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New York State

Medicaid Update

JANUARY 2014

VOLUME 30 ■ NUMBER 1

THE OFFICIAL NEWSLETTER OF THE NEW YORK STATE MEDICAID PROGRAM

Medicaid Evidence-Based Dossier Review Process Underway

In response to a Medicaid Redesign Team (MRT) initiative, the New York State Department of Health (DOH) established a systematic process for making decisions regarding Medicaid benefits using the best available research evidence. All efforts associated with this systematic process ensure that Medicaid coverage and payment decisions best align with the Centers for Medicare and Medicaid Services' (CMS) Triple Aim health care vision of achieving better health, better quality, and lower costs.

As part of this process, DOH initiated the Medicaid Evidence-Based Dossier Review Process to support transparent and consistent coverage decisions. **DOH began accepting evidence-based dossiers for review on December 1, 2013.** The process provides a structured and uniform way for individuals or entities to submit evidence related to the effectiveness and safety of a particular service, technology, or device. Individuals or entities submitting evidence dossiers must answer a series of questions related to the service and submitted evidence, assess the methodological quality of the submitted evidence, and calculate the net health impact of the service based on the evidence submitted. Methodological guidance is provided as part of the dossier instructions package.

The dossier instructions package, available on the DOH website listed below, includes: the general instructions for assembling and submitting a dossier to the Department, a dossier submission form, and a document providing guidance as to the methods entities or individuals must use in assessing the quality of submitted evidence and calculating the net health impact of the service under review. This package allows for systematic review, ensuring fair judgment and streamlining of the review process.

After DOH receives/reviews an evidence dossier, entities and individuals will then have thirty days to submit additional supporting evidence relevant to the service under review. This process helps DOH better understand the clinical research evidence related to the service(s) under review, including what limitations on use may be appropriate, and whether coverage of the service represents significant value to the people of New York State. Once final coverage determinations have been made, DOH will post these decisions to the Medicaid Evidence-Based Dossier Review Process website.

To access the relevant documents and to obtain instructions on how to submit a dossier for review, please visit: http://www.health.ny.gov/health_care/medicaid/redesign/basic_benefit_ebdsp.htm.

Further questions or concerns about this process can be directed via e-mail to: dossier@health.state.ny.gov.

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JANUARY 2014 NEW YORK STATE MEDICAID UPDATE

POLICY AND BILLING GUIDANCE

ALL PROVIDERS

Transition of Nursing Home Benefit and Population into Managed Care

Effective March 1, 2014, in New York City, Nassau, Suffolk and Westchester Counties, all eligible recipients over age 21 in need of long term placement in a nursing facility, as defined by §1919(a)(1)(C) or 42 U.S.C. 1396r, requirements for nursing facilities, will be required to join a Medicaid managed care plan (MMCP) or a Managed Long Term Care Plan (MLTCP). The rest of the State is scheduled to transition beginning September 2014 for both dual eligible and non-dual eligible populations. The phase-in schedule for the transition of the nursing home benefit and population is reflected in Table 1. As indicated in Table 1, the remaining upstate counties will transition between September 1, 2014 and December 1, 2014 consistent with the schedule for mandatory MLTC enrollment for the community based population. All current long term custodial care beneficiaries in a Medicaid certified skilled nursing facility (nursing home [NH]) prior to any managed care phase-in date will remain in fee-for-service Medicaid and will not be required to enroll in a managed care organization (MCO)[1].

Six months after the implementation of the initial transition, the State will allow any individual in Phase 1 residing in a nursing home to enroll in an MCO on a voluntary basis. Therefore, as of September 1, 2014, individuals in Phase 1 who are in long term placement in a nursing home prior to March 1, 2014 will be allowed to enroll in an MCO on a voluntary basis. All current upstate long term placements prior to September 1, 2014 will be allowed to enroll in an MCO on a voluntary basis on January 1, 2015. This population will no longer be excluded, but exempt from mandatory enrollment into mainstream Medicaid managed care.

In addition, individuals currently enrolled in a MMCP will not be disenrolled if they need long term placement. The managed care plan will be responsible for covering this benefit after February 28, 2014 in the Phase I counties. Individuals will not be required to change nursing homes resulting from this transition. New placements will be based upon the MCO's contractual arrangements and the needs of the individual.

MCOs are required to pay the NH the current Medicaid fee-for service (benchmark) rate or a negotiated rate, acceptable to both plans and nursing homes, for three (3) years after March 1, 2014 for Phase 1 counties, and for three (3) years after January 1, 2015 for all other counties. After the transition period, NHs and MCOs will negotiate a rate of payment for services.

[1] When the term "MCO" is used, it applies to both the mainstream managed care plan and the managed long term care program

Nursing Home Transition Phase-In Schedule	
Month	**County**
March 1, 2014 (Phase 1)	New York City - Bronx, Kings, New York, Queens, Richmond Nassau, Suffolk, Westchester
September 1, 2014	For the above counties (Phase 1) - voluntary enrollment in Medicaid managed care becomes available to individuals residing in nursing homes who are in fee-for-service Medicaid
September 1, 2014 (Phase 2)	Albany, Broome, Cayuga, Chenango, Clinton, Columbia, Delaware, Dutchess, Erie, Essex, Franklin, Fulton, Greene, Hamilton, Herkimer, Madison, Monroe, Montgomery, Niagara, Oneida, Onondaga, Orange, Oswego, Otsego, Putnam, Rensselaer, Rockland, Saratoga, Schenectady, Schoharie, Sullivan, Ulster, Warren, Washington
October 1, 2014 (Phase 3)	Allegany, Cattaraugus, Chautauqua, Jefferson, Lewis, St. Lawrence, Steuben
November 1, 2014 (Phase 4)	Chemung, Cortland, Schuyler, Seneca, Tioga, Yates
December 1, 2014 (Phase 5)	Genesee, Livingston, Ontario, Orleans, Tompkins, Wayne, Wyoming
January 1, 2015	For all Upstate counties (Phases 2 – 5) – voluntary enrollment in Medicaid managed care becomes available to individuals residing in nursing homes who are in fee-for-service Medicaid

The steps toward this transition require that each party (MCOs, providers and the State) ensure that individuals in need of long term care services receive care in the most integrated and least restrictive setting with needed community supports. The ultimate goal is to foster a care delivery model that promotes transitional planning across the health care delivery system with the focus on providing services in the community whenever possible.

Questions regarding the transition can be directed to the Division of Health Plan Contracting and Oversight at 518-473-1134 or to omcmail@health.state.ny.us.

Request for Medicaid Provider Documentation

The Centers for Medicare & Medicaid Services (CMS), in partnership with the New York State Office of the Medicaid Inspector General (OMIG), will measure improper payments in the Medicaid and State Child Health Insurance programs under the **Payment Error Rate Measurement (PERM)** program. This will be the third time New York State has participated. The state last participated in federal fiscal year 2011.

CMS, their contractor, and OMIG have the authority to collect this information under Sections 1902(a)(27) and 2107(b)(1) of the Social Security Act. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) federal statutes and regulations require the provision of such information upon request, and the information can be provided without patient consent.

Documentation for medical review of randomly selected claims will be requested by **A+ Government Solutions, Inc.,** the CMS contractor. If claims you submitted are selected, the CMS contractor will request from you, in writing, documentation to substantiate claims paid in federal fiscal year 2014 (October 1, 2013 - September 30, 2014). Your cooperation and a timely response are appreciated. Submit the specific medical documents for the patient, as requested in the letter you receive from the CMS contractor, **directly** to the CMS contractor with a copy to OMIG.

Requests for documentation will begin in **March 2014.**

Requests and subsequent receipt/non-receipt of documentation will be tracked.

Failure to provide requested records will result in a determination of erroneous payment, and OMIG will pursue recovery.

Questions? Please contact **PERM Project staff** at (518) 486-7153.

Extension of the Medicaid Primary Care Rate Increase (PCRI) Attestation Deadline

With the rollout of the PCRI, New York had established a three month attestation window from May 1, 2013 to August 1, 2013 for the retroactive payment of the Medicaid PCRI from January 1, 2013 forward. After consultation and approval from CMS, New York is implementing an updated attestation and re-attestation process to permit otherwise eligible physicians who missed the attestation deadline to retroactively begin or change their effective date in the program. Please see updated PCRI FAQs and forms on the provider enrollment webpage as well as the general guidance below.

- Physicians who missed the August 1, 2013, attestation deadline for retroactive qualification may now re-attest and change their qualifying effective date for the PCRI program. Use the new *PCRI Change/Update Attestation and Qualification* form to change your PCRI effective date. The effective date must be between January 1, 2013 and December 31, 2014. Submit the form as soon as possible so that retroactive payment adjustments can be processed. If the original attestation included Nurse Practitioners/Nurse Midwives, they also need to complete and sign the form with an effective date within their supervising physician's qualification period.

- If you are unsure of your effective date, please check the PCRI website. The *Physician's List* spreadsheet includes the effective date of each physician, labeled as "PCRI Begin Date." Most physicians already have an effective date of January 1, 2013. If your effective date is January 1, 2013, you do not need to do anything.

- Physicians who are attesting for the first time will continue to use the *Primary Care Rate Increase Attestation* form and will specify an effective date for their qualification.

- eMedNY will retroactively re-process your applicable Medicaid fee-for-service claims with the increased payment on a quarterly basis for you. Medicaid managed care plans will also incorporate retroactive payment to physicians who have attested to a new effective date.

- If you would like to withdraw your qualification from the PCRI program, you must submit the *PCRI Change/Update Attestation and Qualification* form. If your original attestation also qualified Nurse Practitioner(s)/Nurse Midwives, they will be withdrawn from the program. They may re-attest under another supervising physician.

For additional questions on the PCRI program, please e-mail: PCRI-L@listserv.health.state.ny.us

Medicaid Reimbursement for a Fourth Generation Combination Immunoassay for HIV

Effective for dates of service on or after December 1, 2013, laboratory providers may claim reimbursement for a fourth generation HIV diagnostic assay that simultaneously detects both antigen and antibodies for the human immunodeficiency virus (HIV).

Laboratories should use CPT-4 procedure code 87389 (infectious agent detection by enzyme immunoassay technique, qualitative or semiqualitative, multiple-step method: HIV-1 antigen(s), with HIV-1 and HIV-2 antibodies, single result) to bill for this test. The maximum reimbursement amount for procedure code 87389 is $18.49.

This single automated test is intended to be used as an aid in the diagnosis of HIV-1/HIV-2 infection, including acute or primary HIV infection. This test is the preferred first step in a new HIV diagnostic testing algorithm. As verified by scientific studies, this algorithm can achieve earlier and more accurate detection of HIV infections. The New York State Department of Health has issued interim guidelines on the use of this new HIV diagnostic testing algorithm.

These guidelines may be accessed at:
http://www.health.ny.gov/diseases/aids/regulations/testing/docs/guidelines_diagnostic_testing.pdf

If you have further questions on coverage of this HIV test, please contact the Office of Health Insurance Programs, Division of Financial Planning and Policy, Medical, Dental and Pharmacy Policy Unit at (518) 473-2160.

Issuance of IRS Form 1099

CSC, the eMedNY contractor for the Department of Health (DOH), issues Internal Revenue Service (IRS) Form 1099 to providers at the beginning of each year for the previous year's Medicaid payments. The 1099s are issued for individual provider's social security number and/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/EFTs; rather, **it is based on the date the checks/EFTs were released to providers.** Due to the two-week check lag between the date of the check/EFT and the date the check/EFT is issued, the IRS 1099 amount will not correspond to the sum of all checks/EFTs issued for your provider identification number during the calendar year.

The IRS 1099 that will be issued for tax year 2013 will include the following:

- Check dated 12/17/12 (Cycle 1843) released on 01/02/2013 through,
- Check dated 12/09/13 (Cycle 1894) released 12/25/13.

Each year, CSC receives calls from individual providers who are issued 1099s for funds the practitioner is can't reconcile. 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 corresponding 1099 will be issued to the individual provider identified on the claim form.

It is imperative that providers keep their addresses current. An incorrect address will impact the provider's ability to receive his/her 1099 form in a timely manner.

Please note that 1099s are not issued to providers whose yearly payments are less than $600.00.

IRS 1099s for the year 2013 will be mailed no later than January 31, 2014.

The above information is provided to assist providers with reconciling the IRS 1099 amount. Any questions should be directed to the eMedNY Call Center at (800) 343-9000.

Medicaid Now Requires All Billing Providers to Register for Electronic Funds Transfer (EFT) Payments and either Electronic Remittance Advice (ERA) or PDF Remittances

Billing providers who have not registered for EFT and ERA or PDF remittances will not be allowed to re-certify their Electronic Transmitter ID Number (ETIN). When the ETIN expires a provider's claims will be rejected by eMedNY and providers' ePACES accounts will be disabled. It is therefore very important that providers who have not registered for EFT and/or ERA/PDF remittances do so right away. Waiting for your ETIN to approach the next expiration date will jeopardize your Medicaid payments.

Find the EFT Authorization form at www.emedny.org, click on the "Go Green" symbol. Please read the instructions carefully. An original voided check or original signed and notarized letter from your bank is required. The tax number entered on the form must match the tax number for the provider NPI on the form.

Find the ERA/PDF Request form at www.emedny.org, click on the "Go Green" symbol. Before submitting this form providers must be registered for either an eMedNY eXchange in-box or be registered for a File Transfer Protocol account with eMedNY. To register for an eXchange in-box the provider must be enrolled in ePACES. The ePACES account name is the same one used for eXchange. FTP users must have submitted a Security Packet B to establish the FTP account before submitting the ERA/PDF Request form.

PDF remittances look like the paper remit but are delivered via the eXchange inbox. ERAs delivered via either eXchange or FTP requires software to interpret the HIPAA-formatted information.

Questions may be directed to the eMedNY Call Center at (800) 343-9000.

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 (EHR) Incentive Program Update

The NY Medicaid EHR Incentive Program provides financial incentives to eligible practitioners and hospitals to promote the transition to EHRs. Provider practices that use EHRs are in the forefront of improving quality, reducing costs, and addressing health disparities. Since December 2011 ***over $487.5 million*** in incentive funds have been distributed *within* ***10,100*** payments to New York State Medicaid 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: NY Medicaid EHR Incentive Program website updated with 2014 guidance.

Have you seen the new updates on the **NY Medicaid EHR Incentive Program website** at: https://www.emedny.org/meipass/? We are pleased to announce that the website has been updated with **new** 2014 program guidance to inform healthcare practitioner and hospital participants:

- February webinar dates on our Upcoming Event Calendar .
- **New** Frequently Asked Questions (FAQs).
- **New** 2014 Eligible Professional Participation Year Webpages and Webinars.
- **Revised** 2014 Eligible Hospital Participation Year Webpages and Webinars.
- **Don't miss a deadline!** Check out the Deadline and Timelines Table.

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/