Additional Inpatient Hospital Discharge Data Now Available on Health Data NY

The New York State Department of Health (DOH) recently announced the release of new hospital discharge data on its Health Data NY website (health.data.ny.gov), providing New Yorkers with 24/7 access to important health information about inpatient treatment in New York State hospitals.

"When public health partners, academia, researchers, or others are asked what type of health data they would like access to in order to support research and analysis, they request hospital discharge data," said State Health Commissioner Nirav R. Shah, M.D., M.P.H. "One of the primary goals of Health Data NY is to be responsive to the health informational needs of New Yorkers, and releasing this data publicly for the first time is an example of how we are listening to New Yorkers and putting valuable data into their hands for use and innovation."

The Statewide Planning and Research Cooperative (SPARCS) Inpatient De-Identified Data for 2011, which is now available today on Health Data NY, contains inpatient hospital discharge level detail on patient characteristics, diagnoses, treatments, services and source of payment for all hospitals in New York State. It is important to note that this data does not contain health information that is protected under the federal Health Insurance Portability and Accountability Act (HIPAA). This data expands upon previous summarized SPARCS data that was published on Health Data NY in March.

The Health Data NY site is the only known open data site in the United States devoted solely to state health data accompanied by targeted public health messaging, extensive metadata and customized visualizations. Health Data NY not only provides raw data, but allows health care providers, researchers, legislators, advocates, academics, and the general public to analyze and download valuable health data in a variety of formats; review comprehensive metadata; create visualizations of the data; embed data and visualizations into their respective web sites with automatic refreshes from health.data.ny.gov; utilize Application Programming Interfaces (APIs) to build mobile applications; and share data and visualizations through popular social media tools like Twitter and Facebook.

Health Data NY supports Governor Cuomo's OPEN NY initiative and its respective state data transparency website, open.ny.gov. Open.ny.gov provides user-friendly, one-stop access to data from New York State agencies, localities, and the federal government. All health data available on Health Data NY is also accessible at open.ny.gov, as well as the federal government's health open data site, HealthData.gov.

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New York State DOH

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MEDICAID DIRECTOR
Office of Health Insurance Programs

OCTOBER 2013 NEW YORK STATE MEDICAID UPDATE

POLICY AND BILLING GUIDANCE

PHARMACY UPDATE

ALL PROVIDERS

Free CME credits with injection safety "Train-the-Trainer" webcast
Follow this link to learn more: http://www.albany.edu/sph/cphce/esphtc_injection_safety_webcast.shtml

Medicaid Moving Toward ICD-10 Code Sets Implementation

General Background

The compliance date for implementation of the federally mandated ICD-10-CM and ICD-10-PCS code sets is October 1, 2014. The original compliance date was October 1, 2013, however, on August 24, 2012 the Department of Health and Human Services (DHHS) announced an extension to the October 1, 2014 date. ICD-10 code sets will replace the previously adopted ICD-9 diagnosis and procedures code sets and their implementation is required for all covered entities that trade HIPAA compliant transactions. With the adoption of the ICD-10 code sets stakeholders will have access to more detailed information on a patient's condition through specific diagnoses and a more precise and modern approach to classifying inpatient hospital procedures.

The transition from ICD-9 to ICD-10 code sets will have a significant impact on providers' business processes and clinical documentation. Providers who utilize the services of a vendor or clearinghouse may believe that they have the resources and support available to complete a smooth transition. The concern is that many of these entities may not possess the required clinical and medical knowledge needed to identify which ICD-10 code corresponds to the ICD-9 code. As such, it is critical that providers start communicating with their vendor and or clearinghouse early in their transition process to make sure that they have the products, services and resources necessary to ensure their transition to ICD-10 does not have an adverse impact on their reimbursement and does not interrupt their productivity or workflow.

Unlike the HIPAA Version 5010 conversion, with ICD-10 providers have the primary responsibility for transitioning their practice and billing system to the new code sets. The Centers for Medicare and Medicaid Services (CMS) has recognized that for many providers this is a daunting task and it has developed an extensive suite of guides specific to providers who may not possess the required resources and support to complete their transition. Providers are urged to visit www.cms.gov/icd10 for a complete list of all CMS resources including: applicable statutes and regulations, ICD-10 implementation guides and timelines, FAQs and a myriad of other valuable information. Providers should also consider signing up for the CMS ICD-10 Industry e-mail updates.

New York Medicaid

New York State Medicaid and Computer Sciences Corporation (CSC), its fiscal contractor, are working aggressively to ensure coding and programming changes required by the transition to ICD-10 are completed well in advance of the October 1, 2014 compliance date. On the following page is information that may be useful to providers and vendors.

Claims Processing

Claims with dates of service prior to October 1, 2014, must be sent with ICD-9 codes. Claims with dates of service on or after October 1, 2014, must be sent with ICD-10 codes. Retroactive claims will be processed based on the date of service.

The following claim types cannot be split and must be submitted using ICD-10 when the discharge date or end date of service is on or after October 1, 2014, regardless of the statement begin date:

- o Inpatient DRG claims
- o Inpatient GME claims
- o Inpatient Psychiatric
- o Clinical APG Episode of Care
- o CHHA Episodic claims

The following electronic claims and **all paper claims** must be split. Separate claims will be required with ICD-9 codes for dates of service prior to October 1, 2014 and for ICD-10 for dates of service on or after 10/01/2014:

- o Inpatient non-DRG claims
- o Professional claims
- o Nursing Home claims

NOTE: Electronic c**laims** that contain ICD code versions that do not match the above criteria will be rejected during pre-adjudication editing in the 277CA. Claims returned in the 277CA will not appear on the provider's remittance advice. Paper claims submitted with ICD code version errors will result in a denial on the provider's remittance advice.

Claims (electronic and paper) that contain a combination of ICD-9 and ICD-10 coding will fail Edit **02230-A Mix of ICD-9 and ICD-10 Submitted on the Same Claim** and will appear as denied on provider's remittance advice.

Provider Testing Environment (PTE)

The Provider Testing Environment (PTE) will be available for ICD-10 testing on **August 25, 2014** for electronic transactions only. New York Medicaid will not mandate ICD-10 testing, but trading partners are urged to test early and test as soon as PTE is available. The PTE is designed to support end-to-end testing, allowing trading partners to submit test transactions and receive responses.

For testing purposes eMedNY will be utilizing a compliance date of **October 1, 2014**. Claims in PTE with a date of service prior to October 1, 2014 should contain ICD-9 codes; claims with a date of service of October 1, 2014 or after will contain ICD-10 codes. For ICD-10 testing purposes, future date of service will be allowed in PTE.

Providers who currently receive PDF remittances will be sent a paper remittance in test, as PDF is only available in the production environment.

Please refer to the eMedNY Trading Partner Information Standard Companion Guide available at: https://www.emedny.org/HIPAA/5010/transactions/index.aspx for complete details on trading partner testing.

NOTE: ICD-10 test files cannot contain more than 50 claims per file and there is a file limit of two files per user/per day. These limits will be enforced.

ePACES

Providers who use ePACES to submit claims should not submit a test file as ePACES is not available in the PTE. The Health Department and CSC will test ePACES internally. Upon ICD-10 implementation ePACES users will simply need to select the correct Diagnosis Code Version (ICD-9 or ICD-10) based on the date of service. The Version button is already in place on the "Diagnosis Tab".

Production Environment

NY Medicaid will deploy ICD-10 Diagnosis and Procedure Codes and related program changes into the eMedNY production transaction processing environment for October 1, 2014. At that time eMedNY will be processing both ICD-10 and ICD-9 claims based on date of service. For ePACES users the ePACES Diagnosis Page of any new claim (Professional, Institutional and Dental) will allow user to choose the ICD-9 version or the ICD-10 version.

Medicaid ICD-10 Resources

Medicaid Update: Future articles will provide ICD-10 updates and requirements.

eMedNY Website (www.emedny.org): Main menu contains link to ICD-10 information.
FAQ answers a list of key ICD-10 questions.

eMedNY LISTSERV®: Pertinent ICD-10 updates will be sent to subscribers. Providers who are not subscribed to the listserv are urged to do so.

eMedNY Call Center (800-343-9000): The eMedNY Call Center will assist callers with rejected or denied claims, due to coding issues. However, the Call Center will be unable to check ICD-10 codes to determine validity prior to submitting claims.

For technical support and transaction formatting issues: eMedNYhipaasupport@csc.com

Ordering/Referring Editing Implementation in Fee-for-Service Medicaid

The Affordable Care Act (ACA) and subsequent federal regulations (42CFR 455.410) requires enrollment for physicians and other healthcare professionals ordering/referring services provided under the Medicaid state plan or under a waiver of the state plan. It **does not** apply to services paid through a Medicaid managed care plan.

The October 1, 2013, implementation of new claims editing requiring Medicaid enrollment for ordering/prescribing/referring/attending (OPRA) physicians and healthcare professionals has been delayed until **January 1, 2014**.

The extended implementation will allow for more time for OPRA providers to request and obtain enrollment. Providers who have submitted enrollment applications will be notified by letter when a determination has been made or if the application was missing information. **Providers who have not yet submitted enrollment applications must do so immediately to avoid future interruption of the services they order for their patients**.

To determine if a physician or healthcare professional is enrolled in Medicaid, use the search feature available here: https://www.emedny.org/info/opra.aspx

Provider Enrollment forms and instructions:
https://www.emedny.org/info/ProviderEnrollment/index.aspx

Provider Enrollment assistance and status checks:
Please call the eMedNY Call Center at (800) 343-9000

OPRA Frequently Asked Questions:
https://www.emedny.org/info/ProviderEnrollment/ProviderMaintForms/Core_OPRA_FAQs.pdf

For updates on OPRA implementation, sign up for eMedNY General Updates via e-mail **LISTSERV**®at:
https://www.emedny.org/Listserv/eMedNY_Email_Alert_System.aspx

Addressing the Risk of Diabetes with Statins

The New York State Medicaid Prescriber Education Program (NYSMPEP) is a collaboration between the New York State Department of Health (NYSDOH) and the State University of New York (SUNY). The NYSMPEP provides prescribers with an evidence-based, non-commercial source of the latest objective information about pharmaceuticals. In conjunction with the NYSMPEP, the Drug Information Response Center (DIRC) assists clinicians in the delivery of health care to their Medicaid patients by providing timely, evidence-based information on pharmacotherapy and serving as a resource for NYSMPEP academic educators in their outreach to prescribers. A response was prepared by the DIRC regarding the risk of diabetes with statins.

The Food and Drug Administration (FDA) issued a drug safety communication in February 2012 reporting changes in the labeling of statins to include increased blood glucose and glycosylated hemoglobin (HbA1c).[1] These changes were implemented based on results from several studies including Justification for the Use of Statins in Primary Prevention: an Intervention Trial Evaluating Rosuvastatin (JUPITER), Pravastatin or Atorvastatin Evaluation and Infection Therapy - Thrombolysis in Myocardial Infarction 22 (PROVE-IT TIMI 22), as well as the Women's Health Initiative and 2 meta-analyses.[2-6]

JUPITER and PROVE-IT TIMI 22 were prospective clinical trials involving use of rosuvastatin and placebo, and pravastatin and atorvastatin, respectively.[2,3] In the former,[2] an FDA review revealed a 27% increase in investigator-reported diabetes in patients treated with rosuvastatin. In the latter, increases in HbA1c levels of 0.5% were observed in 28% of the group treated with pravastatin (40 mg daily) and 44% of the group treated with atorvastatin (80 mg daily).[3,4] In a substudy of the Women's Health Initiative, Culver et al determined that statin use at baseline was associated with an increased risk of diabetes (hazard ratio [HR] =1.71; 95% confidence interval [CI]: 1.61 to 1.83) in postmenopausal women.[5] This risk was consistent across all statins.

Additionally, data from several meta-analyses suggest an increased risk of diabetes with statins. Rajpathak et al[6] pooled data from 6 randomized trials involving statins and identified a total of 57,593 patients with a mean follow-up of 3.9 years during which 2,082 cases of new-onset diabetes were reported. They calculated a relative risk (RR) of 1.13 (95% CI: 1.03 to 1.23) but also noted significant heterogeneity among the studies (I^2=57.7%). Sattar et al[7] pooled data from 13 randomized trials involving statins which included a total of 91,140 patients. Over a mean follow-up of 4 years, 4,278 patients developed diabetes (2,226 on statins). Sattar et al calculated a 9% increased risk of incident diabetes with statin use (odds ratio [OR] =1.09; 95% CI: 1.02 to 1.17) and noted little heterogeneity among the included studies (I^2 = 11%). Most recently, Preiss et al conducted a meta-analysis evaluating the risk of incident diabetes with intensive-dose and moderate-dose statin therapy.[8] The investigators included data from 5 randomized trials, involving a total of 32,752 patients.

Of these, 2,749 patients developed diabetes (1,449 in the intensive groups and 1,300 in the moderate groups) with approximately 2.0 additional cases in the intensive groups per 1,000 patient-years (OR=1.12; 95% CI: 1.04 to 1.22). No heterogeneity was observed in this respect (I^2=0%).

The available literature does suggest that statin use increases the risk of diabetes, and this is acknowledged by the FDA as evidenced by the required changes to the statin labels.[1] However, this does not preclude statin use. As the *Pharmacist's Letter* asserts, patients should be informed about how this risk compares to the cardiovascular benefits associated with the drugs.[9] Per the 2011 meta-analysis by Preiss et al, usage of high-dose (compared to moderate-dose) statins was associated with an increase of two cases of incident diabetes vs. a reduction of 6.5 cases of cardiovascular events for every 1,000 patients per year.[8] Additionally, significant cardiovascular benefits have been observed in patients with and without established cardiovascular disease, and these benefits may be greater in patients with diabetes compared to those without diabetes.

The clinician is advised to inform patients accordingly and to screen these patients for diabetes as recommended by the American Diabetes Association (generally, in adults of any age who are overweight or with body mass index ≥25 kg/m^2 with ≥1 risk factor for diabetes, or adults ≥45 years of age in the absence of these criteria, every 3 years or more frequently depending on initial results).[10]

To contact an NYSMPEP academic educator in your area, please visit: http://nypep.nysdoh.suny.edu/contactus.

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3. Cannon CP, Braunwald E, McCabe CH, et al. Intensive versus moderate lipid lowering with statins after acute coronary syndromes. *N Engl J Med*. 2004;350(15):1495-1504.

4. Sabatine M. High-dose atorvastatin associated with worse glycemic control: a PROVE-IT TIMI 22 substudy. In: American Heart Association Scientific Sessions; November 10, 2004; New Orleans, LA. Abstract 3848.

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6. Sattar N, Preiss D, Murray HM, et al. Statins and risk of incident diabetes: a collaborative meta-analysis of randomized statin trials. *Lancet*. 2010;375(9716):735-742.

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9. Hester SA. Do statins cause diabetes? *Pharmacist's Letter*. 2011;27(8):270804.

10. American Diabetes Association. Standards of medical care in diabetes—2013. *Diabetes Care*. 2013;36(Suppl 1):S11-S66.

Updated 10-2-13

NYS MEDICAID FEE-FOR-SERVICE (FFS) PROGRAM

Pharmacists as Immunizers Fact Sheet

Effective October 14, 2010, the administration of select vaccines by qualified pharmacists employed by, or under contract with, Medicaid enrolled pharmacies is reimbursable under NYS Medicaid. Administration of vaccines is conducted pursuant to NYS Education Law and regulations (8NYCRR63.9) which permits licensed pharmacists who obtain additional certification to administer influenza and pneumococcal vaccinations to adults 18 years of age and older is based on a **patient-specific or non-patient specific order.**

Effective October 16, 2012, the administration of zoster (shingles) vaccine to Medicaid FFS non-dual enrollees aged 50 and older by qualified pharmacists employed by, or under contract with, Medicaid enrolled pharmacies is reimbursable under NYS Medicaid pursuant to a **patient-specific order** by a physician or nurse practitioner. Administration of vaccines will be conducted pursuant to NYS Education Law and regulations.

Effective October 29, 2013, the administration of meningococcal vaccine to Medicaid FFS beneficiaries 18 years of age or older, by qualified pharmacists employed by, or under contract with, Medicaid enrolled pharmacies is reimbursable under NYS Medicaid pursuant to a **patient-specific order or a non-patient specific order**. Administration of vaccines must be conducted pursuant to NYS Education Law and regulations.

The following conditions apply:

o   Only Medicaid enrolled pharmacies that employ or contract with NYS certified pharmacists to administer vaccines will receive reimbursement for immunization services and products. Pharmacy interns cannot administer immunizations in New York State.

o   Services must be provided and documented in accordance to NYS Department of Education laws and regulations. Visit http://www.op.nysed.gov/prof/pharm/pharmimmunizations.htm for additional information.

o   Pharmacies will only be able to bill for Medicaid fee-for-service non-dual enrollees. Medicaid managed care and Family Health Plus enrollees will continue to access immunization services through their health plans. Dual eligible enrollees will continue to access immunization services through Medicare.

o   Reimbursement for influenza, pneumococcal and meningococcal vaccines will be based on a patient specific order or non-patient specific order. Reimbursement to zoster (shingles) vaccine is based on a patient specific order. These orders must be kept on file at the pharmacy. The ordering prescriber's NPI is required on the claim for the claim to be paid.

o Consistent with Medicaid immunization policy, for administration of vaccines ages 19 and over, pharmacies will bill the administration and acquisition cost of the vaccine using the appropriate procedure codes listed below. Please note that NDCs are not to be used for billing the vaccine product. Reimbursement for the product will be made at no more than the *actual* acquisition cost to the pharmacy. No dispensing fee or enrollee co-payment applies. Pharmacies will bill with a quantity of "1" and a day supply of "1".

o For administration (ages 19 and older) of multiple vaccines on the same date, code 90471 should be used for the first vaccine and 90472 for ANY other vaccines administered on that day. One line will be billed for 90472 indicating the additional number of vaccines administered with a quantity of "1 or 2" (depending on the number of additional vaccines) and a day supply of "1".

o Vaccines for individuals under the age of 19 are provided free of charge by the Vaccines for Children (VFC) program. Medicaid will not reimburse providers for vaccines for individuals under the age of 19 when available through the VFC program. For reimbursement purposes, the administration of the components of a combination vaccine will continue to be considered as one vaccine administration.

o For administration (through 18 years of age) of multiple VFC vaccines on the same date, code 90460 should be used for each vaccine administered.

The following procedure codes should be billed for pharmacist administration of select influenza, pneumococcal and meningococcal vaccines for age 18 and over, and zoster for age 50 and over:

Procedure Code	Procedure Description
90656	Influenza virus vaccine, split virus, preservative free, for use in individuals 3 years of age and above, for intramuscular use.
90658	Influenza virus vaccine, split virus, for use in individuals 3 years of age and above, for intramuscular use.
90660	Influenza virus vaccine, live, for intranasal use in individuals 2 years of age through 49.
90672	Influenza virus vaccine, quadrivalent, live, for intranasal use in individuals 2 years of age through 49.
90686	Influenza virus vaccine, quadrivalent, split virus, preservative free, when administered to individuals 3 years of age and older, for intramuscular use.
90732	Pneumococcal polysaccharide vaccine, 23-valent, adult or immunosuppressed patient dosage, for use in individuals 2 years of age or older, for subcutaneous or intramuscular use
90733	Meningococcal polysaccharide vaccine (any group(s)), for subcutaneous use, age 2 years of age and older.
90734	Meningococcal conjugate vaccine, serogroups A,C,Y and W-135 (trivalent), for intramuscular use, age 11 through 55.
90736	Zoster (shingles) Vaccine, live, for subcutaneous injection, age 50 and older.
90460	Immunization **administration through 18 years of Age** via Any Route of Administration with Counseling; First or Only Component of Each Vaccine or Toxoid Administered (to be used by VFC enrolled pharmacies when administering vaccines obtained from VFC Program) **$17.85.**
90471	Immunization **administration ages 19 and older** (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); 1 vaccine (single or combination vaccine/toxoid) **$13.23.**
90472	Immunization **administration ages 19 and older** (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); each additional vaccine (single or combination vaccine/toxoid) (list separately in addition to code for primary procedure) **$13.23.**
90473	Immunization **administration ages 19 and older** of seasonal influenza intranasal vaccine **$8.57.**

NOTE: The maximum fees for vaccine drugs are adjusted periodically by the State to reflect the estimated acquisition cost. Insert acquisition cost per dose in amount charged field on claim form.

For VFC enrollment information, go to:
http://www.health.ny.gov/prevention/immunization/vaccines_for_children.htm.

Questions regarding Medicaid reimbursement of immunizations may be directed to the Medicaid Pharmacy Program at (518) 486-3209 or via e-mail to: PPNO@health.state.ny.us.

Additional information on influenza can be found at NYS Department of Health's website at http://www.health.ny.gov/diseases/communicable/influenza/.

Certification of Compliance with Section 6032 of the Deficit Reduction Act of 2005, Section 1902 of the Social Security Act, and Title 42 of the United States Code Section 1396a(68)

THIS IS A REMINDER FROM THE NEW YORK STATE OFFICE OF THE MEDICAID INSPECTOR GENERAL (OMIG) FOR ALL PROVIDERS WHO ARE SUBJECT TO THE REQUIREMENTS UNDER TITLE 42 OF THE UNITED STATES CODE SECTION 1396A(68), [42 USC §1396A(68)].

On Sunday December 1, 2013, OMIG will make available on OMIG's website, the Federal Deficit Reduction Act (DRA) of 2005, DRA Certification Form (Certification Form) for 2013.

OMIG will host a webinar on November 21 to explain the new 2013 certification form. Please check OMIG's listserv, Facebook page and Twitter feeds for when registration for this session will be available.

42 USC §1396A(68) provides that:

(a) A State plan for medical assistance must—

> (68) provide that any entity that receives or makes annual payments under the State plan of at least $5,000,000, as a condition of receiving such payments, shall—

> > *(A) establish written policies for all employees of the entity (including management), and of any contractor or agent of the entity, that provide detailed information about the False Claims Act established under sections 3729 through 3733 of title 31, United States Code, administrative remedies for false claims and statements established under chapter 38 of title 31, United States Code, any State laws pertaining to civil or criminal penalties for false claims and statements, and whistleblower protections under such laws, with respect to the role of such laws in preventing and detecting fraud, waste, and abuse in Federal health care programs(as defined in section 1128B(f));*

> > *(B) include as part of such written policies, detailed provisions regarding the entity's policies and procedures for detecting and preventing fraud, waste, and abuse; and*

> > *(C) include in any employee handbook for the entity, a specific discussion of the laws described in subparagraph (A), the rights of employees to be protected as whistleblowers, and the entity's policies and procedures for detecting and preventing fraud, waste, and abuse; ...*

OMIG addresses this mandate by monitoring a provider's certification of compliance status and conducting compliance program reviews of required providers. The certification form and frequently asked questions (FAQs) are available on the OMIG website, on the Compliance landing page at http://www.omig.ny.gov/compliance. If you have any questions, please contact the OMIG's Bureau of Compliance at (518) 408-0401 or by using the Bureau of Compliance's dedicated e-mail address at: compliance@omig.ny.gov.

Mandatory Compliance Program Certification Requirement under 18 NYCRR §521.3(b)

THIS IS A REMINDER FROM THE NEW YORK STATE OFFICE OF THE MEDICAID INSPECTOR GENERAL (OMIG) FOR ALL REQUIRED PROVIDERS WHO ARE SUBJECT TO THE NYS SOCIAL SERVICES LAW SECTION 363-d MANDATORY COMPLIANCE PROGRAM REQUIREMENT.

On Sunday December 1, 2013, OMIG will make available on OMIG's website, the NYS Social Service Law Compliance Program Certification Form (Certification Form) for 2013. The Certification Form for 2012 will remain active on OMIG's website until December 1, 2013 for newly enrolling Medicaid providers.

OMIG will host a webinar on November 21 that will explain the new 2013 certification form. Please check OMIG's listserv, Facebook page and Twitter feeds for webinar registration information.

The following Required Providers must have compliance programs. If you are required to have a compliance program, you are also required to certify on OMIG's website (www.omig.ny.gov) that your compliance program meets the requirements of the applicable law and regulations. The certification must occur in December of each year.

OMIG has actively enforced Social Services Law § 363-d and Part 521, of Title 18 of the New York State Codes, Rules and Regulations since 2009. The regulation mandates all Required Providers under the Medicaid program who fall under the following categories to **certify in December of each year** that they have adopted, implemented and maintain an effective compliance program:

   o *persons subject to the provisions of articles 28 or 36 of the New York State Public Health Law;*

   o *persons subject to the provisions of Articles 16 or 31 of the New York State Mental Hygiene Law;*

   o *other persons, providers or affiliates who provide care, services or supplies under the Medicaid program, or persons who submit claims for care, services or supplies for or on behalf of another person or provider for which the Medicaid program is or should be reasonably expected by a provider to be a substantial portion of their business operations.*

   (emphasis added)

Under 18 NYCRR § 521.2 (b), "substantial portion" of business operations means any of the following:

   1. *when a person, provider or affiliate claims or orders, or has claimed or has ordered, or should be reasonably expected to claim or order at least $500,000 in any consecutive 12-month period from the Medical Assistance Program;*

   2. *when a person, provider or affiliate receives or has received, or should be reasonably expected to receive at least $500,000 in any consecutive 12-month period directly or indirectly from the Medical Assistance Program; or*

3. *when a person, provider or affiliate who submits or has submitted claims for care, services, or supplies to the Medical Assistance Program on behalf of another person or persons in the aggregate of at least $500,000 in any consecutive 12-month period.*

Each compliance program must contain the eight elements required under SSL § 363-d and 18 NYCRR § 521.3 (c). **Upon applying for enrollment in the medical assistance program, and during the month of December each year thereafter**, 18 NYCRR 521.3 (b) requires those subject to the mandatory compliance program obligation to certify to the Department of Health and OMIG that a compliance program meeting the requirements of the regulation is in place.

The regulation and Frequently Asked Questions (FAQs) are available on the OMIG website, on the Compliance landing page at http://www.omig.ny.gov/compliance. The 2013 form will available at that same location starting on December 1, 2013.

It is the responsibility of required providers to determine if:

o *it has a compliance plan that meets the requirements of SSL § 363-d and 18 NYCRR § 521.3 (c); and*

o *its compliance program is effective.*

How required providers assess their compliance programs will determine whether the Required Provider can certify that its compliance program is effective or is not effective.

Additionally, OMIG recommends a regular visit to its website to review the information and resources that are published under the Compliance Tab on OMIG's home page. The Compliance Library under the Compliance Tab provides copies of current forms, publications and other resources that could prove helpful in conducting a self-assessment and completing the certification form in December.

OMIG also recommends that required providers sign up for e-mail notices from OMIG by subscribing to OMIG's listserv. Anyone can become a subscriber at no cost by signing up on OMIG's home page. The listserv is a great way to keep informed of the introduction of new compliance tools and information on compliance. As additional compliance-related resources are posted by OMIG, those on OMIG's listserv will receive notices of their publication. Providers may also wish to follow OMIG on Twitter at @NYSOMIG or follow OMIG on Facebook.

If you have any questions, please contact the OMIG's Bureau of Compliance at (518) 408-0401 or via e-mail to: compliance@omig.ny.gov.

Training Available for Providers

We are pleased to announce that the Statewide Training Center for New York's Health Insurance Programs (TCHIP) website has officially launched at: http://tchip.caiglobal.org.

Provider training is now available in a web-based format. Training includes the presumptive eligibility component as well as application assistance for the following programs:

Family Planning Benefit Program (FPBP)
Pregnant Women
Children Under the Age of 19

Previously trained staff are not required to re-take this training. However, we recommend reviewing the training as a refresher. New staff or staff new to a particular program should take this training.

This website is designed to ensure that you can easily find the information you need for registration and policies. The site features menus to ease site navigation, and includes:

- Links to Online Learning Programs, with easy-to-use and accessible registration;

- Basic information on New York's health insurance programs and policies in the Resource Center;

- The latest news and training updates right on the homepage; and

- ADA compliant browsing and courses, to provide accessible content for all.

The New York State Department of Health selected Cicatelli Associates, Inc. (CAI) to provide training and technical assistance to health care providers and social service workers.

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, (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.

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

Do you have questions about billing and performing MEVS transactions?
Please call the eMedNY Call Center at (800) 343-9000.

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

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

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

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

NY Medicaid EHR Incentive Program

NY Medicaid Electronic Health Records Incentive Program Update

The NY Medicaid EHR Incentive Program provides financial incentives to eligible practitioners and hospitals to promote the transition to electronic health records (EHR). Providers who practice using EHRs are in the forefront of improving quality, reducing costs, and addressing health disparities. Since December 2011 *over $433 million* in incentive funds have been distributed to *over 7,550* New York State Medicaid unique providers.

For more information about the EHR Incentive Program, we encourage you to visit the program website at www.emedny.org/meipass/ or attend one of the informational webinars hosted by the NYS Department of Health.
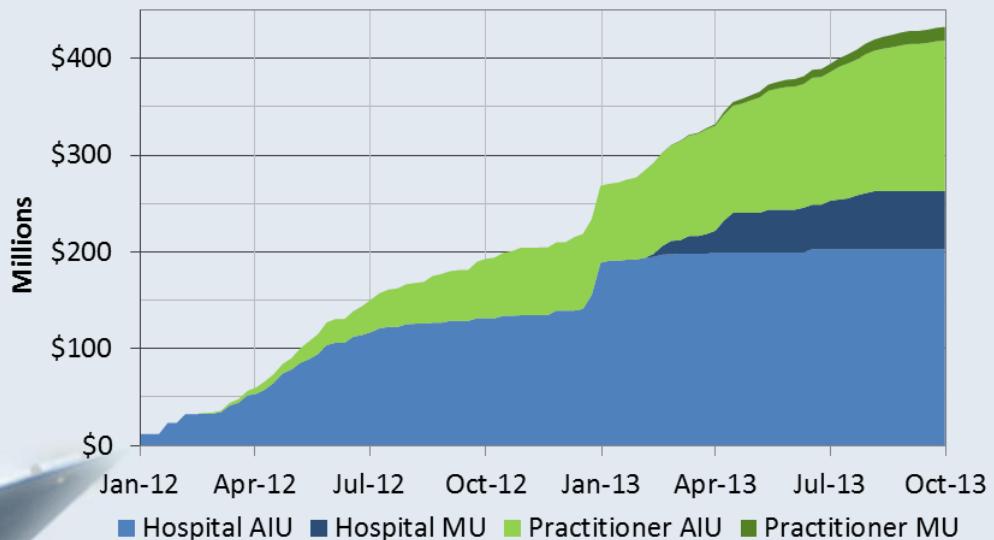
Taking a closer look: Incentive Payment Update*

$263 million (210 payments) to ~150 eligible hospitals.

$170 million (9070 payments) to ~7,400 eligible professionals.

Legend: ■ Hospital AIU ■ Hospital MU ■ Practitioner AIU ■ Practitioner MU

*As of October 8, 2013

To see the complete schedule of events and webinars, please view our improved **Upcoming Event Calendar** at www.emedny.org/meipass/info/Events.aspx.

Have Questions? 877-646-5410

Contact hit@health.state.ny.us for program clarifications and details.

www.emedny.org/meipass/