



Department
of Health

Medicaid Update

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2018-2019 Enacted Budget: Special Edition

2018-2019 Enacted Budget Initiative: Medicaid Transportation Ambulance Rate Increase

The Enacted 2018-2019 State Budget will increase Medicaid Ambulance fees totaling \$12.56 million in 2018-2019 for a Medicaid fee increase for both emergency and non-emergency ambulance transports at the Advanced Life Support and Basic Life Support level of service. The statewide fee increases reflect the value of the first two years of a four-year phase-in.

The updated fees **effective for dates of service on or after April 1, 2018** are posted at:
<https://www.emedny.org/ProviderManuals/Transportation/index.aspx>.

Questions?

Please contact the Bureau of Medicaid Transportation at (518) 473-2160 or medtrans@health.ny.gov.

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2018-2019 Enacted Budget

2018-2019 Enacted Budget Initiative: Center of Operational Excellence

The Office of Health Insurance Programs is instituting a Center of Operational Excellence, which will focus on improving cost avoidance measures and enhance fraud, waste, and abuse deterrence.

The first initiative of the Center of Operational Excellence is to expand the cost avoidance functions currently in place. A key component will focus on strengthening claims editing by adding staff to monitor system edits to ensure optimal performance and compliance with national claims editing standards. This initiative requires enhancements to the existing claims processing system. The second component of this initiative will enhance the review processes for delays in claims filing.

The other key focus of the Center of Operational Excellence is in dental fraud, waste, abuse detection and deterrence. By expanding the use of software services that provide data analytic reviews to identify anomalies and data conflicts, improper payments and fraud will be more easily detected and prevented. These services include powerful tools to detect fraud, waste, and abuse.

For more information on this initiative, please email dprum@health.ny.gov.

2018-2019 Enacted Budget Initiative: Health Home Program

The Enacted Budget contains several initiatives for the Health Home Program. These performance initiatives will provide incentives for Health Homes and Managed Care Plans to link eligible high-risk Members to a Health Home and create a Health Home Quality Performance Incentive Pool.

Health Home Performance Initiatives Effective April 1, 2018

Health Home Quality Performance Management Program - The Department will work with the Health Home/Managed Care Organization (MCO) workgroup, Quality Subcommittee, to integrate the State set of Centers for Medicare and Medicaid Services (CMS) performance goals, and other metrics that have been or will be developed under the State's Health Home Quality Improvement Program, into a Quality Performance Pool for adult members enrolled in Health Homes. Managed Care Plans will have access to Health Home Performance data measures. The Health Home Performance Quality Incentive Pool will provide incentives for Health Homes and care management agencies to meet established performance metrics and goals. The Incentive Pool will impose penalties on underperforming Health Homes and care management agencies and reward higher performers that meet the performance goals. The State will engage the Health Home/MCO workgroup to develop approaches to establishing penalties and distributing rewards to high performers. The pool will be funded from a rate reduction and redistributed based on pre-established quality goals. These quality goals must include standardized measures already in the Health Home performance program and should also include process measures such as adherence to face-to-face requirements for engaging high-risk adult Health Home members, and/or maintaining caseload sizes that may not exceed more than 10 percent of the currently recommended caseloads. These process requirements may be waived when Health Homes and downstream care management agencies enter into value based payment arrangements which include care management.

Additional required activities to address Health Home quality performance include:

- Evaluating opportunities for expanding current cost reporting to include more specific itemization of cost and volume for care management;
- Ensuring Health Homes are complying with requirements pertaining to connectivity with Regional Health Information Organizations (RHIOs) to support case management and service connectivity; and
- Providing public reports on Health Home quality data by Health Home, including standardized scorecards of comparative Health Home performance.

Health Home Healthy Rewards - The Health Home Healthy Rewards program will be a Managed Care Plan-administered program for adult Health Home-enrolled members (21 years and older). The purpose of the program is to promote wellness through proactive access to preventative care, help members stay engaged in Health Home care management, and as a result, derive Medicaid savings from the reduction of preventable emergency visits and preventable inpatient hospital stays. Health Home members will be rewarded for participating in wellness activities, including, but not limited to:

- Annual physicals
- Maintaining a healthy body mass index (BMI)
- Smoking cessation activities
- Continuous enrollment in Health Home

Incentives to Enroll High-Risk Plan Members in Health Homes - This initiative is designed to ensure high-risk, high-need, high-cost Medicaid members are enrolled in Health Home and receive comprehensive care management (including access to critical Home and Community Based Services [HCBS]). Accordingly, Managed Care Plans will be assessed penalties when eligible Health and Recovery Plan (HARP) members and other high-risk adult and children (under 21 years old) are not enrolled in Health Homes at target percentages. These Managed Care penalties, of which up to 50 percent may be passed along to the Health Home, will provide incentives for the Plans and the Health Homes to work collaboratively to enroll high-risk members in Health Homes. The rates of penalty will be structured in a tiered manner, i.e., the further away Plans/Health Homes are from the target, the larger the penalty. This incentive will apply to HARP, HIV/SNP and mainstream plans.

Restructuring Outreach Resources and Other Outreach Reform Efforts – Effective October 1, 2018, outreach resources will be reduced and further restructured to directly engage the Plans in efforts to identify, locate and enroll high-risk, high-cost, high-need members (adults and children) in Health Homes. No later than August 1, 2018, each Plan will be required to submit a detailed Outreach Plan to the Department for approval, describing how it intends to optimize outreach resources and payments to identify, locate and enroll high-risk members in Health Home. Plans will be required to include a projection of the number of members they expect to enroll based on their analysis of members who meet high-risk criteria as defined by the Department.

The Plans will have the opportunity to propose approaches in their Outreach Plan that build on successful Health Home and Delivery System Reform Incentive Payment (DSRIP) activities, including using outreach resources to support the inclusion of Health Home outreach staff in shelters, hospitals, and Local Departments of Social Services (LDSS). Plans will be required to document and track the use of outreach resources within the State-authorized purposes and as included in their approved Outreach Plan. The Plan will use its data and other resources to directly assist the Health Home locate and identify such members. This restructured approach to more efficiently use outreach resources is intended to better leverage the Plan's ability to identify higher risk members in plan data, locate and find members, and allow Health Homes to focus more of their efforts on providing care management services and linking members to services, including HCBS services. The State will also work with the plans and their representatives to issue model outreach approaches that would not require prior approval for implementation.

New Background Check Requirements for Health Homes and Children's HCBS Providers

The statute was amended to require prospective background checks and Statewide Central Register checks for Health Home care managers and HCBS providers (i.e., new hires) that serve Medicaid children and members with intellectual and developmental disabilities (I/DD). In addition, such providers are required to be mandated reporters. The State has scheduled webinars for April 25 and May 17 to brief Health Homes and other providers on the process and procedures for meeting the background checks and other requirements included in the legislation. A link to the Background Check Webinar can be found at: https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/hh_children/index.htm.

For more information regarding these initiatives, please contact the Office of Health Insurance Programs at 518-476-5569 or via email at: https://apps.health.ny.gov/pubdoh/health_care/medicaid/program/medicaid_health_homes/emailHealthHome.action.

2018-2019 Enacted Budget Initiative: MLTC Partial Capitation Plans Contracting with Licensed Home Care Service Agencies

Limitation on Number of Contracted LHCSAs in a Partial Capitation Plan Network

The Enacted Budget amends the Public Health Law §4403-f(7) by adding a new paragraph (j). The new statutory provision is **effective October 1, 2018** and sets, over a two-year period, the maximum number of licensed home care services agencies (LHCSA) with which a Managed Long Term Care (MLTC) **partial capitation** plan may contract.

The methodology used to determine the number of allowable LHCSAs in a MLTC partial capitation plan's network is based upon the plan's enrollment and location. There are separate analyses for plans that are operating Downstate (defined as New York City, Nassau, Suffolk, and Westchester counties) and plans that are operating in Rest of State (ROS). By October 1, 2018, each partial capitation plan will be expected to contract with a maximum number of LHCSAs in accordance with the following ratios:

- For Downstate, the ratio is one LHCSA per each 75 enrollees (1:75)
- For ROS, the ratio is one LHCSA per each 45 enrollees (1:45)

Example: If an MLTC plan has 7,500 enrollees in its Downstate counties, as of October 1, 2018 the plan may contract with up to 100 LHCSAs to service those Downstate enrollees. If the same MLTC plan also had 4,500 enrollees in its ROS counties, as of October 1, 2018 the plan may contract with up to 100 LHCSAs to service those ROS enrollees. If the plan had a LHCSA operating in both Downstate and ROS, it would count towards both the Downstate ratio and the ROS ratio.

By October 1, 2019, each partial capitation plan will be expected to contract with a maximum number of LHCSAs in accordance with the following ratios:

- For Downstate, the ratio is one LHCSA per each 100 enrollees (1:100)
- For ROS, the ratio is one LHCSA per each 60 enrollees (1:60)

A plan that is operating in both Downstate and ROS shall meet the requirements for its enrollment and LHCSA network in each region. In no event will a plan be expected to contract with less LHCSAs than required to comply with network adequacy standards.

This statute does not limit the number of enrollees that a LHCSA may serve. This statute applies to contracts between partial capitation plans and LHCSAs, and applies whether those contracts are direct or indirect through an intermediary contracting entity such as an Independent Practice Association (IPA).

LHCSA Moratorium

Effective April 1, 2018, a 2-year moratorium is imposed on the licensing of new LHCSAs. Broader health system planning needs will be considered on a limited exception basis by permitting applications to be considered by the Public Health and Health Planning Council (PHHPC) if they meet certain criteria, including purposes related to the provision of new Assisted Living Program (ALP) services, consolidation of existing licensees, access/geographic coverage, or other considerations related to lack of adequate and appropriate care as determined by the Commissioner. The moratorium also applies to all applications that are currently under review, but have not been approved by PHHPC as of April 1, 2018. During the period of the moratorium, the New York State Department of Health will develop and implement a licensure process that includes a determination of public need and financial feasibility of the applicant.

LHCSA Registration

The Enacted Budget also added a new Public Health Law §3605-b that requires LHCSAs to register annually with the Department. Any LHCSA that has not registered with the Department during any annual reporting period beginning January 1, 2019 shall not be permitted to operate or provide nursing, home health aide, or personal care services, or receive reimbursement for the provision of services.

A LHCSA that fails to submit a complete and accurate registration by the deadline will be fined \$500 per month (or part thereof) that the LHCSA is in default. A LHCSA that fails to register in the prior year by the deadline of the current year will not be permitted to register unless it submits any unpaid late fees. The Department will pursue revocation of a LHCSA's license if it fails to register for two annual registration periods, whether or not such periods are consecutive. If a LHCSA has a pattern of late registration over multiple years, it may have its license revoked at the discretion of the Department.

The Department will post on its public website a list of all LHCSAs, with an indication of the current registration status of each. Questions regarding this article can be sent to: DLTCEB19@health.ny.gov.

2018-2019 Enacted Budget Initiative: Managed Long-Term Care Plan Closure Oversight

Effective April 1, 2018, the New York State Department of Health (“the Department”) will require the submission of a report to the Department approximately one year after the effective date of the transaction of any merger, acquisition, or similar arrangements approved by the Department involving the involuntary transition of enrollees from one managed long term care (MLTC) plan to another MLTC plan. The report will be filed by the receiving plan(s).

This is in addition to MLTC Policy 17.02 (MLTC Plan Transition Process – MLTC Market Alternation) that offers 120 days continuity of care to MLTC enrollees who are required to involuntarily transition from one MLTC plan to another as the result of plan closure, service area reduction or withdrawal, or merger, acquisition or similar transaction.

Less than 1,000 transferred Enrollees

For mergers, acquisitions, or similar arrangements where less than 1,000 enrollees transferred to the receiving plan, the report will list the following:

- Each enrollee, by Client Identification Number (CIN), that transferred to the receiving plan because of the merger, acquisition or similar arrangement, and that remains an enrollee of the receiving plan one year after such transfer;
- The hours of personal care each enrollee was receiving at the time of the transfer;
- The hours of personal care each enrollee was receiving one year after the time of the transfer;
- A percent of change in hours of personal care; and
- In the event the hours of personal care provided have declined, an explanation why the hours have declined with supporting documentation.

1,000 or more transferred Enrollees

For mergers, acquisitions, or similar arrangements where 1,000 or more enrollees transferred to the receiving plan, the receiving plan shall first send the Department a list of each enrollee, by CIN, that transferred to the receiving plan because of the merger, acquisition, or similar arrangement, and that remains an enrollee of the receiving plan one year after such transfer.

The Department will select a sufficient and random sample from such list and provide it to the receiving plan. The receiving plan shall complete the report for the enrollees selected by the Department in accordance with the above steps.

The report shall be certified by an officer of the MLTC plan. Subsequent to submission of the report, the Department will choose a random sample from the report, in a sample size determined by the Department, for which the receiving plan shall send supporting documentation of the personal care services being provided.

Once the review is completed by the Department, a de-identified version of the report, without supporting documentation, will be made public by the Department. Questions regarding this article can be sent to: DLTCEB19@health.ny.gov.

2018-2019 Enacted Budget Initiative: Patient Centered Medical Home Statewide Incentive Payment Program: Revised Incentive Payments and Updated Billing Guidance

Effective May 1, 2018, in accordance with the 2018-2019 enacted State budget, New York State (NYS) Medicaid is changing the reimbursement amounts for providers working at practices that are recognized as a Patient Centered Medical Home (PCMH) by the National Committee for Quality Assurance (NCQA). The revised policy applies to both Medicaid Managed Care (MMC) and Medicaid Fee-For-Service (FFS). This policy replaces the policy outlined in the [January 2018](#) issue of the *Medicaid Update*.

The Enacted State Budget established a \$200 million spending cap for the PCMH incentive program for State Fiscal Year (SFY) 2018-2019 and SFY 2019-2020. The changes outlined in this policy reflect the standards and PCMH incentive payment amounts that were agreed upon as part of the enacted budget.

For the months of **May and June 2018**, the table below summarizes, by provider type and recognition status, the MMC per member per month (PMPM) amounts and the FFS 'add-on' amounts for visits with qualified evaluation and management codes. Practices recognized under the NCQA 2014 Level 3, NCQA 2017, or NYS PCMH standards will receive a MMC incentive payment of \$5.75 PMPM. The PCMH FFS incentive payment add-on amounts will remain unchanged at \$29.00 and \$25.25 for professional and institutional claims, respectively. All PCMH incentive payments for providers recognized under NCQA's 2014 Level 2 standards will be permanently eliminated for both MMC and FFS effective **May 1, 2018**.

NYS Medicaid will provide incentive payments to Advanced Primary Care (APC) providers, who are Gates 2 and 3 recognized, once federal approval is obtained. They will be paid at the 2014 PCMH Level 3 rates.

PCMH Statewide Incentive Payment Program				
MMC-PMPM and FFS 'Add-on' Amounts				
<i>Effective May 1, 2018 – June 30, 2018</i>				
Incentive	2014 NCQA Level 2 Standards	2014 NCQA Level 3 Standards or APC	2017 NCQA Standards	NYS PCMH Standards
MMC-PMPM	\$0.00	\$5.75	\$5.75	\$5.75
Professional FFS claim add-on	\$0.00	\$29.00	\$29.00	\$29.00
Institutional FFS claim add-on	\$0.00	\$25.25	\$25.25	\$25.25

Beginning **July 1, 2018**, the PCMH incentive amounts will change as shown in the table below:

PCMH Statewide Incentive Payment Program MMC-PMPM and FFS 'Add-on' Amounts Effective July 1, 2018				
Incentive	2014 NCQA Level 2 Standards	2014 NCQA Level 3 Standards or APC	2017 NCQA Standards	NYS PCMH Standards
MMC-PMPM	\$0.00	\$6.00	\$6.00	\$6.00
Professional FFS claim add-on	\$0.00	\$29.00	\$29.00	\$29.00
Institutional FFS claim add-on	\$0.00	\$25.25	\$25.25	\$25.25

These amounts will remain through the end of SFY 2018-2019. The Department has engaged key stakeholders to discuss future linking of the PCMH incentive payments with the principles of Value Based Payments (VBP) and to explore options to tie the incentive payments to VBP participation and quality. Any revised PCMH incentive payment changes will be published in future Medicaid Updates.

Please refer to the [April 2017](#) issue of the *Medicaid Update* for additional information on FFS policy and billing guidance relative to the PCMH incentive program. Please refer to the [June 2016](#) issue of the *Medicaid Update* for additional information on plan types that are included in the PCMH incentive payment program.

Questions/Information:

- For questions related to FFS PCMH incentive payments, including but not limited to missing PCMH incentive payments, PCMH claim add-on incentive payment amounts, and/or PCMH recognition dates, please contact Computer Sciences Corporation (CSC a/k/a CSRA) at 1-800-343-9000 / emednycallctr@csra.com or visit <https://www.emedny.org/> for additional information.
- For questions related to MMC PMPM incentive payments, please contact the MMC plan that is responsible for the distribution of PCMH incentive payments. The NYS Division of Health Plan Contracting and Oversight is responsible for ensuring that the applicable laws and regulations relative to the MMC contracts are adhered to. Additional information and/or questions regarding MMC contracting issues may directed to bmcfhelp@health.ny.gov.
- Providers seeking assistance with FFS policy questions regarding the alignment of the PCMH incentive payment with the principles of Value Based Payments (VBP), policy questions regarding PCMH incentive payment calculations, and/or any other question regarding the PCMH incentive payment program should contact the Office of Health Insurance Programs at 518-473-2160. Additional information regarding Medicaid VBP may be found on the Department's webpage at www.health.ny.gov/health_care/medicaid/redesign/dsrip/vbp_reform.htm.

Policy & Billing Guidance

New York State Medicaid Coverage of Professional Glucose Monitoring for Type 1 Diabetics

New York State Medicaid fee-for-service (FFS) and Medicaid Managed Care (MMC) Plans will begin covering short-term (**three to seven days**) professional monitoring of glucose levels in interstitial fluid for Type 1 diabetics whose condition is uncontrolled. This coverage is **effective April 1, 2018 for FFS, and July 1, 2018 for MMC**.

MMC Plan Billing

Providers participating in MMC should check with the individual health plans to determine how each MMC plan will implement this policy. Questions regarding MMC reimbursement and/or documentation requirements should be directed to the enrollee’s MMC plan.

FFS Billing

Providers operating within their scope of practice may bill for professional (office) provided equipment, sensor placement, hook-up, calibration of monitor, patient training, removal of the sensor, and printout of the reading. This procedure is eligible for reimbursement **twice per year**. The analysis, interpretation and report cannot be billed more than once during the monitoring period (**three to seven days**).

Current Procedural Terminology (CPT) Codes Included in this Policy*	Descriptions
95250	Ambulatory continuous glucose monitoring of interstitial tissue fluid via a subcutaneous sensor for a minimum of 72 hours ; physician or other qualified health care professional (office) provided equipment, sensor placement, hook-up, calibration of monitor, patient training, removal of sensor, and printout of recording
95251	Analysis, interpretation and report

*Providers please check fee schedules for current reimbursement rates.

Policy questions regarding Medicaid FFS may be directed to the Office of Health Insurance Programs, Division of Program Development and Management at (518) 473-2160. Questions regarding Medicaid FFS billing or claims should be directed to the eMedNY Call Center at (800) 343-9000.

Immigrants in Need of Nursing Home Care and Services

This is to remind Nursing Home and Long-Term Care providers that Qualified Non-Citizens, including Lawful Permanent Residents (LPR), refugees, asylees, and others, as well as those Permanently Residing Under Color of Law (PRUCOL) are entitled to Medicaid coverage of nursing home care and services, if otherwise Medicaid eligible. This also includes “Aliessa” individuals who may be enrolled in the Essential Plan (EP).

An individual’s status as PRUCOL or Qualified Non-Citizen should not be used as a factor by providers in determining the need for nursing home care or for nursing home admittance. The term PRUCOL is a public benefit eligibility category. Admittance to a nursing home or receipt of long-term care services must be based on an individual's need and Medicaid eligibility, not immigration status.

The NY State of Health and local departments of social services (LDSS), including the New York City Human Resources Administration, determine whether an individual meets the immigration eligibility requirements for Medicaid as part of the Medicaid or Essential Plan eligibility determination. An individual who is determined to be eligible for Medicaid or the Essential Plan has met the immigration requirements to receive Medicaid coverage.

An individual who is PRUCOL or a Qualified Non-Citizen who has been determined eligible for Medicaid is eligible for the same Medicaid coverage, including long-term nursing home care, as citizens.

Note that individuals who have been found eligible for Essential Plan also meet the Medicaid immigration eligibility requirements.

Individuals with NY State of Health coverage (identified in ePACES with the "Office Field" code of H78) who need permanent nursing home placement, must have their case administration transferred from NY State of Health to their LDSS to determine nursing home Medicaid eligibility. Long-term care providers can notify either the LDSS or NY State of Health of the need to transition the case.

The LDSS can be notified by submitting the Medicaid application, Access NY Healthcare (DOH-4220), Supplement A (DOH-4495A), along with a LDSS-3559, "Residential Health Care Facility Report of Medicaid Recipient Admission/Discharge/Readmission/Change in Status" form or an approved local equivalent.

The NY State of Health can be notified by emailing the information to: hxfacility@health.ny.gov. NY State of Health will then notify the LDSS and a Medicaid application packet will be mailed to the individual for completion. We strongly encourage long-term care providers to assist such individuals in completing and submitting the application packet to help facilitate the eligibility for nursing home care.

For additional referral and provider contact information, please see the *Medicaid Update* publication, dated April 2016 here: https://www.health.ny.gov/health_care/medicaid/program/update/2016/2016-04.htm#ep.

New Date for Taxi (Category of Service 0603) and Livery (Category of Service 0605) Claims Requirement

This is a reminder to comply with claims requirements published in the [December 2015](#) issue of the Medicaid Update. Failure to comply with the documentation requirements will result in claims denials.

The Department of Health has reached agreement with the Office of the Medicaid Inspector General and the Attorney General's Medicaid Fraud Control Unit to require that **claims submitted by taxi/livery providers include both the driver license and vehicle license plate number**. The Department agrees that reporting this information will aid in its intent to ensure quality services and program integrity.

After a lengthy transition period to accommodate systems changes and provider needs, the Department has determined that **effective May 24, 2018, claims that do not include the required fields will be denied for edit 00267, "VEHICLE LICENSE PLATE / DRIVER'S LICENSE NUMBER REQUIRED."**

Questions may be referred to the Medicaid Transportation Unit at (518) 473-2160 or via email to MedTrans@health.ny.gov.

For more information on this initiative, please email dprum@health.ny.gov.

Pharmacy Update

Medicaid Pharmacy Prior Authorization Programs Update

On February 15, 2018, the New York State Medicaid Drug Utilization Review (DUR) Board recommended changes to the Medicaid pharmacy prior authorization (PA) programs. **Effective April 19, 2018**, the fee-for-service pharmacy program will implement the following parameters:

Second Generation Antipsychotics

- Duration Limit: Prescriber involvement required for utilization of three or more different oral second-generation antipsychotics for greater than 180 days
- Informational intervention letter will be sent to prescribers with a history of prescribing three or more different oral second-generation antipsychotics for greater than 90 days

Zolpidem IR Duration Limit

- No more than a 30-day supply with a maximum of five refills (180 days)

Codeine- and Tramadol-Containing Products

- Prescriber involvement required for all codeine- and tramadol- containing products for members younger than 12 years of age
- Educational letter through retrospective drug utilization will be sent to prescribers highlighting the updates to prescribing information for codeine- and tramadol-containing products

Initiation of Methadone Therapy

- Confirm diagnosis for chronic non-cancer pain
- Prescriber involvement required if absence of covered diagnosis in the patient's claim history
- Step-Therapy: Trial with a long-acting opioid prior to the initiation of methadone therapy for the management of chronic non-cancer pain

For more detailed information on the DUR Board, please refer to: http://www.health.ny.gov/health_care/medicaid/program/dur/index.htm.

Below is a link to the most up-to-date information on the Medicaid fee-for-service (FFS) Pharmacy PA Programs. This document contains a full listing of drugs subject to the Medicaid FFS Pharmacy Programs: https://newyork.fhsc.com/downloads/providers/NYRx_PDP_PDL.pdf.

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

Medicaid-enrolled prescribers can also initiate PA requests using a web-based application. PAXpress® is a web-based pharmacy PA request/response application accessible through a new button "PAXpress" located on eMedNY.org under the MEIPASS button.

Additional information is available at the following websites: <http://www.nyhealth.gov> or <http://newyork.fhsc.com> or <http://www.eMedNY.org>.

Update on Pharmacists Administering Influenza Vaccines for Medicaid Enrollees Under the Age of 19

In accordance with New York State Education Law section 6803, **effective April 1, 2018**, NYS certified pharmacists may administer influenza vaccines to children between the ages of 2 years and 18 years.

The influenza vaccine is provided **free of charge** by the Centers for Disease Control and Prevention (CDC) to the Vaccine for Children (VFC) Program and in turn to VFC-enrolled pharmacies for administration to Medicaid-enrolled and uninsured children under the age of 19. Pharmacies not already enrolled in VFC are strongly encouraged to enroll to enable access to influenza vaccine for both Medicaid and uninsured children. A pharmacy-specific enrollment application will be available in late summer; in the interim interested pharmacies may apply to join using the general enrollment application. For NYS VFC (outside NYC) enrollment information, go to: https://www.health.ny.gov/prevention/immunization/vaccines_for_children/. For enrollment in the NYC VFC program, go to: <http://www1.nyc.gov/site/doh/providers/nyc-med-cir/vaccines-for-children-forms.page>.

During the effective period of Executive Order 176, New York State Medicaid suspended the requirement for pharmacies to only use vaccines obtained from the VFC Program for enrollees under the age of 19. **The suspension of this requirement ends with the expiration of the Executive Order, currently set for April 21, 2018.**

NYS Medicaid should **never** be billed for the cost of influenza vaccines for Medicaid members under the age of 19, as these vaccines are available to pharmacies free of charge through the VFC Program. **Pharmacies that bill Medicaid for vaccines available through VFC may be subject to recovery of payment.**

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 links to additional information, including the reporting of all immunizations administered to persons less than 19 years of age to the New York State Department of Health using the New York State Immunization Information System (NYSIIS) or to the New York Citywide Immunization Registry.

Billing Instructions

When billing NYS Medicaid fee-for-service (FFS), providers must submit via National Council on Prescription Drug Programs (NCPDP) D.0, in the Claim Segment field 436-E1 (Product/Service ID Qualifier), a value of "09" (HCPCS), which qualifies the code submitted in field 407-D7 (Product/Service ID) as a Procedure code. In field 407-D7 (Product/Service ID), enter the procedure code.

Pharmacies should use procedure code 90460 when billing NYS Medicaid FFS for administration of a vaccine to a Medicaid enrollee under 19 years of age when available through the VFC Program; reimbursement for such is \$17.85. There is no reimbursement for the vaccine in these instances, as it is available for free through the VFC Program.

For Medicaid Managed Care Organization (MCO) billing guidance, please check with the individual Medicaid Managed Care Plan.

New HCPCS Code to be Used When Billing for Axicabtagene Ciloleucel (brand name YESCARTA™)

Effective April 1, 2018, hospital claims for Axicabtagene Ciloleucel (brand name YESCARTA™) should be billed using Healthcare Common Procedure Coding System (HCPCS) code Q2041. Hospitals submitting claims for YESCARTA™ for the period December 1, 2017 through March 31, 2018 should bill using HCPCS code J3590, unlisted biologic.

When specific criteria are met, New York State Medicaid covers YESCARTA™ for members 18 years of age and older who have a diagnosis of B-cell lymphoma. Coverage criteria and billing guidelines are outlined in the [January 2018](#) issue of the *Medicaid Update*.

All Providers

NY Medicaid EHR Incentive Program Update

The NY Medicaid Electronic Health Records (EHR) Incentive Program provides financial incentives to eligible professionals (EPs) and hospitals to promote the transition to EHRs. Providers who practice using EHRs are in the forefront of improving quality, reducing costs, and addressing health disparities. Since December 2011, **more than \$903 million** in incentive funds have been distributed through **33,166** payments to New York State Medicaid providers.

Eligible Professionals and Eligible Hospitals Total

Payments Made:
33,116

Amount Paid:
\$903,384,178

Are you Eligible to Attest to 2017 Meaningful Use and Receive Incentive Payments from the EHR Incentive Program? Eligible Professionals (EPs) who have attested at any time in the past remain eligible to participate in the program.

NY Medicaid EHR Incentive Program Eligibility Fast Facts

- An EP may be eligible even if they have only attested once in the past.
- An EP may be eligible even if they did not attest last year, since it is acceptable to skip years.
- An EP may be eligible even if they have only attested to Adopt, Implement, or Upgrade in the past.
- EPs who will attest for the second time in PY 2017 can still receive all six years of incentive payments, if they continue to attest every year through PY 2021.
- Participation in an alternative program, including the Medicare Merit-based Incentive Payment System (MIPS), does not exclude participation in the NY Medicaid EHR Incentive Program.

Have you participated previously? Find out by visiting the New York State health data site and search by name or NPI here: <https://health.data.ny.gov/Health/Medicaid-Electronic-Health-Records-Incentive-Progr/6ky4-2v6j/data>. You can also call the NY Medicaid EHR Incentive Program Support Team at 877-646-5410, **Option 2** or email: hit@health.ny.gov and include your name and NPI.

Once you determine you are eligible to attest to Meaningful Use, it is time to begin preparing. The New York Medicaid EHR Incentive Program has not yet begun accepting 2017 Meaningful Use (MU) attestations in the Medicaid EHR Incentive Program Administrative Support Service (MEIPASS) system. Despite this, it is never too early to begin getting ready. Here is a quick check list of items for EPs to complete before attestation time arrives:

- **CMS Registration:** Prior to attesting, verify your Centers for Medicare & Medicaid Services (CMS) registration information is accurate and up to date. If any information needs to be updated, such as email address or telephone number, correct it in the CMS Registration and Attestation System here: <https://ehrincentives.cms.gov/hitech/login.action>.
- **Fee-for-service Enrollment:** EPs must be registered as fee-for-service Medicaid providers and enrollment must be active throughout the entire attestation, until payment has been processed. For more information visit eMedNY (<https://www.emedny.org/>) for more information or call eMedNY Provider Services at 1-800-343-9000.

- **CEHRT ID:** Obtain your EHR Certification ID from the Certified Health IT Product List here: <https://chpl.healthit.gov/#/search>.
- **ETIN Certification:** EPs must maintain Electronic/Paper Transmitter Identification Number (ETIN) certification for Medicaid enrollment and program eligibility. More information is located here: https://www.emedny.org/info/ProviderEnrollment/ProviderMaintForms/490501_ETIN_CERT_Certification_Statement_Cert_Instructions_for_Existing_ETINs.pdf.
- **ePACES:** The ePACES username and password are used to submit your attestation online through MEIPASS. For assistance with ETIN, ePACES, and MEIPASS: call the support team at 877-646-5410 Option 1 or email meipasshelp@csra.com.

As soon as the MEIPASS system is available for 2017 attestations, an announcement will be posted to the EHR Incentive Program website and a message will go out through the NY Medicaid EHR Incentive Program Listserv. Stay tuned for more information.

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

Tips to Prevent Rejection of Certification Forms

New York Medicaid policy requires that each provider annually recertify their Electronic Transmitter Identification Number (ETIN). If the certification is not renewed annually, claims and other transactions will be rejected after ETIN the decertification date.

During each 12-month period, eMedNY distributes two renewal notices accompanied by a preprinted Certification Statement with the provider and ETIN information listed on the form. The first notice is sent 45 days prior to the date the yearly decertification will take place, and a second notice is sent 30 days prior to the decertification date.

For providers applying for a new ETIN, the Certification Statement must accompany the Provider ETIN Application. Both forms can be found at: www.emedny.org.

Please adhere to the following instructions to prevent the rejection of your certification forms:

- All information written on the form should be legible; red ink is prohibited.
- Please make certain that the name of the provider and the provider number match what is on file.
 - When submitting a certification for an individual practitioner, the name of the individual must be entered on the form.
 - When submitting a certification for a group practice, the group practice name must correspond with the group provider number.
- For most providers, the National Provider Identifier (NPI) is required on the Certification Statement. If you are a provider that is exempted from the NPI rule, your NY Medicaid MMIS Provider ID should be entered. NPIs are 10 digits in length and Medicaid numbers are eight digits.
- All provider and notary signatures must be original ink signatures.
- The name of the person signing before the notary must be entered in the blank line following the words: "before me personally came."
- The notary should use the official notary stamp. However, if the stamp is not available, the written information in place of the stamp must include the notary's number, expiration date, and signature.

Questions? Please contact the eMedNY Call Center at (800) 343-9000.

Provider Directory

Office of the Medicaid Inspector General:

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

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

Please visit the eMedNY website at <https://www.emedny.org/>.

Providers wishing to listen to the current week's check/EFT amounts:

Please call (866) 307-5549 (available Thursday PM for one week for the current week's amount).

Do you have questions about billing and performing MEVS transactions?

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

Provider Training:

To sign up for a provider seminar in your area, please enroll online at <https://www.emedny.org/training/index.aspx>. For individual training requests, call (800) 343-9000.

Beneficiary Eligibility:

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

Medicaid Prescriber Education Program:

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

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

Need to change your address? Does your enrollment file need to be updated because you have experienced a change in ownership? Do you want to enroll another NPI? Did you receive a letter advising you to revalidate your enrollment?

Visit <https://www.emedny.org/info/ProviderEnrollment/index.aspx> and choose the link appropriate for you (e.g., physician, nursing home, dental group, etc.).

Medicaid Electronic Health Record (EHR) Incentive Program questions?

Contact the New York Medicaid EHR Call Center at (877) 646-5410 for assistance.

Comments and Suggestions Regarding This Publication?

Please contact the editor, Chelsea Cox, at medicaidupdate@health.ny.gov.