Guide_Tapering-a.pdf.

2019 Spousal Impoverishment Income and Resource Levels Increase

Attention Providers of nursing facility services, certain home and community-based waiver services, and services to individuals enrolled in a managed long term care plan: obligation to inform individuals receiving services. Providers of nursing facility services, home and community-based waiver services, and services to individuals enrolled in a managed long term care plan are required to **print** and **distribute** the “Information Notice to Couples with an Institutionalized Spouse” (pages 13-15 of this newsletter) at the time they begin to provide services to their patients.

Effective January 1, 2019, the federal maximum community spouse resource allowance increased to **\$126,420** while the community spouse income allowance increased to **\$3,160.50**. The maximum family member monthly allowance increased to **\$705**.

This information should be provided to any institutionalized spouse, community spouse, or representative acting on their behalf to avoid unnecessary depletion of the amount of assets a couple can retain under the Medicaid program’s spousal impoverishment eligibility provisions.

Income and Resource Amounts

Date	Allowance
January 1, 2019	<p>Federal Maximum Community Spouse Resource Allowance: \$126,420 Note: A higher amount may be established by court order or fair hearing to generate income to raise the community spouse’s monthly income up to the maximum allowance. Note: The State Minimum Community Spouse Resource Allowance is \$74,820.</p>
January 1, 2019	<p>Community Spouse Minimum Monthly Maintenance Needs Allowance is an amount up to: \$3,160.50 (if the community spouse has no income of his/her own). Note: A higher amount may be established by court order or fair hearing due to exceptional circumstances that result in significant financial distress.</p>
January 1, 2019	<p>Family Member Monthly Allowance for each family member is an amount up to: \$705 (if the family member has no income of his/her own).</p>

Note: If the institutionalized spouse is receiving Medicaid, any change in income of the institutionalized spouse, the community spouse, and/or the family member may affect the community spouse income allowance and/or the family member allowance. Therefore, the social services district should be promptly notified of any income variations.

New Enhanced Mileage Accuracy Requirement for Medicaid Transportation Providers

Many transportation providers currently submit mileage claims that round the fractional mileage distance from the nearest tenth of a mile traveled to the next highest whole number (e.g., from 2.7 miles to 3.0 miles). The New York State Department of Health (the Department) has now determined that the current capabilities of the prior authorization and claims payment systems can accommodate fractional mileage claims that reflect distance to the nearest tenth of a mile. The submission of fractional mileage claims will enhance payment accuracy, reduce Medicaid overpayments, achieve alignment with current Medicare mileage reimbursement policy, and better reflect the advent of geocoded trip recording technologies.

Effective for dates of service on or after August 1, 2019, claims for loaded mileage must be reported as fractional units to the tenth of a mile (for trips totaling less than one mile, enter a “0” before the decimal point (e.g. 0.9). Rounding mileage units up to the nearest whole number is *not* allowed for claims with dates of service on or after August 1, 2019. **Rounded-up claims may be deemed fraudulent and therefore subject to any recoveries and associated penalties by enforcement agencies.** Transportation providers who are unable to comply with the August 1, 2019 fractional mileage reporting requirement, due to software limitations or other reasons, may round mileage units *down* to the nearest lowest whole number until a time determined by the Department.

As always, the Medicaid program will only reimburse transportation providers for “loaded” miles. Loaded miles are those miles during which an enrollee occupies the vehicle. Questions regarding this policy should be directed to the Bureau of Medicaid Transportation at medtrans@health.ny.gov .

New York Medicaid EHR Incentive Program

Distribution to Eligible Professionals & Eligible Hospitals Since the Start of the Program in 2011*

Number of Payments:	Distributed Funds:
39,016	\$972,087,596

*As of 4/26/2019

Through the New York (NY) Medicaid Electronic Health Record (EHR) Incentive Program eligible professionals (EPs) and eligible hospitals (EHs) in NY who adopt, implement, or upgrade certified EHR technology (CEHRT) and subsequently become meaningful users of CEHRT, can qualify for financial incentives. The Centers for Medicare and Medicaid Services (CMS) is dedicated to improving interoperability and patient access to health information. The NY Medicaid EHR Incentive Program is a part of the CMS Promoting Interoperability Program but will continue to operate under the current name, NY Medicaid EHR Incentive Program.

MEIPASS Opening Date for Payment Year 2018

The Medicaid EHR Incentive Program Administrative Support Service (MEIPASS) opens for Payment Year (PY) 2018 Attestations on July 1, 2019. A demonstration and discussion regarding recent updates to MEIPASS will take place on Wednesday, June 26 via webinar. A Questions and Answers (Q&A) session will also be part of the agenda. Registration for the webinar is available at: <https://attendee.gotowebinar.com/register/1080451992228290059>.

New York State (NYS) Regional Extension Centers (RECs)

NYS RECs offer free support to help providers achieve Meaningful Use of CEHRT. Support provided by NYS RECs includes but is not limited to: answers to questions regarding the program and requirements, assistance on selecting and using CEHRT, or help meeting program objectives. NYS RECs offer **free** assistance for all practices and providers located within New York.

Providers located **inside** the five boroughs of New York City (NYC) should contact:

NYC REACH

Phone: 1-347-396-4888

Website: <https://www.nycreach.org>.

Email: pcip@health.nyc.gov.

Providers located **outside** the five boroughs of NYC should contact:

New York eHealth Collaborative (NYeC)

Phone: 1-646-619-6400

Website: <https://www.nyehealth.org>

Email: hapsinfo@nyehealth.org

Webinars and Q&A Sessions

A calendar with the date and times of upcoming webinars, as well as registration information, can be found at: https://www.health.ny.gov/health_care/medicaid/redesign/ehr/calendar/.

NY Medicaid EHR Incentive Program Post-Payment Audit Education Series

NY Medicaid EHR Incentive Program has produced a series of Post-Payment Audit Educational tutorials to assist providers for preparation in the event of a post-payment audit. Links to available tutorials can be found at: https://www.health.ny.gov/health_care/medicaid/redesign/ehr/audit/.

Questions

The EHR Incentive Program has a dedicated support team ready to assist. Please contact the program at: **1-877-646-5410 (Option 2)** or via email at: hit@health.ny.gov.

Please Complete the New York Medicaid EHR Incentive Program Customer Satisfaction Survey

The NY Medicaid EHR Incentive Program values provider insight. The survey can be found at: https://www.surveymonkey.com/r/NY_EHR.

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).

For 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, 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>

eMedNY

For a number of services including: change of address, updating an enrollment file due to an ownership change, enrolling another NPI, or revalidating an existing enrollment please visit: <https://www.emedny.org/info/ProviderEnrollment/index.aspx> and choose the appropriate link based on provider type.

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, Georgia Wohnsen, at medicaidupdate@health.ny.gov.

Appendix

Information Notice to Couples with an Institutionalized Spouse

Medicaid is an assistance program that may help pay for the costs of your or your spouse's institutional care, home and community-based waiver services, or enrollment in a managed long term care plan. The institutionalized spouse is considered medically needy if his/her resources are at or below a certain level and the monthly income after certain deductions is less than the cost of care in the facility.

Federal and State laws require that spousal impoverishment rules be used to determine an institutionalized spouse's eligibility for Medicaid. These rules protect some of the income and resources of the couple for the community spouse.

Note: Spousal impoverishment rules do not apply to an institutionalized spouse who is eligible under the Modified Adjusted Gross Income (MAGI) rules.

If you or your spouse are:

1. In a medical institution or nursing facility and are likely to remain there for at least 30 consecutive days;
or
2. Receiving home and community-based services provided pursuant to a waiver under section 1915(c) of the federal Social Security Act and are likely to receive such services for at least 30 consecutive days;
or
3. Receiving institutional or non-institutional services and are enrolled in a managed long term care plan;
and
4. Married to a spouse who does **not** meet any of the criteria set forth under (1) through (3), these income and resource eligibility rules for an institutionalized spouse may apply to you or your spouse.

If you wish to discuss these eligibility provisions, please contact your local department of social services. Even if you have no intention of pursuing a Medicaid application, you are urged to contact your local department of social services to request an assessment of the total value of you and your spouse's combined countable resources. It is to the advantage of the community spouse to request such an assessment to make certain that allowable resources are not depleted by you for your spouse's cost of care. To request such an assessment, please contact your local department of social services or mail the attached completed "Request for Assessment Form." New York City residents should contact the Human Resources Administration (HRA) Medicaid Helpline at (888) 692-6116.

Information about resources:

Effective January 1, 1996, the community spouse is allowed to keep resources in an amount equal to the greater of the following amounts:

1. \$74,820 (the State minimum spousal resource standard); or
2. The amount of the spousal share up to the maximum amount permitted under federal law (\$126,420 for 2019).

For purposes of this calculation, "spousal share" is the amount equal to one-half of the total value of the countable resources of you and your spouse at the beginning of the most recent continuous period of institutionalization of the institutionalized spouse. The most recent continuous period of institutionalization is defined as the most recent period you or your spouse met the criteria listed in items 1 through 4 (under "If you or your spouse are:"). In determining the total value of the countable resources, we will not count the value of your home, household items, personal property, your car, or certain funds established for burial expenses.

The community spouse may be able to obtain additional amounts of resources to generate income when the otherwise available income of the community spouse, together with the income allowance from the institutionalized spouse, is less than the maximum community spouse monthly income allowance, by requesting a fair hearing or commencing a family court proceeding against the institutionalized spouse. You can contact your local department of social services or an attorney about requesting a Medicaid fair hearing. Your attorney

can provide you with more information about commencing a family court proceeding. You may be able to get a lawyer at no cost to you by calling your local Legal Aid or Legal Services Office. For the names of other lawyers, call your local or State Bar Association.

Either spouse or a representative acting on their behalf may request an assessment of the couple's countable resources, at the beginning or any time after the beginning of a continuous period of institutionalization. Upon receipt of such request and all relevant documentation, the local district will assess and document the total value of the couple's countable resources and provide each spouse with a copy of the assessment and the documentation upon which it is based. If the request is not filed with a Medicaid application, the local department of social services may charge up to \$25.00 for the cost of preparing and copying the assessment and documentation.

Information about income:

You may request an assessment/determination of:

1. The community spouse monthly income allowance (an amount of up to \$3,160.50 a month for 2019); and
2. A maximum family member allowance for each minor child, dependent child, dependent parent, or dependent sibling of either spouse living with the community spouse of \$705 for 2019 (if the family member has no income of his/her own).

The community spouse may be able to obtain additional amounts of the institutionalized spouse's income, due to exceptional circumstances resulting in significant financial distress, then would otherwise be allowed under the Medicaid program, by requesting a fair hearing or commencing a family court proceeding against the institutionalized spouse. Significant financial distress means exceptional expenses which the community spouse cannot be expected to meet from the monthly maintenance needs allowance or from amounts held in resources. These expenses may include but are not limited to: recurring or extraordinary non-covered medical expenses (of the community spouse or dependent family members who live with the community spouse); amounts to preserve, maintain, or make major repairs to the home; and amounts necessary to preserve an income-producing asset. Social Services Law §366-c(2)(g) and §366-c(4)(b) require that the amount of such support orders be deducted from the institutionalized spouse's income for eligibility purposes. Such court orders are only effective back to the filing date of the petition. Please contact your attorney for additional information about commencing a family court proceeding.

If you wish to request an assessment of the total value of your and your spouse's countable resources, a determination of the community spouse resource allowance, community spouse monthly income allowance, or family member allowance(s) and the method of computing such allowances, please contact your local department of social services. New York City residents should call the Human Resources Administration (HRA) Medicaid Helpline at (888) 692-6116.

Additional Information: Spousal Refusal and Undue Hardship Concerning a Community Spouse's Refusal to Provide Necessary Information

For purposes of determining Medicaid eligibility for the institutionalized spouse, a community spouse must cooperate by providing necessary information about his/her resources. Refusal to provide the necessary information shall be reason for denying Medicaid for the institutionalized spouse because Medicaid eligibility cannot be determined. If the applicant or recipient demonstrates that denial of Medicaid would result in undue hardship for the institutionalized spouse and an assignment of support is executed or the institutionalized spouse is unable to execute such assignment due to physical or mental impairment, Medicaid shall be authorized. However, if the community spouse refuses to make such resource information available, then the Department or local department of social services, at its option, may refer the matter to court for recovery from the community spouse of any Medicaid expenditures for the institutionalized spouse's care.

Undue hardship occurs when:

1. A community spouse fails or refuses to cooperate in providing necessary information about his/her resources;
2. The institutionalized spouse is otherwise eligible for Medicaid;
3. The institutionalized spouse is unable to obtain appropriate medical care without the provision of Medicaid; and
 - a. The community spouse's whereabouts are unknown; or
 - b. The community spouse is incapable of providing the required information due to illness or mental incapacity; or
 - c. The community spouse lived apart from the institutionalized spouse immediately prior to institutionalization; or
 - d. Due to the action or inaction of the community spouse, other than the failure or refusal to cooperate in providing necessary information about his/her resources, the institutionalized spouse will be in need of protection from actual or threatened harm, neglect, or hazardous conditions if discharged from appropriate medical setting.

An institutionalized spouse will not be determined ineligible for Medicaid because the community spouse refuses to make his or her resources in excess of the community spouse resource allowance available to the institutionalized spouse if:

1. The institutionalized spouse executes an assignment of support from the community spouse in favor of the social services district; or
2. The institutionalized spouse is unable to execute such assignment due to physical or mental impairment.

Income Contribution From Community Spouse

The amount of money that Medicaid will request as a contribution from the community spouse will be based on his/her income and the number of certain individuals in the community household depending on that income. Medicaid will request a contribution from a community spouse of 25 percent of the amount his/her otherwise available income that exceeds the minimum monthly maintenance needs allowance plus any family member allowance(s). If the community spouse feels that he/she cannot contribute the amount requested, he/she has the right to schedule a conference with the local department of social services to try to reach an agreement about the amount he/she is able to pay.

Pursuant to §366(3)(a) of the Social Services Law, Medicaid **must** be provided to the institutionalized spouse if the community spouse fails or refuses to contribute his/her income towards the institutionalized spouse's cost of care. However, if the community spouse fails or refuses to make his/her income available as requested, then the Department or the local department of social services, at its option, may refer the matter to court for a review of the spouse's actual ability to pay.

Date: _____

Request for Assessment Form

Institutionalized Spouse's Name: _____

Address: _____

Telephone Number: _____

Community Spouse's Name: _____

Current Address: _____

Telephone Number: _____

/We request an assessment of the items checked below:

- Couple's countable resources and the community spouse resource allowance
- Community spouse monthly income allowance
- Family member allowance(s)

Check if you are a representative acting on behalf of either spouse. Please call your local department of social services if we do not contact you within 10 days of this request.

NOTE: If an assessment is requested without a Medicaid application, the local department of social services may charge up to \$25 for the cost of preparing and copying the assessment and documentation.

Signature of Requesting Individual

Address and telephone # if different from above