



Medicaid Update

The Official Newsletter of the New York State Medicaid Program

July 2017
Volume 33 | Number 7

NYS Medicaid Coverage of Pasteurized Donor Human Milk

Effective July 1, 2017, in accordance with the 2017-18 enacted state budget, pasteurized donor human milk (PDHM) for inpatient use is a covered benefit under the Medicaid program.

In accordance with an amendment to subdivision 2 of section 365-a of the Social Services Law, inpatient use of pasteurized donor human milk (PDHM), with fortifiers as medically indicated, requires a written medical order from a licensed medical practitioner. Medically necessary PDHM is covered for infants who:

- Have a documented birth weight of less than 1500 grams; or
- Have a congenital or acquired condition that places the infant at a high risk of developing necrotizing enterocolitis (NEC) and/or infection; or
- Have other qualifying condition(s) as determined by the Commissioner of Health or his/her designee.

PDHM is covered when infants meet the above criteria and there is a written medical order. Coverage of PDHM is for infants who are medically or physically unable to receive maternal breast milk or participate in breast feeding, or in cases where the mother is medically or physically unable to produce maternal breast milk at all or in sufficient quantities, or is unable to participate in breast feeding despite optimal lactation support.

Medicaid managed care (MMC) plans are required to cover inpatient use of PDHM when medically necessary.

Questions regarding MMC reimbursement and/or documentation requirements should be directed to the enrollee's MMC plan.

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The Medicaid Update is a monthly publication of the New York State Department of Health.

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Pharmacy Update

Medicaid Pharmacy Prior Authorization Programs Update

Per the 2017-18 enacted State budget, effective July 20, 2017, New York State Medicaid will implement clinical criteria to diabetic test strips subject to the Preferred Diabetic Supply Program (PDSP).

The goal of this initiative is to expand point-of-sale clinical editing across medical/supply claim types to ensure appropriate utilization. This will be achieved by using frequency, quantity, and duration limits, diagnosis and duplicate therapy editing.

The Medicaid FFS pharmacy program will implement the following parameters to diabetic test strips:

- **Diabetes Type I:** Maximum of 300 test strips dispensed as a 30-day supply
- **Diabetes Type II:** Maximum of 100 test strips dispensed as a 30-day supply

Note: Claims which meet the above clinical criteria will approve systematically and will not require prescriber involvement.

The most up-to-date information on the Medicaid Fee-For-Service (FFS) Pharmacy Prior Authorization (PA) Programs and a full listing of drugs/supplies subject to the Medicaid FFS Pharmacy Programs can be found at: 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, 7 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 "PAXpress" button located on eMedNY.org under the MEIPASS button.

Additional information, such as the Medicaid Standardized PA form and clinical criteria, are available at the following websites: <http://www.health.ny.gov> or <http://newyork.fhsc.com> or <http://www.eMedNY.org>. For more detailed information on the PDSP please refer to: <https://newyork.fhsc.com/providers/diabeticsupplies.asp>.

Changes to Medicaid Fee-For-Service Pharmacy Reimbursement per CMS Final Rule on Covered Outpatient Drugs and the Enacted 17/18 Budget

Per the enacted budget, changes will be made to Fee-For-Service (FFS) pharmacy reimbursement for ingredient cost and professional dispensing fees effective April 1, 2017, pending Centers for Medicare and Medicaid Services (CMS) state plan approval. These reimbursement changes will only apply to FFS. Medicaid Managed Care Plans and/or their contracted pharmacy benefit managers will continue to set their reimbursement rates. This topic was previously mentioned in the [March 2016 Medicaid Update](#).

The Department is currently in the process of applying system logic to accommodate these changes. The implementation date of these changes will be communicated once CMS approval is obtained, and the system project has been completed.

- Once the changes have been implemented, a determination will be made on how to process the retroactive adjustments back to April 1, 2017. Retro adjustments will be spread out over a period of time, will show on remittance (at claim level detail) and will be communicated to providers.

The new pricing methodology will be determined as follows:

Drug Type	If NADAC is available, reimburse at:	If NADAC is unavailable, reimburse at:	Professional Dispensing Fee (applies if not paid at U&C)
Generics	Lower of NADAC, FUL, SMAC or U&C	Lower of WAC – 17.5%, FUL, SMAC, or U&C	\$10.00
Brands	Lower of NADAC or U&C	Lower of WAC – 3.3%, or U&C	\$10.00
OTCs (<i>Covered Outpatient Drugs</i>)	Lower of NADAC, FUL, SMAC or U&C	Lower of WAC, FUL, SMAC, or U&C	\$10.00

Note: Claims will pay at the pharmacy's Usual and Customary Pricing if lower than drug ingredient cost plus dispensing fee. OTCs that do not meet the definition of a covered outpatient drug will continue to pay at current methodology.

National Average Drug Acquisition Cost (NADAC) is determined by a federal survey and is an average of the drug acquisition costs submitted by retail community pharmacies.

- The NADAC Help Desk will investigate provider inquiries and will evaluate them based upon invoice data collected from the pharmacy initiating the review, additional pharmacies contacted by the help desk, and other market factors, such as compendia price changes. For more information, please visit: <https://www.medicaid.gov/medicaid/prescription-drugs/retail-price-survey/index.html>.

Covered Outpatient drugs are defined in Section 1927(k)(2)(3) of the Social Security Act.

- The following links provide information on the Covered Outpatient Drug Policy & FAQ per CMS: <https://www.medicaid.gov/medicaid/prescription-drugs/covered-outpatient-drug-policy/index.html> <https://www.medicaid.gov/federal-policy-guidance/downloads/faq070616.pdf>.

Update on Medicaid Fee-for-Service (FFS) Pharmacy Billing Instructions for Coordination of Benefits (COB) Submission

Effective July 27, 2017, the Department will implement system enhancements to improve the submission of Medicaid FFS pharmacy claims when the patient has other third-party coverage. These changes are being made to ensure that all values in specified fields are recognized and function appropriately, other patient responsibility amounts are accepted and other third party insurance billing is validated when the claim is not covered. This is an update to previous guidance on this topic issued in the [May 2014 Medicaid Update](#).

Coordinating benefits ensures the correct party pays first. Medicaid is always the payor of last resort; federal regulations require that all other available resources be used before Medicaid considers payment. If there is a responsible third-party that should be paying for the patients' health benefits, such as a health insurance provider, the responsible third-party should pay first.

Medicaid pays the lesser of Patient Responsibility (PR) or the Medicaid fee, regardless of the Patient Responsibility Amount. For pharmacy, this rule applies to all PR, which includes deductible, co-insurance, copay and other patient responsibility.

The following list of values reported in field 308-C8 (Other Coverage Code) are considered acceptable. This field is used by the pharmacy to indicate whether the patient has other insurance coverage or is enrolled in a Medicare Managed Care Organization (MCO). Valid entries for field 308-C8 are:

- 0 = Not Specified
- 1 = No Other Coverage Identified
- 2 = Other Coverage Exists, Payment Collected
- 3 = Other Coverage Exists, This Claim Not Covered
- 4 = Other Coverage Exists, Payment Not Collected

The following updates will be made to the specified values submitted in field 308-C8 when the Other Coverage Code of "4" is submitted:

- Submission of Other Coverage Code "4" (Other Coverage Exists, Payment Not Collected). If the value code of "4" is submitted in field 308-C8 for situations where the prior payer did not make a payment, however PR- (Patient Responsibility Amount) is due, the system **will enforce that a COB segment is submitted** and that the amount reported in field 431-DV "Other Payer Amount Paid" is **not greater than zero**.

The following list of values has been updated and is recognized when reported via NCPDP D.0 in the COB segment, field 351-NP (Other Payer Patient Responsibility Amount Qualifier) when the Other Coverage Code of "4" is submitted. These values are considered as acceptable for payment when qualifying PR amounts are reported in field 352-NQ (Other Payer Patient Responsibility Amount) for claims involving third-party liability (TPL) other insurance. All payments paid by any/all third parties, including Medicare, should be included on the claim.

Qualifier values Accepted- Field 351-NP:

- Blank = Not Specified
- 01= Deductible
- 04= Amount reported from previous payer as Exceeding Periodic Benefit Maximum
- 05= Copay Amount
- 06= Patient Pay Amount
- 07= Coinsurance Amount
- 09= Health Plan Assistance Amount
- 12= Coverage Gap Amount

The following list of values reported in field 351-NP (Other Payer Patient Responsibility Amount Qualifier) will **not** be considered acceptable for payment when the Other Coverage Code of "4" is submitted. If any of the

following values are submitted, the claim will fail a Pre-adjudication edit NCPDP Reject code 536 (Other Payer - Patient Responsibility Amount Qualifier Value Not Supported).

Qualifier values Not Accepted - Field 351-NP:

- 02= Product/Selection/Brand Drug Amount
- 03= Sales Tax Amount
- 08= Product Selection/Non-Preferred Formulary Selection Amount
- 10= Provider Network Selection Amount
- 11= Product/Selection/Brand Non-Preferred Formulary Selection Amount
- 13= Processor Fee Amount

The Provider must work with the primary insurance to obtain coverage for the member. This could involve prior authorization requirements or changes to medications ordered to align with the primary plans formulary products, etc.

Contact the eMedNY Call Center at (800) 343-9000 for questions regarding COB billing or any billing issue.

Policy & Billing Guidance

Guidance on Implementation of Face-to-Face Encounter Requirements For Medicaid Coverage of Home Care Services & Medical Equipment Under Federal Rule 42 CFR Section 440.70 Home Health Services

Section 6407 of the Affordable Care Act requires a face-to-face (F2F) encounter with Medicaid members for the initial authorization for home health services provided by a Certified Home Health Agency (CHHA) and certain durable medical equipment (DME) ordered in conjunction with these services. Compliance with F2F encounter requirements is mandated by July 1, 2017.

The purpose of this document is to describe for physicians, authorized non-physician practitioners (NPPs), home health agencies and durable medical equipment providers the terms of the F2F rule as applied to Medicaid, and to provide guidance for compliance.

The F2F encounter rules for Medicaid home health cases only **apply to Medicaid fee-for-service (FFS) coverage** serviced by CHHAs. The CHHA must maintain a copy of the F2F documentation in the clinical record.

F2F rules **are not applied** to managed care cases, or to cases that are personal care service-only. The managed care exclusion encompasses cases served under Mainstream Medicaid managed care plans and Managed Long Term Care plans.

42 CFR § 440.70 Face-to-Face Home Health Services Requirements:

F2F encounters for Medicaid home health cases require:

- Physicians to document a F2F encounter related to the primary reason the Medicaid member requires home health services;
- A F2F encounter for the **initial ordering** of home health services **only**; the F2F encounter is **not** required for recertification, and;
- The F2F encounter occurs within the **90 days before** or the **30 days after** the CHHA start of services.

A F2F performed for a dually eligible Medicare-Medicaid member is performed once and solely for the initial ordering of services. If the member is discharged and care is subsequently restarted, the F2F encounter must be completed at the start of the new episode of care. If a Medicaid or dually eligible Medicare-Medicaid member is receiving home health services under managed care and transitions to FFS home care services, the F2F exemption under managed care would continue for as long as the member continues receiving home care services under FFS (unless there is a discharge and restart of care under FFS).

Who can provide the F2F Encounter:

F2F encounters for Medicaid home health services may be performed by either a physician or certain non-physician practitioners (NPPs). Practitioners include:

- A nurse practitioner as authorized by New York State law;
- A licensed midwife as authorized by New York State law;
- A physician assistant, under the supervision of a physician or;
- The attending acute or post-acute physician, for members admitted to home health immediately after an acute or post-acute stay.

The F2F provider must be enrolled in the NYS Medicaid Program. Physicians and NPPs can complete the necessary F2F documentation, but the ordering physician must sign off as the practitioner responsible for ordering home health services. The ordering physician remains the sole authorized practitioner for home health services covered by Medicaid. The ordering physician (who establishes the written plan of care) must document that the F2F encounter requirements were met even if he or she did not perform the encounter directly.

If an attending acute or post-acute care physician or NPP conducts the F2F encounter, the attending or NPP is required to communicate the clinical findings of the encounter to the member's ordering physician so that the ordering physician may document the F2F encounter in the plan of care or any applicable attestation. This is intended to ensure that the ordering physician has sufficient information to determine the need for home health services in the absence of personally conducting the F2F encounter.

Certification of patient eligibility for Medicaid home health services:

Medicaid requires that the member be certified as medically needing home health care services. Medicaid requires a basic determination of medical necessity for home health services and allows medically necessary home care services to be provided in any setting where normal life activities take place.

42 CFR § 440.70 Medicaid Face-to-Face Requirements for Durable Medical Equipment (DME)

A F2F encounter is required for the ordering and dispensing of DME under home care services and must be related to the primary reason the individual requires the medical equipment. The encounter may be performed by the member's ordering physician or by one of the NPPs listed above, except a licensed midwife. The encounter must occur no more than **6 months prior** to the dispensing of medically necessary equipment.

The Medicaid F2F requirement for DME applies to items that would be subject to the Medicare F2F requirement for DME and are covered items on the New York State DME Fee schedule found at www.emedny.org

Payment for F2F Encounter Services and Durable Medical Equipment

The F2F encounter is reimbursed when provided by licensed practitioners enrolled in the Medicaid Program. Reimbursement should be submitted by the practitioner performing the F2F encounter using the current evaluation and management codes found in the Physician Provider Manual.

DME providers should verify that a F2F encounter with the Medicaid member was performed and documented prior to dispensing equipment being ordered through home health services and maintain this information as part of their records to support payment.

A CMS Fact Sheet regarding these rules is available here: <https://www.medicaid.gov/medicaid/benefits/downloads/health-home-factsheet.pdf>. If you have Medicaid program questions, please contact the Office of Health Insurance Programs, Division of Program Development and Management at 518-473-2160. If you have Medicaid billing questions, please contact eMedNY Provider Services at (800)-343-9000. General questions can be directed to the Office of Primary Care and Health Systems Management, Division of Home and Community Based Services at 518-408-1638 or homecare@health.ny.gov.

All Providers

Reminder-Breastfeeding Grand Rounds 2017: The Impact of Social and Cultural Values on Breastfeeding Practices and Strategies to Address Disparities

Breastfeeding grand rounds (BFGR) 2017 will air on August 3, 2017 from 8:30 AM – 10:30 AM. This BFGR will demonstrate how United States (U.S.) social values influence breastfeeding practices among mothers from different racial-ethnic and socioeconomic groups. Presenters will describe strategies that have worked to change cultural norms and societal values in ways that positively affect breastfeeding rates among different U.S. groups. This webcast is intended for healthcare professionals and paraprofessionals and will offer CME, CNE, CHES, LCERP or general continuing education credits. For more information and to register, please visit: <http://www.albany.edu/sph/cphce/bfgr.shtml>.

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, **over \$802 million** in incentive funds have been distributed **through 25,356** payments to New York State Medicaid providers.

25,356
Payments

\$802+
Million Paid

Are you **eligible?**

For more information, visit: www.health.ny.gov/ehr

Last Chance to Participate

The deadline to report 2016 Meaningful Use (MU) for the New York State Medicaid EHR Program is **September 15, 2017**. Incentive payments to EPs are disbursed over the course of six participation years. EPs may receive up to \$21,250 for the first participation year and \$8,500 for each remaining participation year. Though incentive payments continue until 2021, the 2016 payment year is the last opportunity for new EPs to begin participation.

2016 MU Deadline: September 15, 2017
Last Chance to Join the MU Program
Total Incentives: \$63,750

To participate in the EHR Incentive Program, you must have a [certified](#) EHR system, be enrolled as a fee-for-service (FFS) New York Medicaid provider, and be registered with CMS.

Incentive payments continue until 2021, but new EPs must be registered and able to report 2016 EHR measures by September 15, 2017.



Prerequisites

<input type="checkbox"/> Using Minimum 2014 Certified Electronic Health Record Technology (CEHRT)	http://healthit.gov/chpl
<input type="checkbox"/> 30% Patient Volume from Medicaid Recipients (20% for Pediatricians)	Medicaid Patient Volume Overview
<input type="checkbox"/> Tracking Meaningful Use Activity – and prepared to report 2016 clinical quality data	EHR Incentive Program Objectives and Measures



Next Steps

<input type="checkbox"/> Register as a Medicaid FFS Provider – this can take up to 90 days to complete	https://www.emedny.org/info/ProviderEnrollment/index.aspx
<input type="checkbox"/> Apply for an ePACES registration with MEIPASS Privileges	https://www.emedny.org/info/ProviderEnrollment/enrollguide.aspx
<input type="checkbox"/> Final day to register for the EHR Incentive Program is 9/14/2017	https://ehrincentives.cms.gov/hitech/login.action

Tutorials

The NY Medicaid EHR Incentive Program website (http://www.health.ny.gov/health_care/medicaid/redesign/ehr/) has recorded video tutorials available for on-demand assistance. The interactive tutorials are instructor-led with step-by-step guidance to assist with completing your MU attestation. Tutorials are being added frequently. To access these videos, visit the Tutorials page here: http://www.health.ny.gov/health_care/medicaid/redesign/ehr/tutorials.htm.

Webinars

The NY Medicaid EHR Incentive Program has several instructor-led webinars available on a variety of topics to assist in the MU attestation process. Webinars are offered at different times, including 7 a.m., to accommodate many schedules. To register for a session, visit the Webinar Calendar page at: http://www.health.ny.gov/health_care/medicaid/redesign/ehr/calendar/.



Contact us at 877-646-5410 option 2 or hit@health.ny.gov

Questions? We have a dedicated support team that will guide you through the registration and attestation process.

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 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.

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.