NEW YORK STATE | Department of Health

Medicaid Update

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Medicaid Pharmacy Prior Authorization Programs Update

On May 16, 2019, the New York State Medicaid Drug Utilization Review (DUR) Board recommended changes to the Medicaid pharmacy prior authorization (PA) programs. The Commissioner of Health has reviewed the recommendations of the Board and has approved changes to the Preferred Drug Program (PDP) within the fee-for-service (FFS) pharmacy program.

Effective July 25, 2019, PA requirements will change for some drugs in the following PDP classes and new classes have been added to the Preferred Drug List (PDL):

- Anticonvulsants – Other
- Central Nervous System (CNS) Stimulants
- Multiple Sclerosis Agents
- Growth Hormones
- Erythropoiesis Stimulating Agents
- Antihyperuricemics (includes the Xanthine Oxidase Inhibitors)
- Anticholinergics/Chronic Obstructive Pulmonary Disease (COPD) Agents

In addition, the following new therapeutic classes will be added to PDL:

- Antimigraine Agents – Other
- Movement Disorder Agents
- Colony Stimulating Factors
- Immunosuppressives – Oral

For more detailed information on the above DUR Board recommendations, please refer to the meeting summary at: https://www.health.ny.gov/health_care/medicaid/program/dur/meetings/2019/.

A full listing of drugs subject to PDP, Clinical Drug Review Program (CDRP), DUR Program, Brand Less Than Generic program (BLTG), Dose Optimization Program and the Mandatory Generic Drug Program (MGDP) can be found at: https://newyork.fhsc.com/downloads/providers/NYRx_PDP_PDL.pdf. This document includes the most up-to-date information on the Medicaid FFS Pharmacy PA programs.

To obtain a PA, please call the Medicaid Pharmacy Prior Authorization Clinical Call Center at 1-877-309-9493. The call center is available 24 hours per day, 7 days per week and is staffed with pharmacy technicians and pharmacists who will assist providers and provider agents in obtaining a PA. Medicaid-enrolled prescriber with an active e-PACES (Electronic Provider Assisted Claim Entry System) account can initiate PA requests through the web-based application PAXpress®. The website for PAXpress is https://paxpress.nypa.hidinc.com/. The website may also be accessed through the eMedNY website at http://www.eMedNY.org as well as Magellan Medicaid Administration's website at http://newyork.fhsc.com.

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In This Issue…

Reminder: Pharmacy Delivery Policy

Prescription and over-the-counter (OTC) drugs dispensed pursuant to a prescription or fiscal order submitted to Medicaid for reimbursement for any portion, may be picked up at the pharmacy provider or may be delivered free of charge to the Medicaid fee-for-service (FFS) or Medicaid Managed Care (MMC) member's home or current residence including facilities and shelters.

Delivery Policy:

- All shipping and/or delivery costs shall be the responsibility of the provider of the service.
- The pharmacy is responsible for the delivery of product to the intended recipient.
- Prior to processing a drug claim, the pharmacy must confirm the drug is needed and that the drug had not been discontinued, changed, or is no longer necessary (e.g., the member had changed pharmacy provider); the confirmation must be maintained in the member's patient record. **Automatic refills are not permitted**.
- Prior to delivery, the pharmacy must obtain consent from the member or the individual authorized to consent on the member's behalf to deliver; consent shall be maintained in the member's patient record.
- Only the member, or the individual authorized, may receive the delivery.
- Pharmacy providers must obtain a signature from the Medicaid member, or the individual authorized to confirm the receipt of drugs; signatures must be retrievable upon audit. Electronic signatures captured at delivery are only permitted if retrievable upon audit.
- Pharmacies that provide drugs via the mail must obtain and maintain for audit purposes either the signature of the member or authorized individual; and the shipping information including member's name, address, prescription number, shipped date, and carrier for non-controlled drugs.
- Pharmacies that provide control prescription drugs via the mail must obtain the signature of the member or authorized individual and be shipped by a method that can be tracked.
- The pharmacy is responsible for drug integrity, and must deliver intact, usable drugs, under the appropriate storage conditions.
- The pharmacy is responsible to replace lost, stolen, or mis-directed drugs at no additional cost to the member or the Medicaid Program.
- Pharmacy providers who deliver medication without member or authorized individual consent will be required to accept the return of the medication, credit Medicaid the claim, and destroy those drugs per State Law.
- All Medicaid claims for drugs not picked up or delivered must be reversed within 60 days or sooner as required by the mandatory part of New York State's compliance programs under 18 NYCRR §521.
- All State counseling laws apply. Additional information can be found at: http://www.op.nysed.gov/prof/pharm/pharmcounseling.htm.

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New York State Medicaid Coverage of CYP2C9 Testing for Siponimod Prescribing

Effective July 1, 2019 for Medicaid fee-for-service (FFS), and November 1, 2019 for Medicaid Managed Care (MMC) Plans (including mainstream MMC plans, HIV Special Needs Plans (HIV SNPs), and Health and Recovery Plans (HARPs)), New York State (NYS) Medicaid will begin covering testing of CYP2C9 gene analysis to determine eligibility for siponimod drug therapy. Testing of the CYP2C9 gene is reimbursable once in a lifetime and should be billed using Current Procedural Terminology (CPT) code **"81227"**.

Questions:

- Medicaid FFS coverage and policy questions should be directed to the Office of Health Insurance Programs (OHIP), Division of Program Development and Management at (518) 473–2160.
- Medicaid MMC general coverage questions should be directed to the OHIP, Division of Health Plan Contracting and Oversight at: covques@health.ny.gov or (518) 473–1134.
- MMC reimbursement, billing, and/or documentation requirement questions should be directed to the enrollee's MMC plan.
- FFS claim questions should be directed to the eMedNY Call Center at (800) 343–9000.

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New York State Medicaid Coverage of Duchenne Muscular Dystrophy (DMD) Testing for Exondys 51® Prescribing

Effective July 1, 2019 for Medicaid fee-for-service (FFS) and November 1, 2019 for Medicaid Managed Care (MMC) Plans (including mainstream MMC plans, and HIV Special Needs Plans (HIV SNPs)), New York State (NYS) Medicaid will begin covering testing of the DMD gene in individuals who are being considered for treatment with Exondys 51® (eteplirsen). Testing of the DMD gene is reimbursable once in a lifetime and should be billed using Current Procedural Terminology (CPT) code **"81161"**.

Questions:

- Medicaid FFS coverage and policy questions should be directed to the Office of Health Insurance Programs (OHIP), Division of Program Development and Management at (518) 473–2160.
- Medicaid MMC general coverage questions should be directed to the OHIP, Division of Health Plan Contracting and Oversight at: covques@health.ny.gov or (518) 473–1134.
- MMC reimbursement, billing, and/or documentation requirement questions should be directed to the enrollee's MMC plan.
- FFS claim questions should be directed to the eMedNY Call Center at (800) 343–9000.

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New York State Medicaid Expansion of Prognostic Tests for Breast Cancer Treatment

This policy outlines New York State Medicaid coverage of prognostic breast cancer assays as of August 1, 2019 for Medicaid fee-for-service (FFS), and November 1, 2019 for Medicaid Managed Care (MMC) Plans (including mainstream MMC plans, HIV Special Needs Plans (HIV SNPs), and Health and Recovery Plans (HARPs)). The prognostic breast cancer assays eligible for reimbursement are Oncotype DX®, EndoPredict® and Prosigna®. Coverage of the Oncotype DX® test for Breast Cancer was added in 2015. Oncotype DX®, EndoPredict®, and Prosigna® prognostic gene expression tests assist practitioners in making determinations regarding the effective and appropriate use of chemotherapy in female or male patients with malignant neoplasms of the breast, when all of the following criteria* are met:

- When the test results will aid the patient and practitioner in making the decision regarding chemotherapy (i.e., when chemotherapy is a therapeutic option and is not precluded due to any other factor); ***and***
- The tumor is estrogen receptor positive (ER+), progesterone receptor positive (PR+), or both; ***and***
- Human epidermal growth factor receptor 2 (HER2) negative; ***and***
- Tumor is T1 or T2; ***and***
- Node-negative or 1-3 positive nodes.

*NYS Medicaid criteria for Oncotype DX®, EndoPredict® and Prosigna® tests is in accordance with current National Comprehensive Cancer Network (NCCN) Guidelines. In between policy reviews, providers are encouraged to follow the most recent NCCN guidance.

FFS Billing

A copy of the pathology report must accompany the laboratory requisition form. Additional laboratory billing guidance and instructions for billing "by report" (BR) codes can be found at the following link: https://www.emedny.org/ProviderManuals/Laboratory/PDFS/Laboratory_Procedure_Codes.pdf.

Reminders:

- MMC Plan rates cannot exceed the negotiated Medicaid FFS rate.
- Specimens tested within two weeks of discharge from hospital inpatient status are included in the APR-DRG payment to the hospital facility.
- Lab tests are carved out of the ambulatory surgery Ambulatory Patient Group (APG) payment; as such, the Article 28 facility should not report the procedure code for these tests on their ambulatory surgery APG claim. The laboratory will bill Medicaid FFS and MMC Plans directly.
- Follow-up genetic counseling should be provided to patients who test positive for a genetic condition.
- Only ***one*** prognostic breast cancer assay per histologically distinct tumor is reimbursable. The criteria in this policy must be met for each assay ordered.
- If the lab determines that the specimen does not meet the testing criteria outlined in this policy, the laboratory will not report a test result and will not bill the payer or the patient.
- Patient records must indicate that the individual tested has met the required criteria outlined in this guidance.
- All documentation must be maintained for a minimum of six years for FFS and 10 years for MMC plans.

Questions:

- Medicaid FFS Coverage and policy questions should be directed to the Office of Health Insurance Programs (OHIP), Division of Program Development and Management at (518) 473-2160.
- Medicaid MMC general coverage questions should be directed to the OHIP, Division of Health Plan Contracting and Oversight at: covques@health.ny.gov or (518) 473–1134.
- MMC reimbursement, billing, and/or documentation requirement questions should be directed to the enrollee's MMC plan.
- FFS claim questions should be directed to the eMedNY Call Center at (800) 343-9000.

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Billing Guidance for Reporting Alternate Level of Care

It has come to the attention of the New York State (NYS) Department of Health (the Department) that some hospitals are billing an inpatient acute level of care status when the patient should have been transferred to alternate level of care (ALC) status. This article reiterates ALC billing guidance to NYS Medicaid providers to ensure that the correct billing procedures are followed regarding ALC days.

New York Codes, Rules, and Regulations (NYCRR) Title 10, §86-1.15(h) defines ALC services as: "those services provided by a hospital to a patient for whom it has been determined that inpatient hospital services are not medically necessary, but that post-hospital extended care services are medically necessary, consistent with utilization review standards, and are being provided by the hospital and are not otherwise available." Hospitals must properly report occurrence span code **"75"** with the date span the member was in ALC on the acute care claim. eMedNY Inpatient Billing Guideline §2.3.3 requires that ALC claims be split-billed. Split-billing is defined in the Guideline as the "submission of multiple date range claims that when compiled represent the period from Admit to Discharge." Hospitals should not bill for acute levels of care for days when patients are in an ALC setting.

For more information regarding inpatient billing please see eMedNY's *New York State UB-04 Billing Guidelines–Inpatient Hospital* manual at: https://www.emedny.org/ProviderManuals/Inpatient/PDFS/Inpatient_Billing_Guidelines.pdf.

Questions:

- Medicaid fee-for-service (FFS) coverage and policy questions should be directed to the Office of Health Insurance Programs (OHIP), Division of Program Development and Management at (518) 473–2160.
- MMC reimbursement, billing, and/or documentation requirement questions should be directed to the enrollee's MMC plan.
- FFS claim questions should be directed to the eMedNY Call Center at (800) 343–9000.

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Update: Credentialed Alcoholism and Substance Abuse Counselor (CASAC) Now Approved for Billing Within an Article 28 Setting for DSRIP Project 3.a.i and Integrated Outpatient Services

This article supersedes the CASAC article published in the February 2019 *Medicaid Update*. Due to technical issues that recently came to our attention, CASAC providers may continue to use the Office of Alcoholism and Substance Abuse Services (OASAS) unlicensed practitioner ID number **"02249145"** consistent with OASAS policy after September 1, 2019 for services rendered in the Article 28 setting. Once the technical issue is resolved, updated guidance will be provided in a future *Medicaid Update* publication.

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Billing Guidance for Reporting Newborn Birth Weights

It has come to the attention of the New York State (NYS) Department of Health that some hospitals are inaccurately reporting newborn birth weights on inpatient claims. Providers are reminded that pursuant to the inpatient billing procedures for All Patient Refined Diagnostic Related Groups (APR DRGs), documented in eMedNY's *New York State UB-04 Billing Guidelines - Inpatient Hospital* manual, claims for newborns must accurately contain the newborn's birth weight in grams. The birth weight is reported using Value Code **"54"** in the Value Information segment. To ensure proper payment when billing Medicaid, fee-for-service (FFS) providers should follow the billing guidelines detailed in eMedNY's *New York State UB-04 Billing Guidelines - Inpatient Hospital* manual §2.3.1.2, Rule 3 – Newborns, which can be found at: https://www.emedny.org/ProviderManuals/Inpatient/PDFS/Inpatient_Billing_Guidelines.pdf.

Questions:

- Medicaid FFS coverage and policy questions may be directed to the Office of Health Insurance Programs (OHIP) Division of Program Development and Management at (518) 473–2160.
- MMC reimbursement, billing, and/or documentation requirement questions should be directed to the enrollee's MMC plan.
- FFS claim questions should be directed to the eMedNY Call Center at (800) 343–9000.

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Billing Guidance for Reporting Mechanical Ventilation

It has recently come to the attention of the New York State (NYS) Department of Health (the Department) that some hospitals may be reporting inappropriate International Classification of Diseases Tenth Revision (ICD-10) procedure codes for mechanical ventilation billed to the NYS Medicaid program. The reporting of inappropriate ICD-10 procedure codes for mechanical ventilation has resulted in overpayments to hospital facilities. Mechanical ventilation is the use of a device to inflate and deflate a patient's lungs to deliver air to a patient whose ability to breathe is diminished or lost. The ICD-10 procedure codes used for mechanical ventilation have specific "consecutive hour" designations used for the claiming of these services.

Hospital inpatient providers need to make certain the ICD-10 procedure code reported on a claim for mechanical ventilation represents the actual number of continuous hours the member received mechanical ventilation. A clinical assessment that supports the member's diagnosis, the requirements for mechanical ventilation, and the actual number of continuous hours the member received mechanical ventilation must be included in the member's medical record and may be subject to review and audit.

The Department has contracted with Island Peer Review Organization (IPRO) to review Medicaid fee-for-service (FFS) hospital inpatient claims. During the Utilization Review of inpatient claims, claims for mechanical ventilation will be reviewed to ensure that these services are accurately coded and reflect the services provided to the member.

Questions:

- Medicaid FFS coverage and policy questions should be directed to the Office of Health Insurance Programs (OHIP), Division of Program Development and Management at (518) 473–2160.
- Medicaid Managed Care (MMC) reimbursement, billing, and/or documentation requirement questions should be directed to the enrollee's MMC plan.
- FFS claim questions should be directed to the eMedNY Call Center at (800) 343–9000.
- Clarification on self-disclosing an overpayment may be obtained by visiting the OMIG website at: https://omig.ny.gov/self-disclosure/submission-information-and-instructions or by contacting OMIG's Self-Disclosure Unit by email at: selfdisclosures@omig.ny.gov or by phone at: (518) 402-7030.

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All Providers

Reminder to Sign-up for Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA) or Portable Document Format (PDF) Remittances

Reminder

Billing providers who are still receiving paper checks and/or paper remittance statements are required to register for Electronic Funds Transfer (EFT) and either Electronic Remittance Advice (ERA) or Portable Document Format (PDF) remittances. Medicaid began phasing in this requirement beginning in September 2012. The advantages of EFT over paper checks include:

- no lost checks;
- no delays caused by misdirected checks;
- mail travel time is eliminated;
- funds are transferred securely; and
- trips to and from the bank to deposit Medicaid paper checks are eliminated.

Remittances

Providers have two options for paperless remittances:

- **Option 1: ERA in the form of HIPAA-compliant 835/820 formats**
  This will require software to interpret but has advantages for systematic posting of payments.

- **Option 2: PDF version paper remittances delivered electronically via eMedNY's secure website**
  The PDF remittances have many advantages over paper remittances, such as they:
  - will be immediately available every week on the Monday which the Medicaid check is dated and will not be subject to the two-week hold like a paper check or EFT release;
  - will trigger a notification in the providers eXchange account regarding the remittance availability, thus removing the wait time for mail;
  - can be downloaded and stored electronically for easy retrieval;
  - can be word-searched in order to help locate specific claims;
  - will look exactly like the paper remittance; and
  - can be printed with Adobe Reader® (6.0 release or higher required); available for download free of charge.

Both the EFT and ERA/PDF remittance applications are available online at: https://www.emedny.org/info/ProviderEnrollment/allforms.aspx. Questions about either application or the sign-up process can be directed to the eMedNY Call Center at (800) 343–9000.

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Reminder: Subscribe to the eMedNY LISTSERV®

The eMedNY LISTSERV® email system is a method for dissemination of eMedNY-related information and notifications to providers, vendors, and other Medicaid partners. The eMedNY LISTSERV® is a supplement to the *Medicaid Update,* the official newsletter of the New York State Medicaid program. The eMedNY LISTSERV® enables subscribers to instantly receive:

- alerts for upcoming changes to claims and other transactions editing;
- announcements about provider training, seminars, webinars, and special web meetings being offered;
- provider type specific changes in policy and claim submission requirements; and
- electronic Provider Assisted Claim Entry System (ePACES) changes and enhancements.

The LISTSERV® email system runs on an open platform and is available free of charge. There is no limitation to the number of individuals who may subscribe from a practice or organization and no limitation on the number of categories one may subscribe to. Providers are encouraged to subscribe to ensure they receive important eMedNY communications that may impact their practice and business processes.

Subscribing to the eMedNY LISTSERV® is quick and easy. Providers can simply visit http://www.emedny.org, select the "eMedNY LISTSERV®" button on the right side of the home page, enter a valid email address then select the categories desired. eMedNY LISTSERV® communications are also archived and available for viewing at a later time. Please contact the eMedNY Call Center at (800) 343-9000 with any questions related to the eMedNY LISTSERV®.

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Provider Training Schedule and Registration

Providers who are new to Medicaid billing, have billing questions, or who are interested in learning more about the electronic Provider Assisted Claim Entry System (ePACES) should consider registering for Medicaid training. eMedNY offers various types of training to providers and their billing staff. Training sessions are available at no cost to providers and cover information including claim submission, Medicaid Eligibility Verification, and the eMedNY website.

Seminars

Seminars are a valuable opportunity to meet personally with the CSRA eMedNY Regional Representatives in your area. Seminars are in-person training sessions with groups of providers and billing staff conducted at locations throughout New York State. A schedule of seminars by location can be found on the eMedNY website at: http://www.emedny.org/training/index.aspx.

Webinar Training

Webinar training opportunities are also available. Webinar training sessions are conducted online and providers are able to join the meeting from their site location via a computer and telephone. Once registered, providers receive an email with instructions on how to log in and join the webinar at the appropriate time. **No travel is necessary.**

Many webinars offer detailed instruction on Medicaid's free web-based program ePACES, the electronic provider assisted claim entry system, which allows enrolled providers to submit the following types of transactions:

- claims;
- eligibility verifications;
- claim status requests; and/or
- prior approval/DVS requests.

Training dates, locations, and fast and easy registration information is available on the eMedNY website at: http://www.emedny.org/training/index.aspx. The website is updated quarterly with new sessions. eMedNY Regional Representatives are eager to meet with and provide guidance to providers at upcoming training sessions. Providers who are unable to access the internet to register, or who have questions about registration, should contact the eMedNY Call Center at (800) 343–9000.

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New York Medicaid EHR Incentive Program

Distribution to Eligible Professionals & Eligible Hospitals Since the Start of the Program in 2011*

Number of Payments:	Distributed Funds:
39,045	$972,441,858

**As of 7/8/2019*

Through the New York (NY) Medicaid Electronic Health Record (EHR) Incentive Program eligible professionals (EPs) and eligible hospitals (EHs) in NY who adopt, implement, or upgrade certified EHR technology (CEHRT) and subsequently become meaningful users of CEHRT, can qualify for financial incentives. The Centers for Medicare and Medicaid Services (CMS) is dedicated to improving interoperability and patient access to health information. The NY Medicaid EHR Incentive Program is a part of the CMS Promoting Interoperability Program, but will continue to operate under the current name, NY Medicaid EHR Incentive Program.

MEIPASS is Open for Payment Year 2018

The Medicaid EHR Incentive Program Administrative Support Service (MEIPASS) opened for Payment Year (PY) 2018 Attestations on July 1, 2019. The deadline to attest for PY 2018 is September 30, 2019. To attest for PY 2018 in MEIPASS please visit: https://meipass.emedny.org/ehr/login.xhtml.

Greenway Health LLC Products

Greenway Health LLC identified that certain EHR products are calculating Promoting Interoperability (Meaningful Use) measures incorrectly and they are working to fix these issues. Providers who used any of the impacted Greenway products during 2018 should complete the "Greenway Health LLC Identification Form." This form is available to download in Microsoft Excel format at: https://www.health.ny.gov/health_care/medicaid/redesign/ehr/repository/docs/greenway_form.xlsx. Completed forms can be submitted as an attachment via email to attenstation@health.ny.gov.

Webinars and Q&A Sessions

A calendar with the date and times of upcoming webinars, as well as registration information, can be found at: https://www.health.ny.gov/health_care/medicaid/redesign/ehr/calendar/. Upcoming webinars include *Security Risk Assessment (SRA)*, *Public Health 2019*, and *PY 2019 State 3 Attestation Preparation*.

NY Medicaid EHR Incentive Program Tutorial Series

The NY Medicaid EHR Incentive Program has produced a series of tutorials to assist providers in preparation of the PY 2018 Meaningful Use Attestation and to aid in the event of a post-payment audit. Registration information for the *PY2018 Meaningful Use Attestation Series* and the *Post-Payment Audit Education Series* can be found at: https://www.health.ny.gov/health_care/medicaid/redesign/ehr/audit/.

New York State (NYS) Regional Extension Centers (RECs)

NYS RECs offer free support to help providers achieve Meaningful Use of CEHRT. Support provided by NYS RECs includes but is not limited to: answers to questions regarding the program and requirements; assistance on selecting and using CEHRT; and help meeting program objectives. NYS RECs offer ***free*** assistance for all practices and providers located within New York.

For Providers Located:	
***Inside* the 5 boroughs of NYC**	***Outside* the 5 boroughs of NYC**
Contact: **NYC REACH** Phone: 1-347-396-4888 Website: https://www.nycreach.org. Email: pcip@health.nyc.gov.	Contact: **New York eHealth Collaborative (NYeC)** Phone: 1-646-619-6400 Website: https://www.nyehealth.org Email: ep2info@nyehealth.org

Questions

The EHR Incentive Program has a dedicated support team ready to assist. Please contact the program at**:** **1-877-646-5410 (Option 2)** or via email at: hit@health.ny.gov.

Please Complete the New York Medicaid EHR Incentive Program Customer Satisfaction Survey
The NY Medicaid EHR Incentive Program values provider insight. The survey can be found at: https://www.surveymonkey.com/r/NY_EHR.

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Provider Directory

Office of the Medicaid Inspector General:
For suspected fraud or abuse complaints/allegations, call 1-877-87FRAUD, (877) 873-7283, or visit www.omig.ny.gov.

Provider Manuals/Companion Guides, Enrollment Information/Forms/Training Schedules:
Please visit the eMedNY website at https://www.emedny.org/.

Providers wishing to listen to the current week's check/EFT amounts:
Please call (866) 307-5549 (available Thursday PM for one week for the current week's amount).

For 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, please enroll online at https://www.emedny.org/training/index.aspx. For individual training requests, call (800) 343-9000.

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

Medicaid Prescriber Education Program:
For current information on best practices in pharmacotherapy, please visit the following websites:
http://www.health.ny.gov/health_care/medicaid/program/prescriber_education/presc-educationprog
http://nypep.nysdoh.suny.edu/home

eMedNY
For a number of services including: change of address, updating an enrollment file due to an ownership change, enrolling another NPI, or revalidating an existing enrollment please visit: https://www.emedny.org/info/ProviderEnrollment/index.aspx and choose the appropriate link based on provider type.

Medicaid Electronic Health Record (EHR) Incentive Program
Contact the New York Medicaid EHR Call Center at (877) 646-5410 for assistance.

Comments and Suggestions Regarding This Publication
Please contact the editor, Georgia Wohnsen, at medicaidupdate@health.ny.gov.