



**NEW YORK STATE
DEPARTMENT OF HEALTH
OFFICE OF THE MEDICAID INSPECTOR GENERAL**

**REVIEW OF WARRENSBURG HEALTH CENTER
CLAIMS FOR DIAGNOSTIC AND TREATMENT CENTER SERVICES
PAID FROM
JANUARY 1, 2007 – DECEMBER 31, 2009**

FINAL AUDIT REPORT

**James G. Sheehan
Medicaid Inspector General**

May 10, 2011



STATE OF NEW YORK
OFFICE OF THE MEDICAID INSPECTOR GENERAL
800 North Pearl Street
Albany, NY 12204

ANDREW M. CUOMO
GOVERNOR

JAMES G. SHEEHAN
MEDICAID INSPECTOR GENERAL

May 10, 2011

[REDACTED]
Warrensburg Health Center
9 Carey Road
Queensbury, NY 12804

Re: Final Audit Report
Audit #: 10-2242

Dear [REDACTED]

Enclosed is the Office of the Medicaid Inspector General (OMIG) final audit report entitled "Review of Warrensburg Health Center" (Warrensburg) paid claims for Diagnostic and Treatment Center services covering the period January 1, 2007, through December 31, 2009.

In the attached final audit report, the OMIG has detailed our objectives and scope, procedures, laws, regulations, rules and policies, sampling technique, findings, provider rights, and statistical analysis.

The OMIG has attached the sample detail for the paid claims determined to be in error. This final audit report incorporates consideration of any additional documentation and information presented in response to the draft audit report dated February 7, 2011. The mean point estimate overpaid is \$1,683,080. The lower confidence limit of the amount overpaid is \$1,181,060. We are 95% certain that the actual amount of the overpayment is greater than the lower confidence limit. This audit may be settled through repayment of the lower confidence limit of \$1,181,060.

[REDACTED]
Page 2
May 10, 2011

If Warrensburg has any questions or comments concerning this final audit report, please contact [REDACTED] at [REDACTED] or through email at [REDACTED]. Please refer to report number 10-2242 in all correspondence.

Sincerely,

[REDACTED]

Director of Provider Audit
Bureau of Fee for Service Audit
Office of the Medicaid Inspector General

[REDACTED]
Enclosure

CERTIFIED MAIL # [REDACTED]
RETURN RECEIPT REQUESTED

OFFICE OF THE MEDICAID INSPECTOR GENERAL

www.omig.ny.gov

The mission of the Office of the Medicaid Inspector General (OMIG), as mandated by New York Public Health Law § 31 is to preserve the integrity of the New York State Medicaid program by preventing and detecting fraudulent, abusive and wasteful practices within the Medicaid program and recovering improperly expended Medicaid funds.

DIVISION OF MEDICAID AUDIT

The Division of Medicaid Audit professional staff conducts audits and reviews of Medicaid providers to ensure compliance and program requirements and, where necessary, to recover overpayments. These activities are done to monitor the cost-effective delivery of Medicaid services for prudent stewardship of scarce dollars; to ensure the required involvement of professionals in planning care to program beneficiaries; safeguard the quality of care, medical necessity and appropriateness of Medicaid services provided; and, to reduce the potential for fraud, waste and abuse.

DIVISION OF MEDICAID INVESTIGATIONS

The Division of Medicaid Investigations (DMI) investigates potential instances of fraud, waste, and abuse in the Medicaid program. DMI deters improper behavior by inserting covert and overt investigators into all aspects of the program, scrutinizing provider billing and services, and cooperating with other agencies to enhance enforcement opportunities. Disreputable providers are removed from the program or prevented from enrolling. Recipients abusing the system are not removed from this safety net, but their access to services is examined and restricted, as appropriate. DMI maximizes cost savings, recoveries, penalties, and improves the quality of care for the state's most vulnerable population.

DIVISION OF TECHNOLOGY AND BUSINESS AUTOMATION

The Division of Technology and Business Automation will continue to support the data needs for the OMIG in the form of audit and investigative support, data mining and analysis, system match and recovery, through the use of commercial data mining products and procurement of expert service consultants.

OFFICE OF COUNSEL TO THE MEDICAID INSPECTOR GENERAL

The Office of Counsel to the Medicaid Inspector General promotes the OMIG's overall statutory mission through timely, accurate and persuasive legal advocacy and counsel.

EXECUTIVE SUMMARY

BACKGROUND

Pursuant to Title XIX of the Social Security Act, the Medicaid program provides medical assistance to low-income individuals and individuals with disabilities. The federal and state governments jointly fund and administer the Medicaid program. In New York State, the Department of Health (DOH) administers the Medicaid program. As part of this responsibility, the OMIG conducts audits and reviews of various providers of Medicaid reimbursable services, equipment and supplies. These audits and reviews are directed at ensuring provider compliance with applicable laws, regulations, rules and policies of the Medicaid program as set forth by the Departments of Health and Mental Hygiene [Titles 10, 14 and 18 of the Official Compilation of Codes, Rules and Regulations of the State of New York] and the Medicaid Provider Manuals.

A diagnostic and treatment center is a medical facility with one or more health services which is not part of an inpatient hospital facility or vocational rehabilitation center. It is primarily engaged in providing services and facilities to out-of-hospital or ambulatory patients by or under the supervision of a physician or dentist, for the prevention, diagnosis or treatment of human disease, pain, injury, deformity or physical condition. A diagnostic and treatment center is certified in accordance with Article 28 of the NYS Public Health Law and/or Article 31 of the Mental Hygiene Law to provide such services on an outpatient basis. The specific standards and criteria for diagnostic and treatment center services are principally found in various parts of 10 NYCRR Chapter V and 18 NYCRR Chapter II, as well as the MMIS Provider Manual for Clinics.

OBJECTIVE AND SCOPE

The objective of our audit was to ensure Warrensburg compliance with applicable federal and state laws, regulations, rules and policies governing the New York State Medicaid Program. With respect to Diagnostic and Treatment Center services, our audit covered services paid by Medicaid from January 1, 2007, through December 31, 2009.

SUMMARY OF FINDINGS

We inspected a random sample of 200 services with \$16,955.85 in Medicaid payments. Of the 200 services in our random sample, 71 services had at least one error and did not comply with state requirements. Of the 71 noncompliant services, some contained more than one deficiency. Specifics are as follows:

<u>Error Description</u>	<u>Number of Errors</u>
Incorrect Servicing Provider on Claim	33
Threshold Visit Billed for Services Rendered in Long Term Care Facility	17
Missing Documentation	14
Claims Submitted Over 90 Days From the Date of Service	11
Incorrect PAC Rate Code	5
Medical Entry Not Signed	2
Threshold Visit Billed for Non-Reimbursable Service	2
No Documented Medical Service	1
Ordered Ambulatory Service Billed as a Threshold Visit	1

Based on the procedures performed, the OMIG has determined Warrensburg was overpaid \$5,355.64 in sample overpayments with an extrapolated point estimate of \$1,683,080. The lower confidence limit of the amount overpaid is \$1,181,060.

TABLE OF CONTENTS

	<u>PAGE</u>
INTRODUCTION.....	
Background	
Medicaid Program	1
New York State's Medicaid Program	1
New York State's Diagnostic and Treatment Center Program	1
Objective, Scope, and Methodology	
Objective	2
Scope	2
Methodology	2
LAWS, REGULATIONS, RULES AND POLICIES.....	3-4
DETAILED FINDINGS.....	5-9
PROVIDER RIGHTS.....	10
REMITTANCE ADVICE	
ATTACHMENTS:	
A – SAMPLE DESIGN AND METHODOLOGY	
B – SAMPLE RESULTS AND ESTIMATES	
C – DETAILED AUDIT FINDINGS	

INTRODUCTION

BACKGROUND

Medicaid Program

Pursuant to Title XIX of the Social Security Act, the Medicaid program provides medical assistance to low-income individuals and individuals with disabilities. The Federal and State governments jointly fund and administer the Medicaid program.

New York State's Medicaid Program

In New York State, the Department of Health (DOH) is the State agency responsible for operating the Medicaid program. Within DOH, the Office of Health Insurance Programs administers the Medicaid program. DOH uses the electronic Medicaid New York Information system (eMedNY), a computerized payment and information reporting system, to process and pay Medicaid claims, including Diagnostic and Treatment Center claims.

As part of this responsibility, the OMIG conducts audits and reviews of various providers of Medicaid reimbursable services, equipment and supplies. These audits and reviews are directed at ensuring provider compliance with applicable laws, regulations, rules and policies of the Medicaid program as set forth by the Departments of Health and Mental Hygiene [Titles 10, 14 and 18 of the Official Compilation of Codes, Rules and Regulations of the State of New York] and the Medicaid Provider Manuals.

New York State's Diagnostic and Treatment Center Program

A diagnostic and treatment center is a medical facility with one or more health services which is not part of an inpatient hospital facility or vocational rehabilitation center. It is primarily engaged in providing services and facilities to out-of-hospital or ambulatory patients by or under the supervision of a physician or dentist, for the prevention, diagnosis or treatment of human disease, pain, injury, deformity or physical condition. A diagnostic and treatment center is certified in accordance with Article 28 of the NYS Public Health Law and/or Article 31 of the Mental Hygiene Law to provide such services on an outpatient basis. The specific standards and criteria for diagnostic and treatment center services are principally found in various parts of 10 NYCRR Chapter V and 18 NYCRR Chapter II, as well as the MMIS Provider Manual for Clinics.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

The objective of our audit was to ensure Warrensburg compliance with applicable Federal and State laws, regulations, rules and policies governing the New York State Medicaid Program and to verify that:

- Medicaid reimbursable services were rendered for the dates billed;
- appropriate rate or procedure codes were billed for services rendered;
- patient related records contained the documentation required by the regulations; and,
- claims for payment were submitted in accordance with DOH regulations and the appropriate Provider Manuals.

Scope

Our audit period covered payments to Warrensburg for Diagnostic and Treatment Center services paid by Medicaid from January 1, 2007, through December 31, 2009. Our audit universe consisted of 123,978 claims totaling \$10,579,746.81.

During our audit, we did not review the overall internal control structure of Warrensburg. Rather, we limited our internal control review to the objective of our audit.

Methodology

To accomplish our objective, we:

- reviewed applicable federal and state laws, regulations, rules and policies;
- held discussions with Warrensburg management personnel to gain an understanding of the Diagnostic and Treatment Center program;
- ran computer programming application of claims in our data warehouse that identified 123,978 paid diagnostic and treatment center claims, totaling \$10,579,746.81;
- selected a random sample of 200 services from the population of 123,978 services; and,
- estimated the overpayment paid in the population of 123,978 services.

For each sample selection we inspected, as available, the following:

- Medicaid electronic claim information
- Patient record, including, but not limited to:
 - Practitioner's Medical Orders;
 - Hospital Patient Medical Records;
 - Long Term Residential Care Patient Medical Records
 - Third Party Payor EOBs; and,
- Any additional documentation deemed by Warrensburg necessary to substantiate the Medicaid paid claim.

LAWS, REGULATIONS, RULES AND POLICIES

The following are applicable Laws, Regulations, Rules, and Policies of the Medicaid program referenced when conducting this audit:

- Departments of Health and Mental Hygiene [Titles 10, 14, and 18 of the Official Compilation of Codes, Rules and Regulations of the State of New York (10 NYCRR, 14 NYCRR, 18 NYCRR)].
- Medicaid Management Information System and eMedNY Provider Manual.
- Specifically, MMIS Provider Manual for Clinics, Public Health Law Article 28, Medicaid Updates June 2002 and October 2009, 10 NYCRR Parts 86-4 and 751, and 18 NYCRR Parts 504, 505, 517, and 540.
- In addition to any specific detailed findings, rules and/or regulations which may be listed below, the following regulations pertain to all audits:

Regulations state: "By enrolling the provider agrees: (a) to prepare and to maintain contemporaneous records demonstrating its right to receive payment . . . and to keep for a period of six years from the date the care, services or supplies were furnished, all records necessary to disclose the nature and extent of services furnished and all information regarding claims for payment submitted by, or on behalf of, the provider . . . (e) to submit claims for payment only for services actually furnished and which were medically necessary or otherwise authorized under the Social Services Law when furnished and which were provided to eligible persons; (f) to submit claims on officially authorized claim forms in the manner specified by the department in conformance with the standards and procedures for claims submission; . . . (h) that the information provided in relation to any claim for payment shall be true, accurate and complete; and (i) to comply with the rules, regulations and official directives of the department."
18 NYCRR Section 504.3

Regulations state: "All bills for medical care, services and supplies shall contain: . . . (8) a dated certification by the provider that the care, services and supplies itemized have in fact been furnished; that the amounts listed are due and owing . . . ; that such records as are necessary to disclose fully the extent of care, services and supplies provided to individuals under the New York State Medicaid program will be kept for a period of not less than six years from the date of payment . . . ; and that the provider understands that payment and satisfaction of this claim will be from Federal, State and local public funds and that he or she may be prosecuted under applicable Federal and State laws for any false claims, statements or documents, or concealment of a material fact provided. . . ."

18 NYCRR Section 540.7(a)

Regulations state: "An overpayment includes any amount not authorized to be paid under the medical assistance program, whether paid as the result of inaccurate or improper cost reporting, improper claiming, unacceptable practices, fraud, abuse or mistake."
18 NYCRR Section 518.1(c)

Furthermore, according to regulations, all providers must prepare and maintain contemporaneous records demonstrating their right to receive payment under the medical assistance program. In addition, the provider must keep, for a period of six years, all records necessary to disclose the nature and extent of services furnished and the medical necessity therefore, including any prescription or fiscal order for the service or supply. This information is subject to audit for a period of six years and must be furnished, upon request.

18 NYCRR Section 517.3(b)

DETAILED FINDINGS

The OMIG's review of Medicaid claims paid to Warrensburg from January 1, 2007, through December 31, 2009, identified 71 claims with at least one error, for a total sample overpayment of \$5,355.64 (Attachment C).

Sample Selection

1. Incorrect Servicing Provider on Claim

Regulations state, "By enrolling the provider agrees ... that the information provider in relation to any claim for payment shall be true, accurate and complete; and comply with the rules, regulations and official directives of the department."

The June, 2002 Medicaid Update states that the Office of the Medicaid Management activated a series of edits that require the identification of servicing and referring practitioners. These edits verify that the practitioner's license or MMIS provider ID numbers reported on clinic claims are accurate and legitimate.

18 NYCRR Section 504.3(h)(i) and Medicaid Update, June 2002, Volume 17, Number 6, Page 3

In 33 instances pertaining to 33 patients, the servicing practitioner was not accurately identified. The servicing practitioner's name on the 33 claims did not match the name of the practitioner who signed the medical entry.

11, 15, 19, 24, 25, 29, 47, 48, 60, 76, 78, 92, 96, 99, 103, 119, 124, 126, 130, 132, 135, 137, 147, 150, 160, 163, 167, 172, 174, 183, 185, 187, 194

2. Threshold Visit Billed for Services Rendered in Long Term Care Facility

Regulations state, "FQHC offsite services must...not be rendered in a nursing facility or long term care facility, to any patient expected to remain a patient in that facility or at that level of care."

10 NYCRR Section 86-4.9(v)

In 17 instances pertaining to 16 patients, a threshold visit was incorrectly billed for a service rendered in a long term care facility.

20, 34, 37, 38, 39, 42, 59, 64, 98, 108, 125, 131, 147, 158, 176, 198, 199

Sample Selection

3. Missing Documentation

1, 28, 31, 38, 47, 89, 97, 113, 131,
133, 157, 166, 168, 198

Regulations require that the Medicaid provider agrees, "to prepare and to maintain contemporaneous records demonstrating its right to receive payment under the medical assistance program and to keep for a period of six years...all records necessary to disclose the nature and extent of services furnished..."

Regulations also require that bills for medical care, services, and supplies contain a certification that such records as are necessary to disclose fully the services provided to individuals under the New York State Medicaid program will be kept for a period of not less than six years. These records must be furnished to the Department upon request.

18 NYCRR 504.3(a)
18 NYCRR 540.7(a)(8) and
18 NYCRR 517.3(b)(1)

In 14 instances pertaining to 14 patients, the services were not documented. Of these services, we found 6 instances pertaining to 6 patients where the medical record did not contain an entry to support services billed. In 6 instances pertaining to 6 patients, the case record did not contain documentation verifying that a physical examination was completed. In 2 instances pertaining to 2 patients, the case record did not contain documentation verifying that a brief provider assessment was completed.

4. Claims Submitted Over 90 Days From the Date of Service

3, 34, 36, 38, 65, 89, 108, 113, 129,
153, 181

Regulations state, "Claims for payment for medical care, services or supplies furnished by any provider under the medical assistance program must be initially submitted within 90 days of the date the medical care, services or supplies were furnished to an eligible person to be valid and enforceable against the department or a social services district, unless the provider's submission of the claims is delayed beyond 90 days due to circumstances outside of the control of the provider. Such circumstances include but are not limited to attempts to recover from a third-party insurer, legal proceedings against a responsible third-party or the

Sample Selection

recipient of the medical care, services or supplies or delays in the determination of client eligibility by the social services district. All claims submitted after 90 days must be accompanied by a statement of the reason for such delay and must be submitted within 30 days from the time submission came within the control of the provider, subject to the limitations of paragraph (3) of this subdivision. (2) Any claim returned to a provider due to data insufficiency or claiming errors may be resubmitted by the provider upon proper completion of the claim in accordance with the claims processing requirements of the department within 60 days of the date of the notification to the provider advising the provider of such insufficiency or invalidity. Any returned claim not correctly resubmitted within 60 days or on the second resubmission is neither valid nor enforceable against the department or a social services district."

The MMIS Provider Manual states, "Medicaid regulations require that claims for payment of medical care, services, or supplies to eligible enrollees be initially submitted within **90 days of the date of service** to be valid and enforceable, unless the claim is delayed due to circumstances outside the control of the provider."

*18 NYCRR Section 540.6(a)(1) and (2) and
MMIS Provider Manual Information for All Providers,
General Billing, Page 6*

In 11 instances pertaining to 11 patients, the claims were submitted more than 180 days after the date of service without the valid use of an exception code as the reason for late submission of claims. Regulations require a claim to be submitted within 90 days of the date of service; however, the OMIG disallowed claims submitted more than 180 days after the date of service without supporting documentation. This is in keeping with general industry standards.

5. Incorrect PAC Rate Code

11, 93, 133, 134, 153

Regulations state, "For payments made pursuant to this section...reimbursement shall be based upon a uniform payment schedule with a discrete price set forth in subdivision (c) of this section."

Regulations also require that any clinic services not covered in subdivision (c) of this section shall be reimbursed based on the provider's established cost-based all inclusive visit rate pursuant to this Subpart.

*10 NYCRR Section 86-4.37(a) and
10 NYCRR Section 86-4.37(h)*

In 5 instances pertaining to 5 patients, the documentation in the medical record did not meet the definition for the PAC rate code billed. These instances should have been billed at the less expensive PAC rate code appropriate for the service that was rendered.

6. Medical Entry Not Signed 128, 154

Regulations state, "The operator shall...ensure that entries in the medical record are current, legible, signed and dated by the person making the entry."

10 NYCRR Section 751.7(f)

In 2 instances pertaining to 2 patients, the practitioner did not sign the entry in the medical record.

7. Threshold Visit Billed for Non-Reimbursable Service 108, 176

Regulations state, "Patient visits solely for the purpose of the following services shall not constitute threshold visits: pharmacy, nutrition, medical social services, respiratory therapy, recreation therapy."

10 NYCRR Section 86-4.9(c)

In 2 instances pertaining to 2 patients, a threshold visit was incorrectly billed for pharmacy services.

8. No Documented Medical Service 4

Regulations state, "Only covered services which are actually delivered to eligible recipients shall be reimbursed."

In addition, "All reimbursable billings shall only be for a documented, definable medical service of face-to-face professional exchange between provider and client..."

*18 NYCRR Section 505.25 (f)(1) and
18 NYCRR Section 505.25(e)(5)*

In 1 instance, the medical record entries documented that medical services were not rendered.

9. Ordered Ambulatory Service Billed as a Threshold Visit 63

Regulations require that the Medicaid provider agrees "to submit claims for payment only for services actually furnished...and the information provided in relation to any claim for payment shall be true, accurate and complete..."

The October 2009 Medicaid Update states that the Office of the Medicaid Management implemented Fee-For-Service billing instructions whereby vaccine administration charges and vaccine charges must be billed as an ordered ambulatory service. These services should not be billed as a clinic visit or as part of a clinic visit.

*18 NYCRR Section 504.3(e)(h) and
Medicaid Update, October 2009, Volume 25,
Number 13, Page 6*

In 1 instance an FQHC Individual Threshold Visit was billed when the patient received an H1N1 flu vaccine. The vaccination should have been billed at the less expensive ordered ambulatory service fee.

PROVIDER RIGHTS

In accordance with 18 NYCRR Part 518 which regulates the collection of overpayments, your repayment options are described below. If you decide to repay the lower confidence limit amount of \$1,181,060, one of the following repayment options must be selected within 20 days from the date of this letter:

OPTION #1: Make full payment by check or money order within 20 days of the date of the final audit report. The check should be made payable to the New York State Department of Health and be sent with the attached Remittance Advice to:

[REDACTED]
New York State Department of Health
Medicaid Financial Management
GNARESP Coming Tower, Room 1237
Albany, New York 12237-0048

OPTION #2: Enter into a repayment agreement with the Office of the Medicaid Inspector General. If your repayment terms exceed 90 days from the date of the final audit report, recoveries of amounts due are subject to interest charges at the prime rate plus 2%. If the process of establishing the repayment agreement exceeds 20 days from the date of the final audit report, the OMIG will impose a 15% withhold after 20 days until the agreement is established.

Furthermore, the OMIG may require financial information from you to establish the terms of the repayment agreement. If additional information is requested, the OMIG must receive the information within 30 days of the request or a 50% withhold will be imposed. OMIG acceptance of the repayment agreement is based on your repaying the Medicaid overpayment as agreed. The OMIG will adjust the rate of recovery, or require payment in full, if your unpaid balance is not being repaid as agreed. The OMIG will notify you no later than 5 days after initiating such action. If you wish to enter into a repayment agreement, you must forward your written request within 20 days to the following:

Bureau of Collections Management
New York State Office of the Medicaid Inspector General
800 North Pearl Street
Albany, New York 12204
[REDACTED]

If within 20 days, you fail to make full payment or contact the OMIG to make repayment arrangements, the OMIG will establish a withhold equal to 50% of your Medicaid billings to recover payment and liquidate the lower confidence limit amount, interest and/or penalty, not barring any other remedy allowed by law. The OMIG will provide notice to you no later than 5 days after the withholding of any funds. In addition, if you receive an adjustment in your favor while you owe funds to the State, such adjustment will be applied against the amount owed.

If you choose not to settle this audit through repayment of the adjusted lower confidence limit, you have the right to challenge these findings by requesting an administrative hearing where the OMIG would seek and defend the point estimate of \$1,683,080. As allowed by state regulations, you must make your request for a hearing, in writing, within sixty (60) days of the date of this report to:

General Counsel
Office of Counsel
New York State Office of the Medicaid Inspector General
800 North Pearl Street
Albany, New York 12204

Questions regarding the request for a hearing should be directed to [REDACTED]
Office of Counsel, at [REDACTED]

Issues you may raise shall be limited to those issues relating to determinations contained in the final audit report. Your hearing request may not address issues regarding the methodology used to determine the rate, or any issue that was raised at a proceeding to appeal a rate determination.

At the hearing you have the right to:

- a) be represented by an attorney or other representative, or to represent yourself;
- b) present witnesses and written and/or oral evidence to explain why the action taken is wrong; and
- c) cross examine witnesses of the Department of Health and/or the OMIG.

The OMIG reserves the right to conduct further reviews of your participation in the Medicaid Program, take action where appropriate, and recover monies owed through the initiation of a civil lawsuit or other legal mechanisms including but not limited to the recovery of state tax refunds pursuant to Section 206 of the Public Health Law and Section 171-f of the State Tax Law.

**NEW YORK STATE
OFFICE OF THE MEDICAID INSPECTOR GENERAL
REMITTANCE ADVICE**

NAME AND ADDRESS OF AUDITEE

Warrensburg Health Center
9 Carey Road
Queensbury, NY 12804

AMOUNT DUE: \$1,181,060

PROVIDER ID # [REDACTED]

AUDIT #10-2242

AUDIT	<input checked="" type="checkbox"/>	PROVIDER
TYPE	<input type="checkbox"/>	RATE
	<input type="checkbox"/>	PART B
	<input type="checkbox"/>	OTHER:

CHECKLIST

1. To ensure proper credit, please enclose this form with your check.
2. Make checks payable to: *New York State Department of Health*
3. Record the Audit Number on your check.
4. Mail check to:

[REDACTED]
New York State Department of Health
Medicaid Financial Management, B.A.M.
GNARESP Corning Tower, Room 1237
File #10-2242
Albany, New York 12237-0048

Thank you for your cooperation.