



STATE OF NEW YORK DEPARTMENT OF HEALTH

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ADMINISTRATIVE DIRECTIVE

TRANSMITTAL: 03 OMM/ADM-2

TO: **Commissioners of
Social Services**

DIVISION: Office of
 Medicaid
 Management

DATE:

SUBJECT: Mail-in Renewal (Recertification) Process for Medicaid/Family Health Plus/Child Health Plus A

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| SUGGESTED DISTRIBUTION: | Medicaid Staff Fair Hearing Staff Legal Staff QA&A Staff Staff Development Coordinators Public Assistance Staff |
| CONTACT PERSON: | Local District Liaison Unit Upstate: (518) 474-8216 NYC: (212) 268-6855 |
| ATTACHMENTS: | A Sample Medicaid Renewal Form (not available on-line) B Manual Renewal Form (available on-line) C Renewal Cover Letter (not available on-line) D Renewal Cover Letter/SSI-Related (not available on-line) E Wording for the Reminder Letter |

FILING REFERENCES

| Previous ADMs/INFs | Releases Cancelled | Dept. Regs. | Soc. Serv. Law & Other Legal Ref | Manual Ref | Misc Ref |
|--|--------------------|-----------------------------------|----------------------------------|------------|--------------------------------|
| 02 OMM/ADM-5 01 OMM/ADM-6 99 ADM-5 94 INF-28 93 ADM-29 86 ADM 47 80 ADM-19 | 86 ADM 47 | 18 NYCRR 350.4, 360.2.2 (e) | 366-a (5) | | GIS 99 MA/037 GIS 03 MA/004 |

I. **PURPOSE**

The purpose of this Office of Medicaid Management Administrative Directive (OMM/ADM) is to inform local social services districts of changes in Medicaid program policy as a result of Chapter 1 of the Laws of 2002, including:

- Elimination of the personal interview at the time of renewal (recertification).
- Introduction of a simplified Medicaid/Family Health Plus/Child Health Plus A renewal form.

II. **BACKGROUND**

Chapter 1 of the Laws of 2002 eliminated the requirement for a personal interview for recipients renewing eligibility for Medicaid, Family Health Plus and Child Health Plus A. This legislation also required the Department of Health to develop a simplified Statewide renewal form for these programs that requests only that information reasonably necessary to determine continued eligibility and/or subject to change since the date of the recipient's initial application. The intent of this legislation is to simplify the recertification process for local social service districts and recipients, and reduce the number of eligible recipients who do not complete the renewal process.

III. **PROGRAM IMPLICATIONS**

Local districts are required to allow Medicaid/Family Health Plus/Child Health Plus A recipients to renew their health coverage without a personal interview. To facilitate this, the Department, in consultation with representatives of local social service districts and advocacy groups, has developed a simplified renewal form, which can be generated through the Client Notices Subsystem (CNS) and a companion manual form to be used in situations where CNS is not available. (Attachments A and B). The new forms request only that recipient information that is reasonably necessary to continue eligibility and is subject to change since the date of the recipient's initial application or last renewal.

This form will be used for most Medicaid/Family Health Plus and Child Health Plus A recipients. The exceptions to this are the following:

- Persons renewing for chronic care: Upstate Districts continue to use the LDSS-4411: "Recertification for Medical Assistance (Chronic Care)". This includes all chronic care recipients regardless of whether they are single or married, with or without dependent family members. In NYC, the W-589 is used when renewing for chronic care Medicaid. A personal interview is not required.
- Specified Low-Income Medicare Beneficiaries (SLIMBs): These individuals use the LDSS 4592 (Rev. 5/02) to renew. A personal interview is not required.
- Qualified Individuals (QI-1s): These recipients use the one-page Medicare Savings Program Re-enrollment form (See 99 GIS/MS 037). A personal interview is not required.
- Persons eligible for the Family Planning Benefit Program. A renewal form for this population is under development.

The statute requires the elimination of the face-to-face interview and the simplified renewal form to be implemented by April 1, 2003.

IV. REQUIRED ACTION

A. Renewal Process

Each month, districts produce reports of cases due for renewal, generally at least 60 days prior to the date coverage expires. Beginning April 1, 2003, a face-to-face interview will no longer be required to complete the renewal process. In lieu of the current CNS process for scheduling interviews, a new renewal package, including a cover notice and renewal form, has been programmed into CNS. The new renewal package will be used for all Medicaid, Family Health Plus, and Child Health Plus A recipients except those described in Section III of this Directive.

As with other CNS notices, the cover notice (Attachment C) contains a heading, which will include local social services district and case specific identifiers as well as contact phone numbers. It advises the recipient that coverage is expiring and explains the need for the recipient to provide current information and documentation to the local district in order for coverage to continue. A deadline for returning this information, and the address to send it to, is determined by each local district.

In an effort to minimize the amount of information the recipient must provide, and to reduce duplicative documentation, the renewal form has been developed to pre-print information from the Medicaid Budget Logic (MBL) and Welfare Management System (WMS). The form provides space for the recipient to amend the pre-printed information and provide new information, when appropriate.

Included in the renewal package will be a documentation checklist, a voter registration form and a pamphlet explaining the Child/Teen Health Program. The signature page includes the Terms, Rights and Responsibilities.

When appropriate, the phone numbers for locating community-based organizations and health plans that provide assistance will be included in the cover notice. It is the responsibility of the recipient to return the renewal form and the required documentation to the local social services district by the deadline provided. However, some individuals may seek assistance from facilitated enrollers in completing the renewal form. Local districts are encouraged to work with their lead agencies to amend their facilitated enrollment protocols as necessary to support the new renewal process.

SSI-related recipients will also use the new renewal form. However, the cover notice (Attachment D) will not contain the toll free phone number for facilitated enroller assistance. The SSI-related person is instructed to return the renewal form directly to the social services district.

B. Content of Form

This section describes the renewal form and outlines required district actions to complete the renewal process.

Question 1 will pre-print the demographic information of active household members as recorded in WMS. The pre-printed information will include the name, date of birth and a program code. The program code will indicate the program that each individual is enrolled in (i.e., Medicaid, Family Health Plus, Child Health Plus A or the Medicare Savings Program). The recipient is instructed to make any changes to incorrect demographic information in the spaces provided.

The social security number (SSN) field will contain the words "On-File" if the individual's SSN is recorded in WMS. If the SSN is not recorded in WMS the words "Not On-File" will print.

The recipient is instructed that if his/her social security number is not on file, the number should be hand-written in the space provided on the form. It further instructs that if a person is pregnant or does not have an SSN due to his/her immigration status, an SSN does not have to be provided. Persons who are undocumented, or who have been refused an SSN by the Social Security Administration, do not need to provide an SSN.

Questions 2 and 3a are designed to capture changes in household size and to identify any other household members who are not in receipt of assistance but are able to be counted in the recipient's household size.

Question 3b allows the recipient to indicate if such household member wishes to apply for health care benefits. Districts will be allowed to determine eligibility for such person without a face-to-face interview. The recipient is instructed to send proof of the person's date of birth and citizenship or immigration status and must include the person's income and/or resources, if appropriate, when completing the remainder of the renewal form. Further details about adding new household members at renewal are provided in Section IV.E. of this Directive.

Question 4 asks if anyone in the household is pregnant. If yes, and this is a previously unreported pregnancy, the individual is instructed to provide an expected date of delivery and medical verification. If obtaining medical verification would delay the pregnant woman from renewing on time, the woman will be allowed to forward the medical statement at a later date. However, the unborn cannot be added to the case until medical verification is received. Districts are encouraged to follow up with the woman if the documentation is not received within 30 days.

In the event the pregnant woman would not be eligible without the addition of the unborn, the district must contact the woman immediately and advise her that assistance cannot continue unless her pregnancy is verified.

Family Health Plus eligible women who indicate that they are pregnant at the time of renewal must be counseled about the choice to remain in Family Health Plus, or to change coverage to Medicaid. Districts are responsible for completing this counseling requirement and taking appropriate action to authorize the pregnant woman and her unborn in a Case Type 20. The renewal process should not be delayed while this counseling occurs.

Questions 5 and 6 ask about any changes to address or housing expenses. The recipient must document any change in address.

Question 7a asks if the citizenship or immigration status of anyone

renewing has changed. If the recipient answers yes, s/he is instructed to send in proof from the Immigration and Naturalization Service (INS) showing the person's current status. **Question 7b** will only be printed if applicable. It lists the names of anyone in the household who must send current proof of immigration status from the INS. The names of these individuals will be printed on the form based on the presence of a Citizenship/Alien Status Code of "T" in WMS. Individuals with code "T" are those individuals who previously documented that they were paroled into the United States for less than one year. Such individuals must prove their current immigration status at renewal.

Note: If a woman who was pregnant at the time of application did not document citizenship or immigration status, she must do so at the first renewal after delivery. If the woman returns the renewal form without documentation, the district must contact her to obtain documentation of her citizenship or immigration status as part of her renewal process. If a woman fails to comply, her coverage can be terminated with timely and adequate notice. Her infant, however, remains eligible until the infant's first birthday. The child will be given the opportunity to renew prior to expiration of his/her eligibility.

In **Question 8**, the amount of previously reported earned and unearned income, as well as related expenses, such as adult/child care expenses, court-ordered child support, health insurance and Medicare expenses, are pre-printed on the renewal form. These amounts are extracted from the recipient's stored MBL budget. In this question, the recipient is instructed to record current income and expenses and to send in proof of the income and expenses with the renewal form. In the event there is no stored MBL budget in the system, the recipient is instructed to provide current information regarding income and expenses and submit proof.

The next section of the renewal form, questions 9, 10 and 11, are required to be completed by the recipient only when changes in circumstances have occurred. If no change has occurred or the situation does not apply to the household, the recipient is directed to check the box that says "Does Not Apply".

Question 9 asks if anyone has lost or has acquired new health insurance since the time of the last application or renewal. If new insurance has been acquired, the recipient is instructed to attach a copy of the insurance card or policy.

Questions 10a and **b** request information about any absent parent/spouse for the purpose of pursuing medical support. Question 10a asks about any legally responsible relative who may have moved out of the home since the last renewal. In the event the recipient is not willing to provide the requested information, the recipient is asked if there is good cause not to contact the absent parent/spouse. If the recipient claims good cause, the district must follow existing procedures as described in Administrative Directive 99 ADM-5, to determine the validity of the claim, but must not delay processing the renewal. Question 10b asks if there is any new information known about an absent parent/spouse.

Note: Women who were pregnant at the time of application may not have previously provided information needed for the district to establish paternity or pursue medical support from an absent parent

or spouse. At the first renewal after delivery, when the woman returns the renewal form, the district must contact the woman to obtain such information or establish if there is good cause not to pursue medical support. If the woman fails to comply without good cause, her coverage can be terminated, with timely and adequate notice. Her infant, however, remains eligible until the infant's first birthday. The child will be given the opportunity to renew prior to expiration of his/her eligibility.

Question 11a requests information from blind and/or disabled recipients about any special non-medical, work-related expenses. If the recipient has such expenses, s/he is instructed to send in receipts.

Question 11b asks if any recipients may now have a serious health problem, so that the local social services district can decide if a disability determination should be undertaken.

Question 11c asks the recipient about any potential third-party benefits that may be available to him/her such as worker's compensation, or no-fault payments. It also serves to identify pending lawsuits.

Question 12 addresses resources. The information to be printed in this section will vary depending upon the Case Type and coding present in MBL.

For recipients in Case Type 24 (Family Health Plus) when a Resource Code of 91 (Resources above the MA level/Determine FHP) is present in the resource field in MBL, the following message will be printed:

When you last applied/renewed, you stated that the total value of your resources was above the Medicaid resource level for your family size. If the value of your resources has gone down (decreased) and you would like a determination of Medicaid eligibility, contact your worker. In the meantime, **if you return this form by the deadline and are found to be otherwise eligible**, your coverage will be renewed.

When this message is printed, districts may assume, unless contacted by the recipient, that the recipient's resources remain above the Medicaid level for the household size and must determine eligibility based on the documented income and other responses on the form.

For recipients in Case Type 24 when the resource field in MBL contains a code other than 91 or is blank, the following message will be printed:

You do not need to provide resource information at this time. We will contact you if we need resource information.

When this message is printed, the district's action will depend upon the documented household income. If such income is above the Medicaid level for the household, but at or below the Family Health Plus level, no further action is required. However, if documented income is now below the Medicaid level, the recipient will need to be contacted to obtain information regarding the amount and type of his/her current resources. If the recipient indicates resources below the Medicaid level, the recipient must document any such resources.

For recipients in Case Type 20 (Medicaid), the type of resource and value as stored in MBL will be printed on the form. The printed message

instructs the recipient to update this information and list all resources and their current value in the spaces provided. Medicaid recipients must provide proof of their resources. In the event there is no stored MBL budget in the system, the recipient is instructed to provide current resource information and submit proof.

The final section of the renewal form contains the Terms, Rights and Responsibilities, signature lines, and an "Office Use Only" section for local district signatures and case disposition.

Also included in the renewal package will be a documentation checklist containing instructions for the recipient about what documents are necessary to support responses on the renewal form. Inserted in the package prior to mailing will be the NVRA-05, NYS Agency-Based Voter Registration Form and the DOH Publication 0575, "Child/Teen Health Program."

The recipient is instructed to return the completed renewal form, with appropriate signatures and documents, to the local social services district prior to the due date printed on the cover letter. In the event a recipient contacts the district prior to case expiration or within 30 days of the case closure for failure to recertify, claiming his/her renewal form was not received, or was lost, districts will have the ability to produce an exact copy of the renewal notice and pre-printed information through the Computer Output to Laser Disc (COLD) application. Districts may use this form, with appropriate documentation to reopen a case closed within the past 30 days.

In the event the recipient returns the renewal form prior to the deadline, but the form is incomplete or is missing documentation, districts must give the recipient an opportunity to submit the missing information or documentation. If the recipient fails to comply, coverage can be terminated with timely and adequate notice.

C. Renewal Reminder Letter

As part of the renewal process, a renewal reminder letter is sent to remind the recipient of the importance of completing the renewal process before coverage expires. CNS generates this reminder letter automatically, without any worker entry, 15 days following the mailing of the renewal package by the district. (Attachment E)

D. Manual Renewal Form

There may be situations in which the CNS Renewal process is not appropriate. For example, many districts handle the renewal process for foster care children internally through their Children's Services Units. To address these situations, the Department has developed a manual renewal form, similar in content to the CNS renewal form. This manual form may also be used to determine on-going eligibility for SSI-cash recipients when SSI payments are discontinued. Districts are reminded that such recipients should only be required to complete a Medicaid renewal when the information on the State Data Exchange (SDX) is insufficient to make a valid eligibility determination, in accordance with 80 ADM-19.

The form attached to this Directive must be reproduced without modification until supplies are available from this Department. Districts

will be notified when this form is available.

E. Adding Family Members to the Renewing Household

As discussed in Section IV. B., districts will be allowed to add family members (spouse, parent or child under age 21) to an existing case without a face-to-face interview. However, certain other procedural requirements must still be fulfilled prior to the individual being added to the case.

1. Drug/Alcohol Screening Requirement

Pursuant to OMM/ADM 97-2, single adults and childless couples who are subject to the Drug and Alcohol screening, assessment and treatment requirements must fulfill these requirements as a condition of eligibility for Medicaid. The LDSS 4571, Alcohol/Substance Abuse Screening Assessment (Rev 6/01), may be mailed to the individual with instructions to return the form to the district. Failure to return the form will result in a denial of the individual's application. This is not a requirement for individuals who are financially eligible for FHPlus.

2. Health Plan Selection for Managed Care

When adding a new FHPlus eligible adult to an existing case, the district is required to mail the applicant a managed care enrollment package and allow him/her a reasonable amount of time to pick a health plan. This person should be registered in WMS as applying, but cannot be added to the case until a health plan has been chosen. The renewal of other active family members should not be delayed. In the event the enrollment form is received after the start of the family's new authorization period, the authorization dates of the new family member should be aligned with the existing case when the enrollment form is received, even if this results in less than 12 months of coverage for the newly added member. If the new FHPlus applicant fails to return the enrollment form s/he should be sent a denial notice.

When adding a new person to an existing Medicaid case in a mandatory managed care county, if the person is not known to be exempted or excluded from Medicaid managed care, s/he will be enrolled in the same health plan as the other family members and notified of such. (See Section IV.G of this directive).

3. Photo Identification and Finger Imaging

Persons subject to the Photo Identification and Finger Imaging requirements do not have to meet these requirements before being added to the case. These requirements must be fulfilled upon the next in-person contact with the district.

F. Temporary Assistance/Food Stamp Implications

1. Temporary Assistance (TA) Recipients

The elimination of a face-to-face interview requirement for Medicaid and Child Health Plus A (CHPlus A) renewal necessitates some changes to the TA recertification process when the TA recipient is also in receipt of Medicaid or CHPlus A. Persons who fail to complete the

face-to-face interview requirement for TA must not have their Medicaid benefits terminated, as this is no longer a Medicaid and CHPlus A requirement.

Effective with the March 24, 2003 WMS migration, Upstate WMS has been modified so the closing of a TA case for failure to comply with the recertification process will generate a six-month extension of Medicaid benefits from the date of the TA closing. A Medicaid redetermination will not be required until the end of this six-month period. At that time, the case will be cycled into the regular Medicaid CNS renewal process. (Note: Since there will be no stored MBL budget for such cases, the information regarding income and resources will not be printed on the renewal form).

New York City WMS will be modified in the near future to provide a Medicaid extension upon the TA closing.

Some social services districts have a waiver from the six-month face-to-face recertification for some TA groups. For households in waiver groups, the TA head of household must complete a mailer at the six-month interval between the required once yearly face-to-face recertifications. Failure to return the recert mailer will result in a TA case closing. TA cases that are closing for failure to return the recert mailer must be continued on Medicaid. This is because Medicaid requires only one recertification in a twelve-month period and the TA case being closed for failure to return the recert mailer will have been recertified within the past six months.

Changes to the TA call-in letters and Medicaid insert language for the TA closing notices have been made to advise recipients that a face-to-face interview is not required to continue Medicaid. Recipients are reminded that they must report any changes in address, income, resources, or household size to the local social services district.

2. Food Stamp Recipients

For local districts that have Food Stamp/Medicaid (FSMA) units, current food stamp recertification procedures require a face-to-face interview. Districts may use such interview to satisfy the Medicaid renewal. However, if a person receiving food stamps and Medicaid fails to appear for the food stamp face-to-face interview, resulting in the closing of the food stamp case, the Medicaid case cannot be closed for this reason. The Medicaid case must be continued until the next scheduled Medicaid renewal date, or if the dates coincide, the Medicaid recipient must be provided an opportunity to comply with the Medicaid renewal process.

G. Managed Care

Pursuant to 02 OMM/ADM 06, a Medicaid adult who at the time of renewal is found FHPlus eligible, and is currently enrolled in a Medicaid managed care plan that is also a FHPlus plan, will remain enrolled in the same plan. The Coverage Code must be changed to FHPlus coverage and the Case Type must be changed to Case Type 24. In addition, the Prepaid Capitation Program (PCP) subsystem must be updated with a new enrollment line using the benefit package code "70."

If the individual is not currently enrolled in a FHPlus participating plan, s/he must be provided an opportunity to choose a FHPlus plan. See instructions contained in the WMS Coordinator letter dated July 15, 2002.

FHPlus adults who are found Medicaid eligible at the time of renewal will remain in the same managed care plan if the plan provides both FHPlus and Medicaid managed care. There is no need to offer a new choice. If the individual is excluded from Medicaid managed care, the individual must be provided fee-for-service coverage. Exempt individuals may request an exemption and disenrollment. Persons whose exemptions are approved will be disenrolled prospectively. The PCP subsystem must also be updated with a new enrollment line using the appropriate benefit package code. The district must ensure no lapse in coverage occurs during these transitions.

H. Frequency of Renewals

Federal regulations at 42 CFR 435.916 require States to re-determine eligibility at least once every 12 months, with respect to circumstances that may change. State legislation for the Family Health Plus program requires that renewal take place no more than once annually. Local social services districts are reminded that Department policy also requires renewal for Medicaid, and Child Health Plus A only once annually.

Federal regulations also require States to establish procedures for timely and accurate reporting of any change in circumstances that may impact an individual's or family's eligibility. States must conduct an eligibility review based on such changed circumstances. The Centers for Medicare and Medicaid Services (CMS) has recently clarified that States may, at their option, treat this review of changed circumstances as a full eligibility review, and such review could constitute a re-determination for purposes of meeting the Federal requirement that eligibility be determined at least once every 12 months. No additional re-determination is required until a year from the date that the State considered the reported change, unless another change is reported.

Effective with the release of this Directive, the Department is adopting this policy for persons other than those receiving chronic care. Thus, districts may treat an eligibility determination completed as a result of an individual or family reporting a change in circumstances as a renewal, and may extend the authorization of the individual or family for 12 months from the date of the re-determination. This process will ease local social services district administrative processes and will serve to keep renewal dates for children under age 19, who are entitled to 12 months of continuous coverage at every re-determination, aligned with the eligibility dates of other household members.

V. WMS IMPLICATIONS

A. Upstate

1. WMS

Effective with the March 24, 2003 migration, the WMS separate determination process has been modified to extend Medicaid coverage for six months from the date of a TA closing for failure to comply with the TA

recertification process. Districts are not required to take any further action on such cases until the case appears on their Medicaid renewal report, unless the recipient reports a change in circumstances. Note: Because there will be no MBL budget stored for these Medicaid cases, the renewal form will not print information about income and/or resources.

2. CNS Renewal Process

The CNS system has been modified to support the simplified renewal process. The following is a description of the changes.

CNS will support the simplified renewal process by use of new batch renewal codes of Z61 for the general population, and Z62 for SSI-Related individuals. CNS will automatically generate a renewal reminder letter (listed as Z63 in Notice History), 15-days after the renewal package is sent to the recipient.

Note: Districts are reminded that, in situations where there exists a Case Type 20 and a Case Type 24 for members of the same household, two renewal packages/forms will be generated. Each form will contain the pre-printed information for the individuals in each case. Pursuant to the WMS Coordinator letter dated October 31, 2002, districts now have the ability to combine expanded eligible children with their parents in a Case Type 24. Combining parents and children in a Case Type 24 will ensure families receive only one renewal form.

The CNS Reason Code Z44 currently used to produce a renewal package, for FHPlus recipients will be replaced with the new reason code, Z61. In addition, the following Reason Codes will now be obsolete: Z30, Z31, Z32, Z33, Z34, Z35, Z36, Z37, Z38, Z40, Z41, and Z42.

Reason Code Z39 continues to be available for Chronic Care renewals. Reason Code Z46 remains available for SLIMBs renewals.

For other than chronic care recipients, in the event that a recipient claims his/her renewal package was not received or was lost, districts have the ability to print a copy of the recipient's Renewal notice and form by using the COLD application.

3. Notice Changes

a) Medicaid

The following closing notices will become obsolete as a result of the mail-in renewal process:

Reason Codes: V10 Failure to appear for Interview Appointment with Agency.
U10 Failure to Comply with Recertification Interview Procedures.
S23 Failure to Comply with Recertification Interview Procedures, Discontinue Mother, Infant Continues.

The existing CNS discontinuance reason code F10 should be used when the recipient fails to return the renewal form and will be allowed at

the individual level.

The LDSS-4023, "Notice Of Intent To Discontinue For Failure To Comply With Recertification Procedures," will be modified to omit the language discontinuing Medicaid for failure to appear for an interview. This notice may continue to be used to discontinue Medicaid for failure to return the renewal form and/or documentation.

b) Temporary Assistance

New Medicaid insert language has been developed to accompany TA closing notices for failure to comply with the TA recertification process. It tells the recipient that although his/her TA case has been closed, the Medicaid benefit will continue unchanged. It also advises the recipient to report any changes in address, income, resources or household size to the social services district.

The language in CNS call-in notices (Reason Codes Z20, Z21, Z25, Z80 and Z81) have been modified to explain that although the TA case will be closed if the recipient does not complete the face-to-face interview, the Medicaid benefit will continue.

The LDSS-2114, (PA Call-In) "Continuing Your Public Assistance, Medical Assistance and Food Stamp Benefits", has been modified to omit language instructing the recipient to appear for a face-to-face interview in order to continue Medicaid benefits. It explains that a face-to-face interview is not required and benefits will continue unchanged; however, the recipient is responsible for reporting any changes in address, income or household size to the district. This notice may continue to be used to schedule an appointment to review TA and Food Stamp eligibility.

B. New York City

New York City has approved local equivalent renewal forms and processes.

VI. EFFECTIVE DATE

This directive is effective April 1, 2003.

Kathryn Kuhmerker
Deputy Commissioner
Office of Medicaid Management