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New York State

Medicaid Update

THE OFFICIAL NEWSLETTER OF THE NEW YORK STATE MEDICAID PROGRAM

Medicaid Redesign Team (MRT) Proposal #11 Bundle Pharmacy into Medicaid Managed Care

GENERAL INFORMATION

Beginning October 1, 2011, members enrolled in mainstream¹ Medicaid managed care and Family Health Plus (FHP) plans will receive pharmacy benefits directly through their plans. Members will be issued new health plan cards by their plans in September and will be instructed to present their new card at the pharmacy, rather than their Medicaid card. Network pharmacies should submit claims directly to the member's managed care plan.



FORMULARY

Plans will establish their own formularies and prior authorization processes. However, plan formularies must include all categories of prescription drugs on the NYS Medicaid fee-for-service list of reimbursable drugs. Plans will also be required to maintain an internal and external review process for exceptions. Managed care plans will administer the enrollment and credentialing of their network providers. Reimbursement rates will be set by the plan and/or their Pharmacy Benefit Manager (PBM). Plans will also be responsible for managing and auditing their pharmacy networks.

SUPPLIES

The Medicaid managed care benefit includes diabetic supplies, hearing aid batteries, enteral nutritional formula, diapers and other medical supplies. This applies to all supplies that are currently covered under the Medicaid fee-for-service program, regardless of the provider type.

The list of covered supplies under the Medicaid benefit is available online at:

https://www.emedny.org/ProviderManuals/Pharmacy/PDFS/Pharmacy_Procedure_Codes.pdf.

The Family Health Plus benefit includes diabetic supplies, hearing aid batteries, and enteral nutritional formula.

COPAYMENTS

Copayments will remain the same as Medicaid pharmacy fee-for-service copayments, with one exception; there will be no co-payments for supplies for Medicaid managed care members. [Copayment exemptions](#) and copayment maximums will be the same as those in the Medicaid Pharmacy fee-for-service program. Pharmacies may not refuse to provide a drug solely because the managed care member cannot afford the co-payment. However, any legal means may be employed to collect unpaid co-payments.

¹ Mainstream managed care plans do not include the following partial capitated managed care programs Southern Tier Pediatrics PC, Southern Tier Priority HC or PCMP 11A, Gold Choice (UB Family Med).

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BUNDLE PHARMACY INTO MEDICAID MANAGED CARE

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CLOTTING FACTOR

Clotting factor products will be "carved-out" of the managed care pharmacy benefit and should be billed to Medicaid on a fee-for-service basis for both Medicaid managed care and Family Health Plus members. The state intends to bundle these products into the managed care plan in the near future.

This carve-out applies to clotting factors administered in *all non-inpatient settings*, including in the home. Clotting factors administered during an inpatient stay will continue to be covered by the managed care plan as part of the APR-DRG or per diem rate.

Pharmacies billing for these services should bill Medicaid using the alpha numeric Client Identification Number (CIN) on the health plan card.

FAMILY PLANNING BENEFIT

Medicaid managed care and Family Health Plus members enrolled in **Fidelis Care New York** will continue to obtain family planning and reproductive health services, **including family planning drugs**, from qualified Medicaid providers and pharmacies.

Pharmacies billing for these services should bill Medicaid using the alpha numeric Client Identification Number (CIN) on the Fidelis card.

TRANSITION POLICY

To ensure a smooth transition of pharmacy benefits for managed care members from the Medicaid fee-for-service program to the managed care plans, the Department and plans are utilizing implementation and transition plans designed to minimize the impact on members, providers and prescribers.

TRANSITION PERIOD

The Department has established a transition period of October 1, 2011, through December 31, 2011. This is to ensure assistance is available for members who are attempting to obtain medications through their Medicaid managed care and Family Health Plus plan for prescriptions that had been previously covered by the Medicaid pharmacy fee-for-service program.

- *During the transition period, plans are required to provide a one-time, temporary fill of each non-formulary drug for up to a 30-day supply of medication. This includes drugs that are on a plan's formulary but require prior authorization or step therapy under the plan's utilization management rules. Several plans have proposed a more generous transition fill policy. Policies of individual plans are available by contacting the plan.*

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TRANSITION PLANS

Managed care plans analyzed fee-for-service pharmacy claims data for their members to identify potential transition issues and submitted a transition plan to the Department of Health which contained detailed information on how they will ensure a smooth transition. Below are the areas that plans were required to address and in general, the actions being taken.

❑ Pharmacy Network Access

- *Where there were members using non-network pharmacies, all the plans are actively working to enroll pharmacies into their networks, including non-participating pharmacies currently servicing Medicaid fee-for-service members.*
- *All plans developed methods to ensure that members can access medications if they go to a non-participating pharmacy.*

❑ Prescriber Network Access

- *Plans will not be editing prescription claims based on the network status of the provider. Therefore, a claim will not deny if the prescriber is not in the plan's network.*

❑ Formulary Analysis

- All plans analyzed their formulary against their members' claims data and identified where their communication efforts to providers and members should be focused. The analysis focused on:
 - *Non-formulary drugs;*
 - *Drugs requiring prior authorization;*
 - *Drugs with coverage limitations such as frequency, quantity, and duration limits;*
 - *Drugs requiring step therapy.*
- All plans will provide a transition fill during the transition period.
- All plans developed targeted communications that included:
 - *letters to affected members and prescribers prior to October 1, 2011, and again during the transition period,*
 - *outreach calls to prescribers, and*
 - *face-to-face meetings with high volume prescribers.*

❑ Program Analysis

- All plans analyzed their members' claims data to assess the impact of transition related to several key areas. Below is a summary of how plans will be handling the transition in each of the key areas:

Limited Access and Specialty Pharmacy Drugs – plans will ensure continued access for these drugs in one of the following ways:

- Members can continue to use the same pharmacies, or
- Members will be transitioned to a network pharmacy, with processes put in place to ensure access until the transition to the network pharmacy has occurred. Such processes include:
 - Utilization of transition fill requirement during the first 90 days.
 - Member outreach to coordinate fills/refills.
 - Targeted provider and member communications that detail how to access medications with a network pharmacy.

The Clinical Drug Review Program (CDRP) and Mandatory Generic Program – plans will ensure continued access for these medications in one of the following ways

- Some plans are “grandfathering” by allowing members to remain on medications for which prior authorizations have already been issued by the Medicaid fee-for-service pharmacy program.
- Plans that are not grandfathering will use the following processes to ensure access to affected prescriptions:
 - Utilization of the transition fill requirement during the first 90 days. Targeted communications were sent to affected members and providers prior to 10/1/2011 and will be sent again during the transition period.

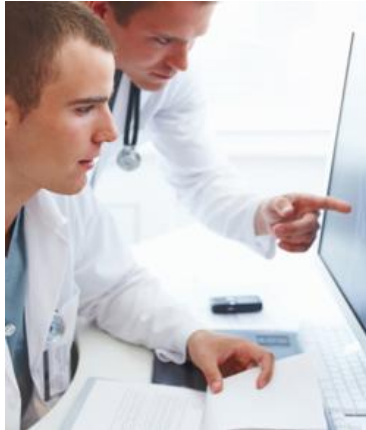
Drug Classes of Concern (Antipsychotics, Immunosuppressants, Antiretroviral therapy, Anticonvulsants and Antidepressants) – plans will ensure continued access as indicated below:

- Several plans are providing open access to these drugs for all members.
- A majority of plans are allowing members that are already on a medication in one of these categories to continue on that medication without a prior authorization requirement. Of these plans, some will continue this for 12 months, at which time they will re-evaluate.
- Some plans will enforce utilization management tools for these classes, but have developed a detailed plan to ensure continued access. The plan will be using the requirement for transition fills, while simultaneously outreaching to the prescriber and member in an attempt to switch to a formulary medication if it is medically appropriate.

Supplies

- Some plans are “grandfathering” and allowing members to continue to use the same provider and/or manufacturer.
- Plans that are not grandfathering will use the following processes to ensure access to covered supplies:
 - Utilization of the transition fill requirement during the first 90 days.
 - Targeted communications were sent to affected members prior to October 1, 2011, and will be distributed again during the transition period.

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COMMUNICATION PLAN

The New York State Department of Health (NYSDOH) along with health plans developed a communication strategy that allowed time for providers and members to take certain actions prior to October 1, 2011, that will minimize transition issues. Below is an overview of the communication timeline:

June 2011

- Bi-weekly stakeholder calls began and are ongoing.
- The calls are open to any interested stakeholder and are facilitated by Department staff.

July 2011

- Special Edition [Medicaid Update](#) published announcing “carve-in.”
- [Frequently Asked Questions](#) posted on the DOH MRT Website.

August 2011

- DOH sent letter of notification to affected members.
- Medicaid Update article published.
- Plans sent letters of notification to affected members.
- Plans sent targeted communication to providers.

September 2011

- Plans sent new health plan cards to members.
- Second Special Edition Medicaid Update published.

MEDICAID REDESIGN TEAM (MRT) PROPOSAL #11 BUNDLE PHARMACY INTO MEDICAID MANAGED CARE

INFORMATION FOR PRESCRIBERS

Determining a Member's Plan

- To identify impacted members, prescribers should ask their Medicaid patients to present their health plan card.
- If members do not have their health plan card, prescribers can confirm a member's enrollment information by:
 - swiping the Medicaid Identification card, and performing a VeriFone eligibility transaction, or
 - calling the MEVS Telephone eligibility line at (800) 997-1111, or
 - performing an eligibility request on ePACES.

See [Attachment 1 ELIGIBILITY INQUIRY TRANSACTIONS](#) of this guidance for specific directions on how to use the above systems

Accessing Plan/Formulary Information:

Plans will be responsible for developing their own formularies and prior authorization criteria. Prescribers can access plan and formulary information by using the DOH Web site, which provides links to the plans' Web sites:

Plans' Home Web Page:

- ▶ For HIV Special Needs Plans (MetroPlus Health Plan Partnership in Care, New York–Presbyterian System SelectHealth, LLC and Amida Care):

<http://www.health.ny.gov/diseases/aids/resources/snps/plans.htm>.

- ▶ For all other Plans:

http://nyhealth.gov/health_care/managed_care/reports/eqarr/2010/plan_profiles.htm.

Plans' Pharmacy/Formulary Information:

Managed Care Plan Pharmacy Benefit Manager and Formulary information is available at:

http://nyhealth.gov/health_care/medicaid/redesign/supplemental_info_mrt_proposals.htm.

The Medicaid fee-for-service "prescriber prevails" provision does not apply to the plans. Therefore, plans will have the ability to deny prior authorization for any drug that does not meet their criteria. However, plans are required to maintain an internal and external review process for such denials. Prescribers can access information on how to initiate the review process by calling the plan or visiting a plan's Web site. Plan phone numbers are located on the member's identification card or by referring to [Attachment 2 PLAN CONTACT AND BILLING INFORMATION](#) of this guidance document.

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BUNDLE PHARMACY INTO MEDICAID MANAGED CARE

INFORMATION FOR PHARMACIES

Pharmacies must be enrolled in a specific managed care plan's network in order to bill services to that plan. If a pharmacy is not enrolled as a network provider, the pharmacy must contact the plan or their PBM directly.

Pharmacy benefits should be billed to Medicaid fee-for-service for dates of service up to and including September 30, 2011, using the members' Medicaid fee-for-service identification number. Medicaid beneficiaries are subject to all Medicaid rules and requirements for pharmacy claims billed to Medicaid fee-for-service for dates of service up to and including September 30, 2011.

For dates of service on or after October 1, 2011, the pharmacy benefit will be the responsibility of the managed care plan and should be billed to the appropriate managed care plan. These claims will be subject to the managed care plan requirements and prior authorization processes.

Determining a Member's Plan

- To identify impacted members, pharmacists should ask their Medicaid patients to present their health plan card.
- If beneficiaries do not have their health plan card, pharmacists can confirm a beneficiary's enrollment information by:
 - *swiping the Medicaid Identification card, and performing a VeriFone eligibility transaction, or*
 - *calling the MEVS Telephone eligibility line at (800) 997-1111, or*
 - *performing an eligibility request on ePACES.*

See [Attachment 1 ELIGIBILITY INQUIRY TRANSACTIONS](#) of this guidance document for specific directions on how to use the above systems

Once you have verified the plan in which the member is enrolled, you can refer to the [Attachment 2 PLAN CONTACT AND BILLING INFORMATION](#) of this guidance document to access pertinent claims processing and plan contact information.

Frequently Asked Questions (FAQ)

General Q&A

Q1. How will members know if their prescriptions are covered by their managed care plan or Medicaid?

Medicaid and Family Health Plus members that are currently enrolled in a managed care plan will receive prescription drugs through their plans beginning on October 1, 2011. Members impacted by this change have been notified by letter.

Q2. Will there be a change to the drugs members take now?

While managed care plans will be required to provide coverage for those categories of drugs currently included in the Medicaid fee-for-service program, managed care plans will have their own list of covered drugs, so it is possible there may be changes to a member's current medications. Communications have been sent by Medicaid and the managed care plans that provide more information regarding covered drugs along with guidance on how to ensure continued access to medications through the managed care plan.

Q3. What pharmacy benefits will be bundled into the managed care plans?

The following items will be included in the pharmacy benefit:

For Medicaid managed care members: prescription and certain non prescription (OTC) drugs, medical supplies, hearing aid batteries, enteral nutritional formula.

For Family Health Plus members: prescription drugs, vitamins when necessary to treat an illness or condition, insulin and diabetic supplies (e.g. insulin syringes, blood glucose test strips, lancets, alcohol swabs), smoking cessation agents including OTCs, select over-the-counter medications included on the Medicaid Preferred Drug List, emergency contraception, hearing aid batteries and enteral nutritional formula.

Q4. Will members be able to stay with their current pharmacy?

Members that have been receiving medications from pharmacies that also participate with their managed care plan can continue to get their medications at their current pharmacy. Plans have actively worked to enroll non-participating pharmacies that have been serving Medicaid fee-for-service members so that members can continue to get their medications at the pharmacies they've been using. Additionally, all plans developed methods to ensure that members can access medications if they go to a non-

participating pharmacy 10/1/2011 or after. Such methods may include initiating a transfer to a participating pharmacy or allowing the non participating pharmacy to bill via a paper claim.

Q5. Will members have to change physicians?

As long as they are seeing physicians that currently participate with their managed care plan, members can continue to use the same physicians. Members should be advised to check with their plan to verify whether their doctor participates in their managed care plan.

Q6. Which managed care plans are in each county/region?

There is a choice of managed care plans in most counties; however a few counties have only one plan. More information is available on managed care plans by county on the DOH Website at:

http://health.ny.gov/health_care/managed_care/pdf/cnty_dir.pdf. Plans will be required to ensure access to pharmacy benefits in all areas of the State in which the plan operates.

Q7: How will manufacturer rebates be administered and collected once the pharmacy benefit is bundled into Managed Care?

New York State will continue to invoice and collect federal level rebates under the National Drug Rebate Agreement by accessing pharmacy claims data, which will be provided by the managed care plans. The plan will be responsible for managing any additional rebates, over and above federal level rebates. The value of these additional rebates has been incorporated into the plans' capitated rates.

Q8: Is the movement of the pharmacy benefit from Medicaid fee-for-service to the managed care plan considered "good cause" to switch managed care plans?

The pharmacy benefit changes are not considered good reason (good cause) to change plans and the member must remain in the current plan. Within the first 90 days of joining the health plan, members may leave and join another plan. However, once the 90 days are over, the member is "locked in" to that plan for the rest of the year (the next nine months). After the first 12 months of enrollment, a member may switch plans at anytime.

Frequently Asked Questions (FAQ)

Prescriber Q&A

Q1: What is the process for a prescriber to obtain authorization for drugs not included or preferred on a plan's formulary?

Plans will be responsible for developing their appeal/prior authorization processes and prescribers will need to contact and work with the managed care plan. Information regarding how to access the plans' Websites is include in "[Accessing Plan/Formulary information](#)" above.

Q2: How will prescribers know what plan is providing the pharmacy benefit?

The managed care plan for the medical and pharmacy benefit will now be the same. Prescribers should verify eligibility at each visit. All eligibility verification systems provide managed care plan information for enrolled individuals. Prescribers with questions about the benefit should contact the managed care plan.

Q3. Will managed care plans provide information to prescribers regarding these changes?

As part of the transition process, managed care plans have sent notifications to prescribers. These notifications outline changes in coverage, actions required to ensure member access after 10/1/2011, and information regarding appeals and medical exceptions.

Q4. Will this change the way physician administered (J-Code) drugs are currently billed?

No, the initiative to bundle the pharmacy benefit into managed care will not change the way that providers are currently billing for physician administered (J-Code) drugs. However, effective October 1, 2011, risperidone microspheres (Risperdal® Consta®), paliperidone palmitate (Invega® Sustenna®) and olanzapine (Zyprexa® Relprevv™) will be carved out of the Medicaid managed care benefit and should be billed to Medicaid on a fee-for-service basis *only when administered to SSI and SSI-related enrollees in mainstream Medicaid managed care plans*. Family Health Plus plans will continue to cover these drugs for their members.

Q5. Will prior authorizations obtained from the Medicaid DVS system, prior to October 1, 2011, be valid for enteral nutritional formula and other supplies?

Current authorizations with approved periods of service past September 30, 2011 for enteral nutritional formula and other supplies will not be valid for managed care members for dates of service on and after October 1, 2011. Providers will need to follow any authorization processes the plan requires.

Pharmacy Provider Q&A

Q1. Will every pharmacy be allowed to enroll in the managed care plans? How will this change affect my pharmacy practice?

Managed care plans will manage the enrollment and credentialing of their providers. If your pharmacy does participate with the managed care plans then effective October 1, 2011, pharmacy claims should be billed to a member's managed care plan. Members will be required to present their health plan benefit card to the pharmacy, rather than their Medicaid card.

Q2. Will the managed care plans be reissuing new health plan cards? If members are not issued new cards and/or they do not bring their new cards to the pharmacy; how will the pharmacy know where to bill the claim?

Plans will be reissuing health plan cards. However, it is expected that not all members will remember to bring their new cards to the pharmacy. Pharmacies can determine the plan in which the member is enrolled by:

- swiping the Medicaid Identification card, and performing a VeriFone eligibility transaction, or
- calling the MEVS Telephone eligibility line at (800) 997-1111.

See [Attachment 1 ELIGIBILITY INQUIRY TRANSACTIONS](#) of this guidance for specific directions on how to use the above systems. Plan specific information pharmacies need to submit claims such as the BIN number, Processor Control Number (PCN), Pharmacy Benefit Manager (PBM), and the plan's customer service phone number can be found in [Attachment 2 PLAN CONTACT AND BILLING INFORMATION](#) of this guidance.

Q3: How can a pharmacy identify a Medicaid member when a managed care card is presented?

A pharmacy can identify a Medicaid Member by the alpha numeric Client Identification Number (CIN). An example of the format of a CIN is AA12345A.

Q4. What is the Medicaid Fee-for-Service (FFS) rejection message that a pharmacy will get when a claim for a managed care member is denied due to the pharmacy benefits being bundled into the managed care plans?

The eMedNY POS will send the NCPDP reject code = 65 "Patient is Not Covered" and the claim denial message for:

Medicaid managed care claims submitted to Medicaid FFS:

01172 - Prepaid Cap Recip – Service Covered Within Plan (Deny)

Family Health Plus claims submitted to Medicaid FFS:

01497 - Family Health Plus Claim Not Covered

Q5. Will the Medicaid Fee-for-Service rejection message that a pharmacy will get when a claim for a managed care member is denied included the managed care plan information?

No. The provider would need to complete an eligibility inquiry transaction as detailed in Attachment 1 ELIGIBILITY INQUIRY TRANSACTIONS.

Q6. Will the pharmacy benefit be uniform for all managed care plans?

Managed care plans have been provided with guidance regarding coverage, plan formularies, and exception processes. Plans will establish their own formularies and prior authorization processes. However, formularies must include all categories of drugs included on the NYS Medicaid formulary. Plans will also be required to maintain an internal and external review process for exceptions.

Q7. Will pharmacy reimbursement rates be set by Medicaid or by the managed care plans?

Reimbursement rates will be set by the managed care plans and/or their Pharmacy Benefit Manager (PBM).

Q8: What role will the plans have in auditing pharmacies? What will OMIG's role be in auditing pharmacies?

Plans will be responsible for managing and auditing their pharmacy networks. If there is a suspicion of fraud or abuse, plans are required to report such cases to the DOH and OMIG. OMIG will review and work with the plan and/or provider to determine if further action is needed. OMIG has a statutory responsibility under NYS Public Health law to examine documents or records of any kind related to the Medicaid program or necessary for the OMIG to perform its duties and responsibilities. As a result, OMIG may also conduct audit and investigation activities relating to program integrity of the provision of pharmacy services as needed.

Q9: Will the OMIG card swipe requirement apply to managed care members?

No. The card swipe requirement will not apply to managed care members. The plans will set policy and/or guidance regarding identity verification and/or signature requirements.

Q10: What is OMIG's strategy for expanding the card swipe program?

While there will be no expansion of the program to pharmacies beyond the twenty (20) that were recently added, it will continue during the course of the transition of members into managed care. Once the transition is complete, the program and the remaining fee-for-service population will be re-evaluated.

Pharmacy Provider Q&A (continued)

Q11: Will this change how the prescription benefit is handled for managed care recipients that are admitted to a long term care facility?

The bundling of pharmacy into the managed care plans will not change the way that plans currently reimburse for prescriptions for members admitted to nursing homes.

Q12. How will the plans reimburse for enteral nutritional formula and supplies?

There is no fee schedule in place that will apply to all managed care plans. Plans will establish their own reimbursement methods and provider networks for covering supplies. Providers will need to submit claims to the managed care plans.

Q13: Can providers use 340B drugs when the pharmacy program is bundled into Managed Care?

When pharmacy benefits are bundled into Managed Care, plans will be able to accept and process 340B claims from participating pharmacies. However, pharmacies will need to be able to identify that they are billing for a 340B drug by using the NCPDP version 5.1, field 423-DN, basis of cost determination. By entering a value of 09 in this field, a pharmacy can designate when they are billing for a 340B drug. Since 340B claims are not subject to federal rebate requirements, this will allow the State to identify 340B claims within the prescription claims encounter data that the plans will submit to the State, and will ensure that manufacturers are not billed for rebates.

340B pharmacy providers that are unable to comply with this guidance will not be able to submit 340B claims to plans until an agreement has been reached between the provider, New York State and the plans; which would include a process to ensure that manufacturers are not billed for rebates for 340B claims.

ATTACHMENT 1

ELIGIBILITY INQUIRY TRANSACTIONS

The Eligibility Inquiry transaction provides the following: **Eligibility Status, Benefit Coverage, Other Potential Payers, Medicaid Managed Care information, Family Health Plus information, Member Provider Restrictions/Exceptions**, and/or if a member is at limits for any of the service categories covered by the Utilization Threshold Program.

VERIFONE ELIGIBILITY INQUIRY TRANSACTION

Follow these simple steps:

1. Press the CANCEL/CLEAR key
2. Press the F4 key
3. Enter Card or ID (swipe the card or key in the access number), then press enter
4. Enter the Transaction Type = 2 (eligibility inquiry), then press enter
5. Enter the date, then press enter (Press # for today's date or enter MMDDCCYY for verification on a previous date of service. Press #.)
6. Select Provider, then press enter
7. Enter the Ordering Provider 10 digit NPI then press enter
8. The VeriFone will now contact eMedNY

MEVS TELEPHONE ELIGIBILITY INQUIRY TRANSACTION

Helpful Hint: Be sure to convert all alpha characters to numeric prior to dialing.

1. Call (800) 997-1111
2. Enter the Medicaid beneficiary identification type
 - a. If entering the alpha numeric CIN , press 1, then press #
 - b. If entering the access number, press 2, then press #
3. Enter the identification number, then press #
4. Enter the Transaction Type = 2 (eligibility inquiry) then press #
5. Enter the date, then press # (Press # for today's date or enter MMDDCCYY for verification on a previous date of service. Press #)
6. Enter the Servicing Provider 10 digit NPI then press #
7. Enter the Ordering Provider 10 digit NPI then press #
8. The VeriFone will now contact eMedNY

ePACES CLIENT ELIGIBILITY REQUEST

Helpful Hint: The more data entered the more likely the system is to find an exact match on the first attempt.

1. Enter Client identification number (CIN)
2. If CIN is not available, enter the following:
 - a. Last Name/ First Name
 - b. Date of Birth (MM/DD/YYYY)
 - c. Gender
 - d. SSN (9 digits)
3. Enter the Date of Service (MM/DD/YYYY)
4. Enter the Ordering Provider 10 digit NPI
5. Click Submit

RESPONSE SECTION

The response returned will provide detailed member information, and **for Medicaid Managed Care or Family Health Plus members** the following plan information will be provided:

- Plan Name
- Plan Address
- Plan Phone Number
- Plan Code

Other Potential Payer Information

- Other Payer Name
- Plan Policy Number (when available)
- Group Number (when available)
- Carrier Code (Medicaid assigned carrier code)
- Other Payer Address (when available)
- Carrier Code
- Phone Number

Detailed information for Verifone/ MEVS can be found in the **MEVS/DVS Provider Manual Version 4.0** at:
<https://www.emedny.org/ProviderManuals/AllProviders/supplemental.aspx>

Helpful: Choosing which MEVS method is right for you.

Detailed information for ePACES can be found in the **ePACES Help Manual** at:
https://www.emedny.org/selfhelp/ePACES/ePACES_Help.pdf

ATTACHMENT 2

PLAN CONTACT AND BILLING INFORMATION

Managed Care Plan	Managed Care Plan Contact Information	Pharmacy Benefit Manager (PBM) or Billing Agent	PBM/Billing Agent Contact Information	Processor Control Number (PCN)	Bin Number	Additional Information Required for Pharmacy Claim Processing
<i>For eligibility information, plan policy and coverage questions</i>		<i>For billing issues, claim processing questions and assistance with claim edits</i>				
Affinity Health Plan	(866) 247-5678	CVS Caremark	(800) 364-6331	ADV	004336	Group: RX4212
Amerigroup	(800) 454-3730	CVS Caremark	(800) 364-6331	ADV	004336	Group: RX4293
Amida Care	(646) 786-1800	Express Scripts	Prescribers: For Prior Authorization call (800) 417-8164 Pharmacists call (800) 824-0898	A4	003858	Group: KJFA
CDPHP	(800) 345-5413 (800) 388-2994	CVS Caremark	(866) 693-4611	ADV	004336	Group: RXCDPHP
Excellus Health Plan, Inc./ Premier Health Plan	(800) 724-5033	MedImpact Healthcare Systems, Inc.	(800) 788-2949	74000	003585	MedImpact will provide plan profile sheet to all their network pharmacies
Fidelis Care	(888) 343-3547	CVS Caremark	(800) 364-6331	ADV	004336	Various Groups: (Refer to ID card) RX6460, RX6461, RX6462, RX6465, RX6466
Healthfirst	(866) 463-6743	Express Scripts	(800) 824-0898	A4	003858	Group: HEFA
HealthNow Inc.	(877) 327-1395	Medco Health Solutions	(866) 544-7948	N/A	610014	Group: HNRXS
HealthPlus	(800) 300-8181	MedImpact Healthcare Systems, Inc.	(800) 788-2949	58080 (HNY03-Health Plus NYS Medicaid)	003585	Medicaid Group: HCP9198, Family Health Plus Group: FHP9198
HIP Health Plan of New York (HIP)	(800) 447-8255	EmblemHealth Pharmacy Benefit Services (EmblemPBS)/ HIP Health Plan of NY	Member: (888) 447-7364 Pharmacist: (800) 824-0898	20111001	015748	
Hudson Health Plan	(800) 339-4557	MaxorPlus	(800) 687-0707	1000019	005377	Medicaid Group: MDC Family Health Plus Group: FHP
Independent Health	(800) 993-9898	Independent Health	Prescribers: For Prior Authorization call (800) 247-1466 ext. 5311 Pharmacists call (800) 993-9898	Not Required	004626	
MetroPlus Health Plan	(800) 303-9626	CVS Caremark	(800) 364-6331	ADV	004336	Group: RXMPHP
MVP Option	(800) 684-9286	Medco Health Solutions	(800) 922-1557	Not Required	610014	Group: MVPCOMM
MVP Option Family	(800) 684-9286	Medco Health Solutions	(800) 922-1557	Not Required	610014	Group: MVPCOMM
Neighborhood Health Providers	(877) 782-8655 or (800) 826-6240	Express Scripts	(800) 824-0898	A4	003858	Group: KJBA
New York Presbyterian System SelectHealth	(866) 469-7774	CVS Caremark	(800) 364-6331	ADV	004336	Group: RX8579
Total Care	(315) 634-5555	Bioscrip	(855) 772-7085	CLAIMNE	900020	
UnitedHealthcare	(800) 493-4647	Prescription Solutions	(877) 305-8952	9999	610494	Group: ACUNY
Univera Community Health, Inc.	(800) 724-5033	MedImpact	(800) 788-2949	74000	003585	MedImpact will provide plan profile sheet to all their network pharmacies
WellCare Health Plans, Inc.	(800) 288-5441	CatalystRx	(800) 288-5441 (after hours and weekends)	01410000	603286	Group: 856257