Mississippi Medicaid Bulletin

Volume 11, Issue 12

December 2005

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Major Medicaid Program Changes Beginning January 1, 2006

The new calendar year will bring along with it some major program changes for the Mississippi Medicaid program—implementation of the Medicare Part D Prescription Drug Program and elimination of the Poverty Level Aged or Disabled (PLAD) category of Medicaid eligibility. Although anticipated for some time, these changes are extreme for both Medicaid beneficiaries and providers.

The Division of Medicaid is committed to assisting all groups in understanding these changes. Therefore, the majority of this issue is devoted to providing information that outlines the details of the program changes. Providers are urged to read this bulletin carefully. If you have questions regarding any of this information, please contact the references indicated within this bulletin.

Medicare Prescription Drug Benefit (Part D) and Medicaid

- Medicare prescription drug coverage is available to everyone with Medicare regardless of their income, how they get their health care or how they currently get their drug coverage.
- Medicare beneficiaries who are currently enrolled in Medicaid (dual eligibles) will be automatically enrolled in and receive drug coverage through Medicare Part D, effective January 1, 2006. Medicaid will cease to provide drug coverage to dual eligibles after December 31, 2005.
- Individuals who are enrolled in Medicaid (dual eligibles) will be automatically enrolled into a Part D plan and no action is required on their part, though they do have the ability to opt out of the assigned plan and select another. Individuals with Medicare and Medicaid (dual eligibles) can change plans at any time with coverage effective the first of the following month
- The Division of Medicaid mailed letters to all dual eligibles (including the PLADs) providing information to help people who have been auto-enrolled choose a plan that better fits their medication needs. The letter provided an easy to understand comparison of current medication therapy vs. other plans, information on which pharmacies are matches, and enrollment phone numbers in one place. This is to streamline the process for enrollment should the individual choose to select a plan other than the randomized auto-enrollment plan.

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(Major Medicaid Changes continued)

- Medicare beneficiaries who receive full Medicaid coverage (dual eligibles) will have no monthly premium or deductibles, but will have nominal copayments with Medicare Part D. In addition, there is no limit on the number of drugs that Medicare will pay for each month.
- Institutionalized individuals in a nursing facility or intermediate care facility for the mentally retarded who receive Medicare and full Medicaid coverage will have no out-of-pocket expenses with Medicare Part D.
- All prescription drug plans meet certain standards to ensure that the Medicare beneficiaries receive the drugs they need. This includes coverage of essentially all drugs in six categories of treatments (drugs for mental illnesses including antidepressants, antipsychotics, and anticonvulsants; drugs for HIV/AIDS; drugs for cancer; and drugs affecting the immune system).
- Plans are required to provide drugs in each therapeutic class or category. This includes prescription drugs, biological products, and insulin. Medical supplies associated with the injection of insulin, such as syringes, needles, alcohol swabs, and gauze, are covered.
- Medicaid will continue to pay for a limited or a very few specific drugs that Medicare will not cover for dual eligibles. Medicaid will cover the following drugs with limitations:
    - Benzodiazepines (These drugs are sleeping agents and commonly used for anxiety.)
    - Barbiturates (These drugs are used as tranquilizers and sedatives.)
    - Certain over-the-counter (OTC) drugs as covered by the Division of Medicaid except OTC insulin products which are covered in the Medicare Part D plans.

Overview of Medicare Part D (Prescription Drug) Benefits

Income Levels	Monthly Premium	Annual Deductible	Copayments
Full-benefit dual eligible (Medicare & Medicaid) Income up to 100% FPL ($9,570/individual; $12,830/couple in 2005)	$0	$0	$1/generic $3/brand-name;
Full-benefit dual eligible (Medicare & Medicaid) Income greater than 100% FPL	$0	$0	$2/generic $5/brand-name;
Income less than 135% FPL (no Medicaid) ($12,920/individual; $17,321/couple in 2005) And assets <$6,000/individual; $9,000 couple	$0	$0	$2/generic $5/brand-name;
Income 135% - 150% FPL ($12,920 -14,355/individual; $17,321-19,245/couple in 2005) And assets <$6,000/individual; $9,000 couple	Sliding scale	$50	15% of total drugs costs up to $5,100; $2/generic $5/brand-name thereafter
All Others	Varies	$250	25% of total drugs costs up to $2,250; then 100% up to $5,100 in drugs costs; greater of $2/generic $5/brand-name or 5% coinsurance thereafter

Medicare Part D Formulary Coverage

- The Centers for Medicare & Medicaid Services (CMS) will review the formularies to ensure that plans are not using them to discourage enrollment of certain groups of people. Formularies must include at least two drugs from each category and class (if two drugs exist). Individual formulary classification structures will be compared to the United States Pharmacopeia (USP) model and other commonly used classification systems to ensure that a formulary includes drugs from a sufficient breadth of categories and classes. CMS will review all formularies for inclusion of at least one drug from the USP "Formulary Key Drug Types" and inclusion of drugs identified in widely accepted treatment guidelines.

(Continued on page 3)

(Medicare Part D continued from page 2)

- Because private companies are setting up the insurance plans for Medicare, each plan will have slightly different characteristics. Not all "covered drugs" will be covered by a Medicare prescription drug plan. Each plan may develop a formulary or a list of preferred medications covered. Some plans may use only certain or network pharmacies while other plans may cover only certain drugs. The cost also may vary slightly by plan. The specific plans, including their formularies, are available at the CMS website www.cms.hhs.gov/pdps. Formulary information will be updated monthly on the CMS website.
- A plan is required to give a 60-day notice to affected enrollees if it removes a Medicare-covered prescription drug from its formulary or makes changes to its tiered cost-sharing structure during a plan year. If the notice requirement is not met, a plan must provide affected enrollees with a 60-day supply of the medication in dispute and a notice of the change when the enrollee requests a refill.
- Pharmacy Access: Plans must provide convenient access no matter where enrollees live.
- Medication Therapy Management: Plans must have medication therapy management programs to help those who have multiple, chronic conditions, use multiple drugs and expect to have high drug costs make sure they are taking safe combinations of drugs.
- Generic Drug Information: Plans and pharmacists are required to inform enrollees if they can save money by using a generic drug.
- Individuals can compare drug plan options (in the "Medicare & You 2006" handbook on www.medicare.gov or by calling 1-800-MEDICARE, 1-800-633-4227) to find a plan that meets their needs. However, if they do not choose a plan, they will be automatically enrolled in one on January 1, 2006 to make sure they have continuous coverage

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Medicare Part D Drug Coverage Exclusions

- The drugs excluded from Medicare prescription drug coverage are the same drugs that were excluded under the Medicare-approved drug discount card or known as Medicaid standard exemptions. These drugs are excluded by federal statute. However, Part D plans may choose to cover them at their own cost or share the cost with enrollees. The drugs include:
    - drugs for weight gain/loss or anorexia;
    - drugs for fertility;
    - drugs for cosmetic purposes;
    - drugs for cough and cold;
    - prescription vitamins other than prenatal vitamins and fluoride treatments;
    - over the counter drugs;
    - barbiturates;
    - benzodiazepines.
- Drugs covered under Medicare Part A or Part B are not covered under this part of Medicare (even though a deductible may apply). If a drug is covered under Part A or Part B, it can be covered under the Medicare drug coverage if the individual does not meet the coverage requirements for the drug under Medicare Part A or Part B. Examples may include immunosuppressive drugs after an organ transplant, some oral anti-cancer drugs, hemophilia clotting factors, drugs that are not self-administered, etc.

Limited Medicaid Drug Coverage

Medicaid will continue to pay for limited or a very few specific drugs that Medicare will not cover. As of January 1, 2006, Medicaid will cover the following drugs with limitations:

- Benzodiazepines: Coverage will be limited to generic formulations of these agents for Medicaid beneficiaries;
- Barbiturates: Coverage of single entity barbiturates will be limited to phenobarbital and mephobarbital (Mebaral) for all Medicaid beneficiaries. Butabarbital, amobarbital, pentobarbital, secobarbital, and amobarbital/secobarbital combination products will not be covered for any Medicaid beneficiary. Coverage for butabarbital combination agents used for headache and/or analgesia will not change.
- Over-the-counter (OTC) drugs: Coverage will be limited to the Division of Medicaid's OTC Medicaid formulary for all beneficiaries. The exception to OTC coverage will be OTC insulin products which will have coverage in Medicare's Part D plans and will not have coverage via Medicaid.

Elimination of the Poverty Level Aged or Disabled (PLAD) Category of Eligibility

In 2005, the Mississippi Legislature passed House Bill 1104 which ends the Poverty Level Aged or Disabled (PLAD) category of eligibility on January 1, 2006. Medicaid will look at every file to see if each person currently enrolled as a PLAD would qualify for Medicaid coverage in another category of eligibility. In addition, individuals in the PLAD class have been given an opportunity to provide additional information to Medicaid to see if this information changes the review outcome.

Based on these reviews, the Division of Medicaid will reassign all persons in the PLAD group to other Medicaid categories of eligibility, the Healthier Mississippi Waiver for those non-Medicare persons, or to one of the Medicare Savings Programs such as the Qualified Medicare Beneficiary (QMB), Specified Low-Income Medicare Beneficiary (SLMB), or Qualified Individual (QI) programs.

Most PLAD beneficiaries will qualify for a Medicare Savings Program that will help pay their premiums, deductibles, and copayments. Non-Medicare eligible PLADS will not qualify for one of these programs, but will remain Medicaid eligible in the Healthier MS Waiver.

Class of Eligibility	Income Limits	Benefits provided by Medicaid as of January 1, 2006
PLAD	Income less than 135% FPL ($12,920/individual; $17,321/couple in 2005)	None
Healthier MS Waiver	Income less than 135% FPL ($12,920/individual; $17,321/couple in 2005) and not eligible for Medicare	Same basic benefits as Medicaid program with certain service exclusions.
QMB	up to 100% FPL ($9,570/individual; $12,830/couple in 2005)	Medicaid pays for Medicare premiums, deductibles, and copayments.
SLMB/QI	less than 135% FPL ($12,920/individual; $17,321/couple in 2005)	Medicaid pays the Medicare Part B premium. Beneficiaries must pay deductibles and copayments.

How does the implementation of Medicare Part D Prescription Drug Program impact the PLAD group?

The Division of Medicaid has provided information regarding all dual eligibles, including PLADS, to the Centers for Medicare and Medicaid Services (CMS). This information was made available so that all dual eligibles would be automatically enrolled into the low-income subsidy program, including the PLAD group. In addition, this same information was used to automatically enroll these same beneficiaries into one of the Part D plans.

All of the plans that qualify for automatic enrollment meet Medicare's standards for access to medically necessary drugs at a convenient local pharmacy. Dual eligible beneficiaries who prefer a different plan can change at any time.

CMS will notify all dual eligibles of the Part D plan to which they have been assigned. The Part D plan will also send a welcome letter to the beneficiary. In addition, the Division of Medicaid provided a letter to each dual eligible to help each person understand their options. Medicaid matched the medications and pharmacies used by the dual eligible beneficiary and provided an analysis to help the beneficiary decide which plan is best based on current medication use.

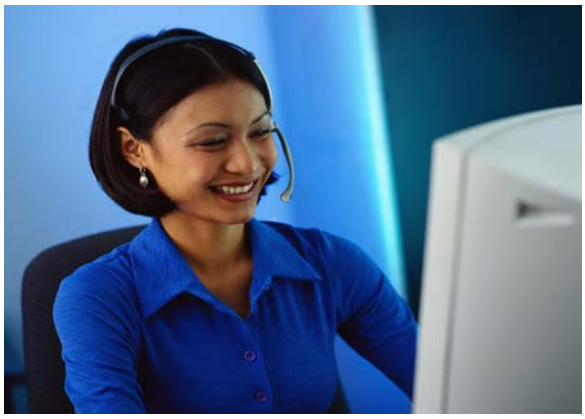
Dates to Remember	
November 15, 2005	First day you can enroll in a Medicare Part D plan
January 1, 2006	First day you can use Medicare Part D drug plan

IF YOU HAVE ANY QUESTIONS REGARDING MEDICARE PART D, CALL 1-800-MEDICARE.
TTY USERS SHOULD CALL 1-877-486-2048.

IF YOU HAVE ANY QUESTIONS REGARDING MEDICAID,
PLEASE CALL 1-800-421-2408 OR 601-359-6050.

ACS Customer Service

For quicker, more efficient service, please have all pertinent information ready when contacting Provider and Beneficiary Services at 1-800-884-3222.



You will need your:

- Provider ID Number
- Beneficiary ID Number
- Dates of Services
- Billed Amount

******Fun Fact:*** Did you know the ACS Provider Services call center takes an average of 3,000 calls per day?

Acquiring Additional Bulletins

One copy of the monthly Medicaid Bulletin is sent to every provider with an active provider number. If additional copies are needed, the bulletins may be downloaded from the publications page of the web portal at the following address: **http://msmedicaid.acs-inc.com**. Or, providers may call the ACS Provider and Beneficiary Services call center at 1-800-884-3222 to request additional copies.

Attention Orthodontic Providers

Orthodontic providers should not bill for services pertaining to the orthodontia evaluation until the denied copy of the prior authorization is received from the Division of Medicaid. This includes orthodontic consultation, cephalogram, diagnostic casts, photographs, and full-mouth radiographs or panoramic radiograph (if taken by the orthodontist). Please refer to Section 11.17 of the Dental Policy, which can be accessed at www.dom.state.ms.us.

Allowable Board of Directors' Fees for Nursing Facilities, ICF-MR's and PRTF's 2005 Cost Reports

The allowable Board of Directors' fees that will be used in the desk reviews and audits of 2005 cost reports filed by nursing facilities (NF's), intermediate care facilities for the mentally retarded (ICF-MR's), and psychiatric residential treatment facilities (PRTF's) have been computed. The computations were made in accordance with the Medicaid State Plan by indexing the amounts in the plan using the Consumer Price Index for All Urban Consumers - All Items. The amounts listed below are the per meeting maximum with a limit of four (4) meetings per year.

The maximum allowable, per meeting Board of Directors' fees for 2005 are as follows:

Category	Maximum Allowable Cost for 2005
0 - 99 Beds	$3,272
100 - 199 Beds	$4,908
200 - 299 Beds	$6,544
300 - 499 Beds	$8,180
500 Beds or More	$9,817

Cataract Surgery and Follow-up Exams

Issues have arisen when an optometrist performs and bills Medicaid for follow-up exams after cataract surgery was performed and billed by another provider. The surgeon performing the cataract procedure should be the only provider billing for the surgery. Any follow-up exams or rechecks should be billed using the appropriate evaluation and management codes for the exams and services provided. Follow-up exams or rechecks must not be billed using surgery codes. Follow-up exams or rechecks can only be billed for the date the patient is treated at the office.

2005 Owner Salary Limits for Long-Term Care Facilities

The maximum amounts that will be allowed on cost reports filed by nursing facilities, intermediate care facilities for the mentally retarded and psychiatric residential treatment facilities as owner's salaries for 2005 are based on 150% of the average salaries paid to non-owner administrators in 2004 in accordance with the Medicaid State Plan. These limits apply to all owners and owner/administrators that receive payment for services related to patient care. The limits apply to salaries paid directly by the facility or by a related management company or home office. Adjustments should be made to the cost report to limit any excess salaries paid to owners. In addition, Form 15 should be filed as part of the Medicaid cost report for each owner.

The maximum allowable salaries for 2005 are as follows:

• Intermediate Care Facilities for the Mentally Retarded (ICF-MR)	$111,392
• Small Nursing Facilities (1-60 Beds)	$ 90,799
• Large Nursing Facilities (61 + Beds)	$115,430
• Psychiatric Residential Treatment Facilities (PRTF)	$ 81,997

License Renewal for Dental Providers

The Mississippi State Board of Dental Examiners would like to extend the license renewal deadline from October 31, 2005 until December 31, 2005. All active dental providers are required to maintain a current license and to submit a copy of their renewed license to DOM (via ACS). Failure to renew your license and submit a copy to DOM by December 31, 2005, will result in the closure of your Medicaid provider number on January 1, 2006.

Copies of dental licenses may be faxed to (601) 206-3015 or mailed to:

ACS State Healthcare
Attn: Provider Enrollment Department
P.O. Box 23078
Jackson, MS 39225

If you have any questions, you may contact the Provider Enrollment Department using the address noted below or call (800) 884-3222 or (601) 206-3000 between the hours of 8:00 a.m. to 5:00 p.m. CST Monday through Friday.

Policy Manual Reminder

This bulletin is a document for the Mississippi Medicaid Provider Policy Manual and must be placed in Section 88 of the manual. All providers are held accountable for all policies in the monthly Mississippi Medicaid Bulletins.

Notice of Paper RA Cut-off

The Division of Medicaid and ACS State Healthcare are transitioning to a paperless environment. Effective January 1, 2006, providers who currently receive a paper remittance advice and an ASC X12N 835 electronic remittance advice will no longer receive the paper remittance advice. The ASC X12N 835 electronic remittance advice will continue to be available.

Providers will be able to accept print images of their remittance advices through the Mississippi Envision Web Portal located at http://msmedicaid.acs-inc.com or retrieve ASC X12N 835 remittance advice files at http://mississippimedicaid.acs-inc.com.

Accessing Print Images of the Remittance Advice

If you are a provider who receives paper remittance advices only, you may access print images of your remittance advice. Print images of remittance advices are available on the Mississippi Envision Web Portal at http://msmedicaid.acs-inc.com. In order to utilize this secure feature of the Mississippi Envision Web Portal, providers will have to be a registered user of the web portal. Once the site has been accessed, providers should click on the link entitled, "Web Account Registration," which is on the left side of the web portal homepage, and complete the appropriate fields to become a registered web portal user.

Once a provider has become a registered user of the web portal, the provider should simply access the web portal at http://msmedicaid.acs-inc.com, log into the secure portion of the web portal by clicking on the link entitled "Log In," and click on the "Print Images" tab. Print images of remittance advices will be listed here and will be available for 60 days for downloading or printing.

Receiving the ASC X12N 835 Electronic Remittance Advice

If you are a provider who currently receives paper remittance advices only and would like to receive the ASC X12N 835 electronic remittance advice, you must be enrolled with ACS EDI Gateway Services to submit claims electronically in order to receive an ASC X12N 835 electronic remittance advice. In order to enroll with ACS EDI Gateway Services, the EDI Provider Agreement and Enrollment Form must be completed and submitted to: Mississippi Medicaid Program, P.O. Box 23078, Jackson, MS 39225. *Please note that ACS State Healthcare offers free software, WINASAP2003, to assist with electronic claims submission.*

The EDI Provider Agreement and Enrollment Form can be accessed by clicking on the "Enrollment Options" link of the Mississippi Envision Web Portal. If you have questions and need additional assistance with completing the EDI Provider Agreement and Enrollment Form or obtaining the WINASAP2003 electronic claims submission software, please contact EDI Support at 1-800-884-3222, option 5.

Once enrolled to submit claims electronically and receive ASC X12N 835 electronic remittance advices, the provider will receive a user name and user number to access the Mississippi EDI Exchange. The Mississippi EDI Exchange is located at http://mississippimedicaid.acs-inc.com. Once the provider accesses the site, supplies the user name and user number, available ASC X12N electronic remittance advices will be listed for downloading.

The Division of Medicaid and ACS State Healthcare would like for this to be a seamless transition for you. If you have questions regarding the elimination of the paper remittance advices and available options, please contact EDI Support at 1-800-884-3222.

Policy Manual Additions/ Revisions

The following policies and policy sections have been added and/or revised in the DOM Provider Policy Manual. Providers of these services may view these changes by accessing the DOM website at www.dom.state.ms.us and clicking on "Provider Manuals" in the left window.

Manual Section	Policy Section	New	Revised	Effective Date
12.0 Non-Emergency Transportation	12.01 Introduction 12.03 Needs Verification 12.06 NET Services by Public Carrier 12.07 Ground Services Provided by Individual, Group and Public Transit Providers 12.09 Individual Mileage/ Group and Public Transit Rates 12.13 Monitoring 12.15 Provider Complaint and Non-Compliance		X X X X X X X	12/01/05
14.0 Hospice	14.03 Physician Certification/ Plan of Care 14.04 Election Procedures 14.06 Election, Revocation, and Change of Hospice 14.07 Dually Eligible Beneficiaries 14.10 Hospice Reimbursement		X X X X X	12/01/05
11.0 Dental	11.12 Prosthodontics (Removable) 11.17 Orthodontics: Prior Authorization		X	01/01/06
15.0 MH/ Community Mental Health	15.30 Billing Guidelines		X	01/01/06
25.0 Hospital Inpatient	25.29 Sterilization		X	01/01/06
38.0 Maternity	38.06 Delivery and Sterilization		X	01/01/06
53.0 General Medical	53.19 Failed Sterilization Procedures 53.21 Blepharoplasty 53.22 Medically Necessary	X X X		01/01/06

Nursing Facility Civil Money Penalty Grant Award Notice

The deadline for submission of grant applications for FY 2006 is January 15, 2006. Application requirements are located on the Division of Medicaid website as follows: www.dom.state.ms.us. At the "select a link", choose Civil Money Penalty (CMP) Funds. A summary of each grant is provided below. If you have any questions, contact Evelyn Silas, Division Director, Case Mix, at 601-359-6750.

Enhancement Grant Award: The goal is to provide grants for enhancements to nursing facilities that have maintained compliance with the federal requirements for long term care. The purpose of the Enhancement Grant Award is to provide a nursing facility with current and past compliance history of the federal requirements the opportunity to receive funding for innovative programs/projects that will directly and/or indirectly benefit the residents by providing an enhanced quality of life. The grant award should be self sustaining once implemented. The grant awards range is $5000 -$50,000. Deadline for completion and receipt of application by DOM is ***January 15, 2006***.

Educational Program Grant Award: The goal is to assist nursing facilities that have not been in substantial compliance with federal requirements for long term care facilities to obtain and maintain compliance. The purpose of the Educational Program Award is to provide a nursing facility with current and past noncompliance history of federal requirements the opportunity to receive funding for educational programs/projects that will directly and/or indirectly benefit the residents as well as assist the facility in providing an enhanced quality of life for the residents. This grant award is a one-time award that will benefit the residents. The grant awards range is $5000 - $20,000. Deadline for completion and receipt of application by DOM is ***January 15, 2006***.

Medicaid Identification Card

It is the responsibility of the Medicaid provider to verify a Medicaid beneficiary's eligibility each time the beneficiary appears for a service. The provider is also responsible for confirming that the person presenting the card is the person to whom the card is issued. This can be done by requesting a picture ID, such as a driver's license, school ID card, or verifying the Social Security number and/or birth date. It is preferred that providers verify the identity of the person presenting for service with a picture ID when possible. If it is found that the person presenting for services is not the Medicaid beneficiary to whom the card was issued, the provider is responsible for refunding any monies paid by Medicaid to the provider for those services provided.

Additional information regarding the Division of Medicaid's policy regarding the Medicaid identification card is in Section 3.05 of the Provider Policy Manual. Providers are reminded that they should review this policy periodically with their office staff.

Verifying Beneficiary Eligibility

Providers have a variety of resources for verifying the eligibility of a Medicaid beneficiary. Eligibility can be checked by contacting the Provider and Beneficiary Services Call Center at 1-800-884-3222, by calling the AVRS at 1-866-597-2675, by utilizing the Mississippi Envision Web Portal at:

http://msmedicaid.acs-inc.com

and by using a swipe card verification device. You may also access the Web Portal for interactive beneficiary eligibility verification.

When verifying eligibility through the call center, please obtain the call record number (CRN) from the Call Center Associate prior to ending the call. When verifying eligibility through the web portal, please print a copy of the documentation which contains the eligibility information. If verifying eligibility through the use of a swipe card verification device, please keep a copy of the receipt. If verifying eligibility though the use of the AVRS, please document the audit reference number.

Top Ten Reasons Claims Are Returned To Providers

1. Provider Signature Missing
2. Group or PIN Number Missing
3. Billing Date Missing
4. Total Charges Missing
5. Service Dates Missing
6. Missing Attachments (EOMB's, EOB's, TPL's)
7. Wrong Claim Type
8. Beneficiary ID Number Missing
9. Correction Fluid/Correction Tape
10. Highlighted Documents (Unable To Image)

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P.O. Box 23078
Jackson, MS 39225

If you have any questions related to the topics in this bulletin, please contact ACS at 1-800 -884 -3222 or 601 -206 -3000

Mississippi Medicaid Manuals
are on the Web
www.dom.state.ms.us
And
Medicaid Bulletins are on the Web Portal
http://msmedicaid.acs-inc.com

December

December 2005

Sunday	*Monday*	*Tuesday*	*Wednesday*	*Thursday*	*Friday*	*Saturday*
				1 **EDI Cut Off 5:00 p.m.**	2	3
4	5 CHECKWRITE	6	7	8 **EDI Cut Off 5:00 p.m.**	9	10
11	12 CHECKWRITE	13	14	15 **EDI Cut Off 5:00 p.m.**	16	17
18	19 CHECKWRITE	20	21	22 **EDI Cut Off 5:00 p.m.**	23 **DOM and ACS CLOSED**	24
25	26 **DOM and ACS CLOSED** CHECKWRITE	27	28	29 **EDI Cut Off 5:00 p.m.**	30	31

Checkwrites and Remittance Advices are dated every Monday. However, funds are not transferred until the following Thursday, and Remittance Advices usually arrive the following Friday.