



Medicaid Update

THE OFFICIAL NEWSLETTER OF THE NEW YORK STATE MEDICAID PROGRAM

Report Indicates Consumer Satisfaction Rates High Among Members of New York's Managed Long-Term Care Plans

The New York State Department of Health (NYSDOH) recently announced that a customer satisfaction survey of enrollees in Medicaid managed long-term care plans (MLTCs) rate their plans highly. The survey conducted by the IPRO concludes that 85 percent of enrollees rated their managed long-term care plans good or excellent. Ninety-one percent would recommend their plan to a friend and 84 percent said the plan helped them and their families manage their illness better. Ratings of plan communication were also high with 85 percent indicating that the plan explains services clearly and 98 percent reporting that they were treated with courtesy and respect.



MLTC plans provide long-term care services such as home care and adult day care to people who are chronically ill or have disabilities, allowing them to stay in their homes and communities as long as possible. The MLTC plan arranges and pays for a large selection of long-term care health and social services including nursing home services when the enrollee is no longer able to stay in his/her home.

The report is based on a standardized satisfaction survey conducted in 2011. Members also rated their caregivers very highly: 87 percent rated the quality of care provided by their care managers as good or excellent with similar levels of satisfaction with their visiting nurses, 86 percent.

"These satisfaction results indicate that managed long-term care will provide excellent service while making our Medicaid system sustainable," said Jason Helgerson, New York State Medicaid Director.

The goal of moving this population to care management is also to improve outcomes. New York currently ranks last in the nation in terms of inappropriate hospital admissions for Medicaid patients. The MLTC program creates incentives for the plans to keep people healthier and in their homes.

A more detailed report of these findings and additional information about the MLTC program are located at: http://www.health.ny.gov/health_care/managed_care/mltc/.



**New York City
Human Resources
Administration (HRA)
has a new phone #!**

**INFOLINE'S NEW NUMBER
IS 718-557-1399**

FEBRUARY 2012 NEW YORK STATE MEDICAID UPDATE

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New Populations to Enroll in Medicaid Managed Care

Effective April 1, 2012, and contingent on New York State receiving the necessary federal approvals, the following circumstances **will no longer** be sufficient reasons for non-dually eligible beneficiaries (Medicaid beneficiaries NOT in receipt of Medicare benefits) to be exempt or excluded from enrolling in a Medicaid managed care plan in mandatory counties. These changes are needed in order to enroll additional populations into Medicaid managed care or other care coordination programs over the next two years, as required by the Governor's Medicaid Redesign Team (MRT) and authorizing legislation. These include:

- **Persons with end stage renal disease (ESRD);**
- **Homeless individuals;**
- **Persons receiving services through the Chronic Illness Demonstration Program (CIDP);**
- **Infants born weighing under 1200 grams or babies under six months of age with a disabling condition;**
- **Persons with characteristics and needs similar to those in the following programs and facilities: Long Term Home Health Care Program (LTHHCP), Care at Home (CAH) program, Traumatic Brain Injury (TBI) program, Nursing Home Transition and Diversion (NHTD) waiver program and the Intermediate Care Facilities for the developmentally disabled program (ICF/DD).**

All providers are strongly encouraged to enter into contractual arrangements with Medicaid managed care plans in their service area in order to continue to provide needed services to members once they transition into a Medicaid managed care plan.

Current Medicaid recipients who fall into one of the above categories and who receive a mandatory informational/enrollment packet, will have thirty days to choose a Medicaid managed care plan. Anyone who fails to choose a plan within thirty days will be automatically assigned to a plan. New Medicaid applicants are expected to choose a plan upon application or they will be automatically assigned. **Providers are encouraged to assist their patients in choosing a plan in which the provider participates.** Persons with self-identified approved exemptions will receive an "End of Exemption" letter and will be afforded time to apply for an alternate exemption, if available.

Persons with ESRD – Please see separate article on enrollment of this population.

Homeless Individuals

Enrollment of homeless individuals will be phased in beginning April 2012. Where identifiable, the state will make every effort to target families with children prior to enrolling single individuals and childless couples. Undomiciled individuals (street homeless) will be targeted last for enrollment to allow ample time to educate these harder to locate individuals. Over a six month period, all homeless individuals will be enrolled statewide.

Medicaid managed care plans will be required to include in their network providers who traditionally treat the homeless population, including at least two federally qualified health centers (FQHCs) with designation under Section 330H of the Public Health Services Act, where available. Additional information will be provided in subsequent Medicaid Updates.

-continued on next page-

Chronic Illness Demonstration Program (CIDP) Participants

The CIDP is scheduled to phase out as of March 31, 2012, and participants will no longer be excluded from Medicaid managed care as of April 1, 2012. CIDP providers will be assisting participants in choosing a health plan that includes the providers the consumer is seeing.

Disabled and Low Birth Weight Infants – Please see separate article on enrollment of this population.

Waiver Program “Look-alikes”

“Look-alikes” are persons who are not enrolled in the waiver program, but have needs similar to persons enrolled in the waiver, and are eligible for nursing home level of care, or care in an ICF/DD, but remain in the community. **Please note that all individuals with Restriction Exemption Code 95 (RE95), as designated by OPWDD, will remain exempt from mandatory enrollment into managed care until such time as the proposed People First 1115 demonstration waiver is fully implemented within their county of residence.**

The LTHHCP waiver program provides enhanced services to individuals who are elderly or disabled, and who are medically eligible for nursing home care to allow them to remain in the community. Beginning April 2012, the state will begin enrolling individuals who “look like” participants in this program, i.e., individuals who are eligible for nursing home level of care but whose needs can safely be met in the community and are not currently enrolled in the waiver program. Additionally, individuals who “look like” participants in the Traumatic Brain Injury (TBI) program, the Care at Home (CAH) program, and who “look like” residents of Intermediate Care Facilities for the mentally retarded (ICF/DD) will be required to enroll in Medicaid managed care. “Look-alike” exempt persons will receive an end of exemption letter to allow an individual to apply for an alternate exemption, if applicable, prior to receiving a mandatory informational/enrollment packet.

Transitional Care Requirements for New Enrollees

Individuals newly enrolled in a Medicaid managed care plan who are undergoing a course of treatment may be eligible to continue the course of treatment with their current provider for a transitional period, regardless of whether the provider is in the plan’s network. **Non-participating** providers may provide transitional care for a period of up to 60 days from date of enrollment. For persons with an already approved course of treatment, such as home care or personal care services, **participating** providers may provide transitional care until the health plan’s approved treatment plan is in place. While transitional care is required to be covered by the plan, prior authorization rules through the plan must be followed.

Information on other exemptions and exclusions from enrollment in Medicaid managed care, as well as information on how to apply for another exemption not listed above, is available from NY Medicaid Choice at (800) 505-5678, the Local Departments of Social Services (LDSS) or in New York City, the Human Resources Department (HRA). See box above to register for a webinar on new populations enrolling in Medicaid managed care, as well as new benefits that will be covered by Medicaid managed care plans.

For a list of managed care plans by county, please visit: www.nyhealth.gov/health_care/managed_care/pdf/cnty_dir.pdf.

For more information on the Medicaid Redesign Team initiatives now being implemented, please visit: http://nyhealth.gov/health_care/medicaid/redesign.

If you have any managed care enrollment questions, please e-mail: OMCmail@health.state.ny.us.

WEBINAR:

Transition of New Populations and Benefits into Mainstream Medicaid Managed Care

Date: Wednesday, March 7, 2012

Time: 3:00 – 4:30PM EST

After registering, you will receive a confirmation via e-mail containing information about joining the webinar.

System Requirements:

PC-based attendees

Required: Windows® 7, Vista, XP or 2003 Server

Macintosh®-based attendees

Required: Mac OS® X 10.5 or newer

Space is limited. Reserve your webinar seat at:

<https://www1.gotomeeting.com/register/637495184>

Health Department Regulations Adopted for Observation Unit Operating Standards

New York State Medicaid, including Medicaid managed care and Family Health Plus (FHPlus) plans, have reimbursed providers, effective April 1, 2011, for hospital observation services delivered in observation units. Payment has been contingent upon approval of a site-specific waiver from the Office of Health Systems Management (OHSM), Division of Certification and Surveillance.

Effective January 11, 2012, Title 10 of the New York Code of Rules and Regulations, Section 405.19, was amended establishing observation unit operating standards. Accordingly, new observation units must be established in compliance with the process and standards set forth in section 405.19, rather than through a waiver. New York State Medicaid will reimburse providers for observation services in observation units that meet the new standards identified in the recently filed regulations.

The regulations governing provision of observation services are available online at:

<http://w3.health.state.ny.us/dbspace/NYCRR10.nsf/56cf2e25d626f9f785256538006c3ed7/8525652c00680c3e8525652c00630a77?OpenDocument&Highlight=0,405.19>.

New York State Medicaid will continue to reimburse hospitals for observation services delivered in an observation unit under authority of a waiver issued by the OHSM. However, please note that pursuant to the recently adopted regulations, facilities that had been granted a waiver are required to comply with the provisions of the new regulatory standards within 24 months of the effective date of the regulation change (i.e., January 11, 2014). Facilities that are not in compliance with the regulations by January 11, 2014, will not be eligible for reimbursement.

Previously published billing instructions for observation services may be found in the May 2011 Medicaid Update at: http://www.health.ny.gov/health_care/medicaid/program/update/2011/2011-05.htm#eme.

Please contact the Division of Certification and Surveillance at (518) 402-1003, if you have questions about the process for establishing an observation unit or operating standards.

If you have questions about Medicaid reimbursement for observation services, please contact the Division of Program Development and Management at (518) 473-2160.

Infants with Low Birth Weight and Infants with Disabilities under Six Months of Age in Medicaid Managed Care

Effective April 1, 2012*, infants born on or after April 1, 2012, weighing less than 1200 grams and infants under six months of age who are disabled **will no longer** be excluded from enrolling in a Medicaid managed care plan and will be enrolled in Medicaid managed care. These changes are being made in response to recent legislation requiring New York State to enroll additional populations into Medicaid managed care or other care coordination programs over the next three years. Infants born prior to April 1, 2012, that are already enrolled in fee-for-service will remain in fee-for-service until they are six months old, at which time they will receive an enrollment packet with a choice of plan.

If the infant's mother is enrolled in a Medicaid managed care plan (HIV-SNP in New York City), the infant will be automatically enrolled in the mother's plan. If the mother is enrolled in a Family Health Plus (FHPlus) plan, and that plan also has a Medicaid managed care product, the infant will be enrolled in that plan's Medicaid managed care product. If the mother's FHPlus plan does not offer a Medicaid option, the infant's mother must choose a Medicaid managed care plan. If the mother fails to choose a plan, the infant will automatically be assigned to a plan. Providers are encouraged to assist their patients in choosing a plan in which the provider participates.

Managed care plans are responsible for notifying the local social services district (LDSS), or HRA in New York City, of any enrollee that is pregnant within thirty days of becoming aware of the pregnancy. In addition, managed care plans should notify the LDSS/HRA when a newborn weighing 1200 grams or more appears to otherwise qualify as disabled.

For a list of managed care plans by county, please visit:
http://www.nyhealth.gov/health_care/managed_care/pdf/cnty_dir.pdf.

For more information on the Medicaid Redesign Team (MRT) initiatives, please visit:
http://nyhealth.gov/health_care/medicaid/redesign.

***contingent upon CMS approval**

Beneficiaries with End Stage Renal Disease Must Enroll in Medicaid Managed Care

Effective April 1, 2012*, recipients with a diagnosis of End Stage Renal Disease (ESRD) **will no longer** be exempt from enrolling in a Medicaid managed care plan in mandatory counties. These changes are being made in response to recent legislation requiring New York State to enroll additional populations into Medicaid managed care or other care coordination programs over the next three years. Effective April 1, 2012, individuals who are identified on eMedNY with a diagnosis of ESRD or individuals who were approved for an ESRD exemption and are otherwise eligible for mandatory enrollment will be sent informational/enrollment packets on how to enroll from either the Local Department of Social Services (LDSS) or in counties that utilize the New York State Enrollment Broker from New York Medicaid CHOICE. Individuals who applied for an ESRD exemption and were approved will receive an "End of Exemption" notice prior to receipt of their mandatory informational/enrollment packet.

Many individuals with ESRD are in receipt of Medicare; those individuals with dual coverage continue to be excluded (unable to enroll) in Medicaid managed care plans but may choose to enroll into a Managed Long Term Care or Medicaid Advantage plan if one is available in their county.

Current Medicaid recipients with ESRD who receive informational/enrollment packets will have thirty days to choose a Medicaid managed care plan. Anyone who fails to choose a plan within thirty days will be automatically assigned to a plan. Providers are encouraged to assist their patients in choosing a plan in which the provider participates. New Medicaid applicants are expected to choose a plan at application or they will be auto assigned; this includes those with ESRD.

Individuals newly enrolled in a Medicaid managed care plan that are undergoing a course of treatment, including dialysis, may be eligible to continue receiving services from their current provider for a transitional period, even if the provider does not participate in the plan's network. Medicaid managed care plans must reimburse **non-participating** providers for such ongoing services during a transitional period of up to sixty days from date of enrollment while the enrollee is transitioned to a participating provider.

The Medicaid Redesign Team (MRT) and legislative initiatives require most Medicaid recipients to enroll in a managed care plan by April 2013. As a result, **all providers are strongly encouraged to enter into contractual arrangements with Medicaid managed care** plans in their service area in order to continue to provide needed services to members once they transition into a Medicaid managed care plan.

For a list of managed care plans by county, please visit:
http://www.nyhealth.gov/health_care/managed_care/pdf/cnty_dir.pdf.

For more information on the Medicaid Redesign Team initiatives, please visit:
http://nyhealth.gov/health_care/medicaid/redesign.

Please note that individuals in fee-for-service Medicaid with chronic medical issues, including ESRD, who have had a relationship for at least six months with a specialist provider not participating in **any** managed care plan are allowed one exemption for a limited period of six months, only. This exemption will defer enrollment into a Medicaid managed care plan for up to six months, and is limited to persons who are in active treatment at the time of the exemption request.

***contingent upon CMS approval**

Billing for Post-op Follow-up Days

The following information clarifies Medicaid's fee-for-service policy on billing for post-op follow-up days.

Patients often return to the hospital clinic for aftercare appointments following a surgical procedure that took place in one of the following settings:

- Inpatient hospital;
- Hospital ambulatory surgery unit; or
- Hospital clinic.

Facilities may bill Medicaid for these visits. This policy applies to post-op aftercare visits that are billed under Ambulatory Patient Groups (APGs), as well as to those aftercare visits that took place prior to the implementation of APGs.

NOTE: The physician may not bill for aftercare visits. Payment to the physician for surgical procedures includes the surgery and the follow-up care. The number of follow-up days assigned to each surgical procedure can be found in the "Physician Manual – Surgery Services Fee Schedule." This information can be accessed at the following website:

<https://www.emedny.org/ProviderManuals/Physician/index.aspx>.

Medicaid Managed Care

Medicaid managed care and Family Health Plus (FHPlus) plans will reimburse in-network providers according to established provider agreements. Reimbursement for out-of-network providers will be at negotiated rates. Questions concerning managed care reimbursement rates should be directed to the health plan Provider Services number.

Questions regarding Medicaid fee-for-service policy and claiming should be sent via e-mail to: pffs@health.state.ny.us.

Attention: Pharmacists



Both Prescription and Over-the-Counter Emergency Contraception is a Covered Benefit for Medicaid, Medicaid Managed Care and Family Health Plus

- FOR FEMALES 17 OR OLDER, A FISCAL ORDER OR PRESCRIPTION IS NOT REQUIRED
- FOR FEMALES 16 AND YOUNGER, A PRESCRIPTION IS REQUIRED
- LIMITED TO 6 COURSES OF THERAPY IN A 12 MONTH PERIOD

BILLING FOR EMERGENCY CONTRACEPTION (Plan B, Plan B One Step, Next Choice)

Dual-labeled (labeled as both prescription and over-the-counter depending on the patient age) emergency contraceptive products, can be dispensed to Medicaid eligible females 17 years and older as an over-the-counter (OTC) product without a fiscal order. A prescription is still required for these emergency contraceptive products for females 16 years and younger.

Medicaid Fee for Service Billing

For members 17 years of age and older without a written order, the prescriber identification field for pharmacy claims may be left blank for these products and the claim will still be processed.

Managed Care Plan Billing

General information on the billing to managed care plans for emergency contraception for Medicaid managed care and Family Health Plus (FHPlus) members 17 years of age and older without a written order is available at: http://www.health.ny.gov/health_care/medicaid/redesign/docs/summary_emergency_contraception.pdf.

**ATTENTION: FEE-FOR-SERVICE PRESCRIBERS
MEDICAID PROGRAM - DISPENSE BRAND DRUGS
WHEN LESS EXPENSIVE**

Frequently Asked Questions (FAQ)

This program promotes the use of certain multi-source brand name drugs when the cost of the brand name drug is less expensive than the generic equivalent.

On April 26, 2010, New York State Medicaid implemented a new cost containment initiative which promotes the use of certain multi-source brand name drugs when the cost of the brand name drug is less expensive than the generic equivalent.

Q: Do brand name drugs included in this program require 'Dispense as Written' (DAW) or 'Brand Medically Necessary' on the prescription.

A: No

Q: Is this program in conformance with New York State Education Law regarding generic substitution?

A: Yes, generic substitution intends that a less costly alternative be dispensed; brand name drugs included in this program have a generic co-payment and are less costly for the state.

Q: What DAW code does the pharmacy need to use when submitting a claim for a drug that is included in this program?

A: Reimbursement does not require the submission of a particular DAW code. Acceptable values for the Dispense As Written/Product Selection code are as follows:

0 = No product selection

1 = Substitution not allowed by prescriber*

4 = Substitution allowed - Generic Drug not in stock

5 = Substitution allowed - Brand Drug dispensed as a Generic

7 = Substitution not allowed - Brand Drug mandated by Law

8 = Substitution allowed - Generic Drug not available in the Marketplace

9 = Substitution allowed by Prescriber – Plan Request Brand

*Claims should only be submitted with a DAW code of '1' when the prescriber indicates in handwriting or by electronic means 'Dispense as Written' (DAW) and 'Brand Medically Necessary' on the prescription.

Q: Will the patient need to obtain a new prescription if the drug is removed from the Dispense Brand Drugs When Less Expensive Program?

A: No. A new prescription is not required if the generic alternative becomes the more cost-effective option.

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Information for Prescribers Regarding Recent Changes to the Medicaid Prior Authorization Programs

The New York State Department of Health (NYSDOH) recently implemented changes to the fee-for-service prior authorization (PA) process. An automated claim review is now being performed at the pharmacy point-of-sale system. Prior to payment, pharmacy claims are run through specific clinical rules, which have been established by the Medicaid Drug Utilization Review Board (DURB) and the Pharmacy & Therapeutics Committee (P&TC). If clinical rules are met, a PA is generated within the system and no additional action is required by the prescriber.

When a claim fails clinical rules, and the prescriber has determined it would not be clinically appropriate to change the prescription, prescribers (or their authorized agents) must contact the clinical call center at (877) 309-9493 to obtain a PA. Callers will be asked to provide clinical rationale for the request and may also be asked to provide documentation to support medical necessity.

Helpful Hints:

- Properly code all medical claims with the appropriate diagnoses. This will allow the system to search a beneficiary's medical claims history, which could eliminate the need for prescribers to call the clinical call center for PA.
- P&TC recommendations for the Clinical Drug Review Program (CDRP) and DURB recommendations for Step Therapy and Frequency/Quantity/Duration are based on best practice, as established by FDA approved manufacturer labeling, official compendia, and major treatment guidelines. Prescribers can avoid the need to obtain PA by following clinical recommendations, which can be found at:

http://www.health.ny.gov/health_care/medicaid/program/pharmacy.htm

https://newyork.fhsc.com/providers/CDRP_about.asp

http://www.health.ny.gov/health_care/medicaid/program/dur/index.htm

- Using preferred products as shown in the Preferred Drug List (PDL) may also prevent the need to obtain PA. The current PDL can be found at: <https://newyork.fhsc.com/>.

Fee-for-Service Pharmacy Providers

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 – March 2012**
- **Issue AAC and COD Survey – April 2012**
- **Verify and Publish Rates – June 2012**
- **Implementation – July 2012**

NYSDOH will utilize the Health Commerce System (HCS) and data will be collected through a secure process and in a manner that ensures provider confidentiality. The Department will require Medicaid enrolled pharmacies that do not currently have accounts, to obtain a HCS Medical Professions Account by March 1, 2012.

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 cannot be shared.

Follow the link below to request a HCS Medical Professions Account Application:

<https://hcsteamwork1.health.state.ny.us/pub/top.html>

After the submitted information is verified, the account application will be sent to you via e-mail to be signed by the practitioner and to have notarized. If you require assistance filling out the form, please contact the Commerce Accounts Management Unit (CAMU) at (866) 529-1890, option #1.

*Any changes to the timeline will be communicated as they occur.

Information Regarding Frequency/Quantity/ Duration (F/Q/D) Editing

Based on the recommendations of the Drug Utilization Review Board (DURB), F/Q/D parameters were instituted to ensure clinically appropriate and cost effective use of drugs and drug classes.

When submitting claims for drugs subject to this program **please be sure to input the correct quantity and to calculate the proper days supply for the medication being dispensed.**

Examples:

Advair Diskus 250-50 Diskus, 60gm - 1 inhalation twice a day = 30 day supply

Flonase, 16gm - Instill 2 sprays in each nostril once a day = 30 day supply

DUR board recommendations are based on FDA approved labeling, current guidelines, compendia sources as well as identified best practices and may be broader or more restrictive than FDA approved labeling alone.

Examples:

Soma 350mg tablets - Maximum of 4 tablets per day up to a 21 day supply, maximum of 84 cumulative tablets per year.

Axert 6.25mg tablet - Maximum of 18 tablets every 30 days - In this case if a claim is submitted for 9 tablets, the days supply could range from 15 -30 days, **claims entered with a lesser day supply would require a prior authorization.**

For more information regarding clinical parameters please visit:
http://www.health.ny.gov/health_care/medicaid/program/dur/index.htm



ATTENTION: PROVIDERS

Please assist us in notifying EPIC members of recent program changes by displaying this poster, the Frequently Asked Questions (FAQs), and the List of Resources for Those Who Need Help With Prescription Costs in your practice. Feel free to copy and distribute.

Effective January 1, 2012

EPIC MEMBERS

This notice provides information regarding the recent changes to your EPIC coverage

- EPIC is a free program, with no fees or deductibles.
- You **must** be enrolled in a Medicare drug plan in order to receive benefits.
- EPIC **only** provides coverage for Medicare Part D covered drugs or Part D excluded drugs purchased during the Part D coverage gap (donut hole).
- Your EPIC copayment for drugs purchased during the Part D coverage gap (donut hole) will be \$3-\$20, depending on the cost of the drug.

For more information call the toll-free EPIC Helpline at **1-800-332-3742**, or write to:

**EPIC
P.O. Box 15018
Albany, New York 12212**

EPIC Members

Effective January 1, 2012 your EPIC coverage changed

Frequently Asked Questions (FAQ)

Q1. How has the EPIC program changed?

ANSWER: Effective January 1, 2012, EPIC is a free program, with no fees or deductibles. All members must be enrolled in a Medicare Part D drug plans in order to receive EPIC benefits. EPIC only provides drug coverage in the Medicare Part D coverage gap (donut hole).

Q2. What drug coverage does the EPIC program provide?

ANSWER: EPIC only provides secondary drug coverage for Medicare Part D covered drugs or Part D excluded drugs purchased during the coverage gap (donut hole).

Q3. What is a Medicare Part D excluded drug?

ANSWER: Part D excluded drugs are medications that are not required to be covered by a Part D plan. (e.g., some anti-anxiety drugs such as benzodiazepines or some anti-seizure drugs such as barbiturates).

Q4. My Medicare Part D drug plan has a deductible. Will EPIC provide secondary coverage during this time?

ANSWER: No, EPIC coverage is limited to drugs purchased during the Part D coverage gap. You will need to pay any deductible required by your Part D drug plan.

Q5. Will EPIC provide secondary coverage of my drugs after I pay my Part D deductible and enter the initial coverage phase (prior to the coverage gap)?

ANSWER: No. EPIC drug coverage is limited to drugs purchased during the Part D coverage gap. You will need to pay the co-payment charged by your Part D plan (approximately 25 percent of the drug cost) during the initial coverage phase.

Q6. How much will I have to pay before EPIC helps me pay for drugs?

ANSWER: You will have to pay approximately \$970 out of pocket before you reach the Medicare Part D coverage gap. Your total cost of drugs prior to the coverage gap (what you pay and what Medicare Part D pays is \$2,930).

Q7. What are the EPIC co-payments for drugs purchased in the Part D coverage gap?

ANSWER: EPIC's co-payment structure has not changed. Members pay EPIC copayments of \$3-\$20 based on the cost of a covered drug.

Q8. Will EPIC provide secondary coverage during the Part D catastrophic coverage phase?

ANSWER: No. You will use your Part D plan for covered drugs and your co-insurance will be approximately 5 percent of the cost of the drug.

Q9. Will EPIC help pay my monthly Part D drug premium?

ANSWER: EPIC will pay the monthly Part D drug premium up to \$39.79 in 2012 for members with income up to \$23,000 if single or \$29,000 if married. Those with higher incomes must pay their Part D drug premium each month.

Q10. How can I reduce my drug costs?

ANSWER: You should work with your doctor and pharmacist to use drugs covered by your Part D plan. You should ask your doctor if you can take a generic drug or a lower cost brand drug that is covered by your Part D plan, if appropriate for you.

Q11. I need additional help in paying for my prescriptions. What can I do?

ANSWER: The Patient Assistance Resources sheet (attached) lists various organizations that may offer financial assistance in paying for your drugs.

Q12. Am I eligible for Extra Help from Medicare?

ANSWER: If your current annual income is up to \$16,335 if single or \$22,065 if married and your total assets are up to \$12,640 if single or \$25,260 if married, you may be eligible for Extra Help from Medicare. If approved in 2012, you will pay copayments as low as \$2.60 for generics and \$6.50 for brand drugs covered by your Part D plan. Please call the EPIC Helpline at **1-800-332-3742** and ask for a **Request for Additional Information** form to be mailed to you. You must complete, sign and return the form to EPIC and we will apply for the benefit for you.

Q13. Am I eligible for a Medicare Savings Program?

ANSWER: If your current annual income is up to \$14,702 if single or \$19,859 if married, you may be eligible for a Medicare Savings Program. There is no asset limit to apply for the benefit. If approved in 2012, you will receive Extra Help from Medicare and you will pay copayments as low as \$2.60 for generics and \$6.50 for brand drugs covered by your Part D plan. Please call the EPIC Helpline at **1-800-332-3742** and request a **Medicare Savings Program** application to be mailed to you. You must complete, sign and return the form to EPIC, along with required income documentation, and we will apply for the benefit for you.

CMS Discretionary Enforcement Period for 5010 Compliance Ends March 31, 2012

Medicaid providers who still submit electronic transactions in the HIPAA Version 4010 format are urged to complete their system transition to Version 5010 as soon as possible. The CMS discretionary enforcement period for Version 5010 compliance ends on March 31, 2012. New York State Medicaid will continue to operate a dual system for inbound transactions through the March 31 deadline. However, in keeping with the federal Version 5010 compliance guidelines, effective April 1, 2012, New York State Medicaid will begin to accept and process only Version 5010 inbound transactions.

If you are experiencing difficulty with the transition, educational and technical resources are available to assist you. Extensive information on all Medicaid changes for Version 5010 is included at www.emedny.org under “eMedNYHIPAASupport” and in the February 2011 5010 Special Edition Medicaid Update. Additionally, the CSC Call Center and EDI technical support staff are available to assist you with your 5010 transition questions and issues and can be reached at (800) 343-9000.

We encourage providers to conduct proper testing in order to minimize any problems during the production phase. The eMedNY Provider Testing Environment (PTE) is available for providers to test their 5010 transactions. The PTE is designed to enable NYS Medicaid trading partners to test batch and real-time Electronic Data Interchange transactions using the same validation, adjudication logic, and methods as the eMedNY production environment. For information on how to start testing refer to the Technical CG at: https://www.emedny.org/HIPAA/5010/transactions/eMedNY_Trading_Partner_Information_CG.pdf.

Medicaid to Discontinue Distribution of Version 4010 Remittances

Effective March 1, 2012, beginning with cycle 1803, Medicaid will no longer support Version 4010 electronic remittances (835s). All electronic remittances will be produced and sent in Version 5010 format. Cycle 1803 covers claims adjudicated from March 1, 2012 through March 7, 2012 and will have a check date of March 12, 2012.

Providers who are still receiving their electronic remittance (835) in the Version 4010 format are urged to expedite their conversion efforts and make sure they will be ready to receive their remittance in the Version 5010 format. It is important that providers who utilize the services of a vendor or a billing service communicate with those partners to ensure necessary changes are initiated. Providers who may need assistance should contact the eMedNY Call Center at the number listed below.

The March 1, 2012, date applies only to outbound electronic transactions (835s). New York State Medicaid will continue to operate a dual system, accepting and processing inbound HIPAA Versions 4010 and 5010 and NCPDP Versions 5.1 and D.0 formats for the entire CMS Discretionary Enforcement Period of January 1, 2012 through March 31, 2012.

If you have any questions or need technical assistance transitioning to the Version 5010 electronic remittance (835) please contact the eMedNY Call Center at (800) 343-9000.

Issuance of IRS Form 1099

Computer Sciences Corporation (CSC), the eMedNY contractor for the New York State Department of Health (NYSDOH), issues IRS (Internal Revenue Service) Form 1099 to providers at the beginning of each year for the previous year's Medicaid payments. The 1099s are issued with the individual provider's social security number or for businesses, with the Federal Employer Identification Number (FEIN) registered with NY Medicaid.

As with previous years, please note that the IRS 1099 amount **is not** based on the date of the checks; rather, **it is based on the date the checks were released to providers.**

Due to the two-week check lag between the date of the check and the date the check is issued, the IRS 1099 amount will not correspond to the sum of all checks issued for your provider identification number during the calendar year. The IRS 1099 amount is based on check **release** date.

The IRS 1099 that will be issued for the year 2011 will include the following:

- **Check dated 12/20/10 (Cycle 1739) released on 01/05/2011 through,**
- **Check dated 12/12/11 (Cycle 1790) released 12/28/11.**

Additionally, each year, CSC receives calls from individual providers who are issued 1099s for funds the practitioner is unaware of. This happens because in order for group practice providers to direct Medicaid payments to a group NPI and corresponding IRS 1099 for the group, group practices must submit the group NPI in the appropriate field on the claim (paper or electronic). Claims that do not have the group NPI entered will cause payment to go to the *individual* provider and his/her IRS 1099. Regardless of who deposits the funds, the 1099 will be issued to the individual provider when the funds had been paid to the individual provider's NPI.

Also note that 1099s are not issued to providers whose yearly payments are less than \$600.00. **IRS 1099s for the year 2011 will be mailed no later than January 31, 2012.**

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

Physician Reminder

Determining Utilization Threshold Status

With the implementation of HIPAA 5010 and D.0 transactions, the New York State Department of Health (NYSDOH) has eliminated the Service Authorization (SA - 278) process. This process required providers to obtain utilization threshold (UT) service authorizations via the Medicaid Eligibility Verification System (MEVS) prior to the payment of claims.

Since service authorization transactions are no longer being supported, the eligibility transaction process will provide information when the member is at limit. Determining a Medicaid member's UT status is critical for accurate billing and payment purposes. The provider risks ***non payment*** if eligibility is not verified.

Please contact the eMedNY Call Center at (800) 343-9000 with any questions.

PROVIDER DIRECTORY

Office of the Medicaid Inspector General:

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

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

Provider Manuals/Companion Guides, Enrollment Information/Forms/Training Schedules:

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

Do you have questions about billing and performing MEVS transactions?

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

Provider Training:

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

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

Enrollee Eligibility:

Call the Touchtone Telephone Verification System at (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?

Fee-for-service providers please call (518) 402-7032.

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

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

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