HINMAN STRAUB

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NYSOH Update

Health Republic Policies to be Canceled Before December

The NYS Department of Financial Services (DFS), the New York State of Health Marketplace (NYSOH), and the Centers for Medicare and Medicaid Services (CMS) recently announced their decision to end all Health Republic policies – both individual and small group – on **November 30, 2015**. The decision comes as a result of a DFS and CMS-led review of Health Republic's finances which found that the company's financial condition is substantially worse than the company previously reported in its filings to DFS. Previously, DFS had ordered Health Republic to cease writing new policies and wind down business after the expiration of its existing policies.

Individuals who purchased a Health Republic plan on the NYSOH are encouraged to take action to choose a new plan for the remainder of 2015 on or **before November 30, 2015** to be covered through December 31, 2015. Employers with small group plans through Health Republic are encouraged to act as soon as possible to choose a new policy from another insurer for its employees to ensure continuity of coverage after the November 30, 2015 end date.

Yesterday DFS announced additional protections for current Health Republic enrollees. According to the announcement, Health Republic individual marketplace consumers who do not select a new plan will be auto-enrolled in a new insurance plan, with details being announced shortly. Additional information regarding opt-out options, deductibles, balance billing protections, continuity of care, and consumer outreach can be found in the press release here.

In addition to provisions for continued coverage, DFS also announced an official investigation into the accuracy of Health Republic's financial reporting to DFS. DFS investigators are collecting and reviewing evidence relating to Health Republic's substantial underreporting of its financial obligations. Among other issues, the investigation will examine the causes of the inaccurate representations to DFS regarding the company's financial condition.

NYSOH Audit

The NYS Office of the State Comptroller recently released an audit report of the NYSOH. The purpose of the audit was to determine if the system has adequate controls to ensure accurate enrollments in the Medicaid program and to determine whether improper enrollments caused Medicaid overpayments. The audit covered the period October 1, 2013 through October 1, 2014.

Despite the Comptroller's conclusion that the Department of Health did not provide auditors with adequate access to the NYSOH system, the audit revealed several design and process flaws in NYSOH's eligibility process which permitted inappropriate Medicaid enrollments. These flaws resulted in about $3.4 million in overpayments since NYSOH was implemented. According to the report, the overpayments stemmed from three major failures, including:

- The enrolling of deceased individuals and continued Medicaid coverage for individuals who had died after enrollment, resulting in Medicaid overpayments of $325,030;
- The issuance of multiple Client Identification Numbers (CINs) to individual recipients, resulting in actual Medicaid overpayments of $2,852,210 and potential overpayments of $188,131; and
- The issuance of unreasonably high numbers of CINs for expected multiple births per pregnancy – in some cases up to ten per pregnancy. In a single case, unnecessary CINs permitted eMedNY to make $4,796 in improper Medicaid payments for nine of ten improbable 'unborn' CINs issued for one pregnancy.

The Comptroller's office developed recommendations to remedy design and process flaws, as well as improve access for further audits. To improve oversight and auditability, the report recommends, with high priority, that the NYSOH system include read-only access, as well as a formal mechanism to independently monitor and manage approved business requirements and functionalities that have yet to be incorporated into the NYSOH production system.

To mitigate overpayments due to deceased individual enrollment, the report advises that the NYSOH investigate the life status of the 354 deceased NYSOH enrollees identified, update their Medicaid enrollment and coverage, and recover the $325,030 in inappropriate payments where appropriate. Other recommendations include improving controls and accuracy of NYSOH's processing of federal Hub responses that indicate whether an individual is alive or deceased, and developing and implementing formal procedures for the routine and timely identification of deceased enrollees.

To mitigate overpayments due to the issuance of multiple CINs, the report recommends a review of the 32,989 multiple CINs identified, ending eligibility and coverage where appropriate, and recovering the $3,040,341 in overpayments where appropriate; designing and implementing controls to prevent the improper addition of newborns when an unborn CIN already exists on an account; designing and implementing controls in the CIN clearance process; and designing and implementing a process to notify the eMedNY claims processing and payment system to link the errant multiple CINs NYSOH created.

Finally, the report recommends that in addition to ending coverage and recovering payments for the 283 unborn CINs, the NYSOH analyze where the breakdown in system development occurred pertaining to establishing a limit on unborn CINs as designed, and take action to prevent similar errors.

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DSRIP Update

Notice of DSRIP Panel and PPS Meeting

The DSRIP Project Approval and Oversight Panel (PAOP) has released the agenda for the **November 9 and 10** meeting that will be held at the Egg Convention Center, Hart Theatre Lounge, Albany, NY. The meeting will be open to the public, but there will be no public comment period. Monday, November 9 will be a full day meeting, structured as an update session for the panel members, and an opportunity for the panel members to check in with each of the PPS. Tuesday will be a half-day meeting. The meeting will be webcast live here.

PPS Speed and Scale and Provider Network Opening

FAQs on PPS Speed and Scale and the reopening of the performance network have been added to the DSRIP website here. Notably, the PPS Provider will not open on October 31 as previously scheduled. It will open two weeks later in the middle of November. Additionally, a new PowerPoint on speed and scale definitions was posted to the DSRIP website here.

Project Valuation Breakdown

The PowerPoint that was provided to PPSs to illustrate the project valuation process (the maximum amount a PPS can earn in a quarter) has been posted to the DOH DSRIP website.

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FIDA-IDD Demonstration Program

Last week, the Centers for Medicare and Medicaid Services (CMS), the New York State Department of Health (NYSDOH), and the Office for People with Developmental Disabilities (OPWDD) announced the creation of a demonstration program, Fully Integrated Duals Advantage for Individuals with Intellectual and Developmental Disabilities (FIDA-IDD), to better serve individuals with intellectual and developmental disabilities who are eligible for both Medicare and Medicaid and will focus on these individuals' long-term care needs.

New York State and CMS expect to contract with Partners Health Plan to offer this FIDA-IDD program in New York City, Long Island, and Rockland and Westchester Counties. Voluntary enrollment in the program will begin no sooner than **April 1, 2016**.

The FIDA-IDD demonstration shares the general goals and structure of the Fully Integrated Duals Advantage (FIDA) demonstration which is already operating in New York, but the two demonstrations involve different populations and Medicare-Medicaid Plans. Other important distinctions between the two demonstrations are that the FIDA-IDD demonstration does not allow for passive enrollment of eligible individuals and will include a benefit package tailored to support individuals with intellectual and developmental disabilities.

More information can also be found on OPWDD's FIDA-IDD page located here.

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OMIG Posts New Compliance Elements Webinar Series

The New York State Office of the Medicaid Inspector General (OMIG) began posting on its website a nine-part webinar series on New York's mandatory compliance program obligation. The Compliance Elements webinar series began on November 2, with the Introductory Webinar (Webinar # 26), which outlined the eight elements required of mandatory compliance programs, identified who is required to have a compliance program, and detailed the areas of a Medicaid provider's operations to which compliance programs must apply.

The series continued with eight individual webinars (Webinar #27 through Webinar #34), each dedicated to one of the eight elements required of Medicaid providers' mandatory compliance programs. Each day, from Tuesday, November 3 through Friday, November 6, OMIG posted two webinars in the series. The webinars identified a specific compliance element's statutory and regulatory requirements, outlined what OMIG's Bureau of Compliance looks for when it assesses a Medicaid provider's compliance program, and detailed compliance related tools and resources available on OMIG's website to assist providers in meeting the mandatory compliance obligations.

The Compliance Elements webinar series is available on OMIG's website here.

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October 2015 Medicaid Update

DOH has released the October, 2015 edition of its monthly *Medicaid Update* publication.

Many important updates are discussed. Some of the highlights include:

- Fee-for-Service Transportation Management Includes the Offices of Mental Health and People with Developmental Disabilities: Effective **December 1, 2015**, the management of FFS transportation for OMH and OPWDD enrollees residing in Nassau and Suffolk counties will be undertaken by the Long Island transportation manager, LogistiCare Solutions (LGTC). For dates of service on or after December 1, 2015, the ordering medical provider must seek authorization from LGTC *instead of* central office staff of OMH or OPWDD. Payment for trips performed without prior approval from LGTC may be denied. Ambulance vendors providing emergency transport to these enrollees must seek authorization from LGTC for the correct reimbursement **within 90 days of the date of service**.
- New York State Medicaid Management Information System (NYMMIS) Update: Provider Training Opportunities: Training opportunities are now available for the new New York State Medicaid Management Information System - NYMMIS. The current schedule of training sessions is available under the Training and Events Calendar link on the website. Current training sessions include:
    - Introduction to NYMMIS – A course for first time users with a focus on understanding the basic system elements and how they work.
    - NYMMIS Features and Functionality – A course to learn the basic features and functionality of NYMMIS including how to login, page layout, working with tables, how to enter information, and key links.
    - Introduction to Provider Enrollment – For **new** Provider Enrollments only - Learn how to use the NYMMIS to complete an electronic enrollment.
    - Enterprise Login and Navigation – External users will be shown how to login and navigate the MMIS.

- NY Medicaid EHR Incentive Program Update: The NY Medicaid Electronic Health Record (EHR) Incentive Program provides financial incentives to eligible practitioners and hospitals to promote the transition to EHRs. Since December 2011 over **$718 million** in incentive funds have been distributed within **20,849 payments** to New York State Medicaid providers.
- New York State Medicaid Coverage of Testing for Lynch Syndrome: This billing guidance clarifies coverage by NYS Medicaid Fee-For-Service (FFS) and Medicaid Managed Care (MMC) of genetic testing for Lynch Syndrome DNA mismatch repair (MMR) gene mutations (MLH1, MSH2, MSH6, and PMS2), and is effective as of November 1, 2015 for FFS and January 1, 2016 for MMC. Reimbursement is available for initial screening of the MLH1 and MSH2 genes when medical criteria are met. Reimbursement for testing of the MSH6 gene is available only following a negative test result in the MLH1 and MSH2 genes. Similarly, testing of the PMS2 gene is only covered following a negative test result in the MLH1, MSH2 and MSH6 genes. Testing is to be reflexed, and it should be indicated on the laboratory requisition form that a new order is not required. This policy does not apply to Lynch Syndrome testing for known familial variants represented by CPT codes: 81293, 81296, 81299 and 81318. To view medical criteria and more information, click here.
- Changes in Personal/Familial History Criteria for Medicaid Breast Cancer (BRCA) Genetic Testing – UPDATE: Effective immediately, New York State Medicaid has implemented changes to the BRCA coverage policy for Medicaid recipients. Physicians, nurse practitioners, physician assistants and midwives may order this laboratory test for their patients when clinically indicated and medically necessary. The changes include updated patient risk factors that substantiate medical necessity. New criteria can be viewed here.
- Medicaid Disallows Payment for Outpatient and Inpatient on Same Date of Service: Medicaid utilizes a Diagnosis Related Group (DRG) payment methodology for services provided on an inpatient basis (rendered to a patient between the date of admission and date of discharge). The DRG facility payment is all inclusive and includes all services provided the patient during the inpatient stay. To enforce the policy, New York State Medicaid recently implemented a payment edit to reinforce billing policy that disallows payment for an outpatient visit concurrent with an inpatient stay. The only exception to this policy is for emergency service procedures done in an Emergency Department. When emergency services are provided on the same date as the date of discharge and the primary diagnosis is different, the Emergency Department visit is Medicaid reimbursable.
- Medicaid Fee-for-Service Program Pharmacists as Immunizers Fact Sheet – UPDATE: Pharmacies are not able to enroll into the New York State Vaccines for Children (VFC) Program. The Fact Sheet that was published in the August 2015 *Medicaid Update* has been modified accordingly and can be accessed here. Please note that pharmacies should not be billing Medicaid for those vaccines that are available to Medicaid enrollees free of charge through the VFC program. New York State Medicaid is the payer of last resort.
- Medicaid Fee-for-Service Pharmacy Prior Authorization Programs Update: **Effective October 16, 2015,** the Fee-for-Service (FFS) pharmacy program implemented parameters for palivizumab (Synagis). These changes are the result of recommendations made by the Drug Utilization Review Board (DURB) at the September 17, 2015 DURB meeting. To view the update click here.

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Submission of Transfer of Ownership Interest Notices

The NYS Department of Health is expanding the NYSE-CON application to include the

electronic submission of Transfer of Ownership Interest Notices (aka 90-Day / 120-Day Notices) required under the Public Health Law for Article 28 facilities and Article 36 agencies.

Effective **November 4, 2015**, all Transfer of Ownership Interest Notices must be submitted via the NYSE-CON system. The Department will no longer accept paper submissions for the notices after this date.

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HARP Update

Delay in Distribution of Notices to HARP Eligible Enrollees

Last month, New York's enrollment broker, New York Medicaid Choice, missed their October target of sending 20,000 notices to Health and Recovery Plan (HARP) eligible enrollees. Only 10,000 notices were sent to enrollees. In order to correct the shortfall, the Department expects that approximately 20,000 notices will be sent in both November and December, 2015 and approximately 10,000 notices in January 2016. According to the Department, they expect to be on track to meet notice targets, with a half-month delay behind the original schedule.

Adult Behavioral Health Home and Community Based Services (BH HCBS) Plan of Care

The Department recently posted several new documents to its HARP webpage. Included in the update is the Adult BH HCBS Plan of Care template that can be used for individuals enrolled in a HARP who are eligible for BH HCBS. The template incorporates all the Federal rules and regulations required for the Adult BH HCBS Plan of Care. Also posted are workflows for HARP eligible persons to receive BH HCBS. Finally, the Department posted a BH HCBS Plan of Care Federal Rules and Regulations checklist, which can be used by care managers to ensure that the Federal rules and regulations are followed during the person centered planning process, and a Person-centered Planning Process Federal Rules and Regulations checklist, which can be used as a guidance tool by any entity that does not choose to use the BH HCBS Plan of Care template.

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Health Home Update

Release of the MAPP HHTS File Specifications Document version 1.1

The Department recently released an updated version of the Medicaid Analytics Performance Portal (MAPP) Health Home Tracking System (HHTS) File Specifications Document. The new Version 1.1 has been posted here with track changes to document the updates that were made.

Implementation Schedule for MAPP Health Home Tracking System Phase 1 and Phase 2 and Enrolling Children in Health Homes

The Department recently announced that Phase 1 of the MAPP HHTS will be implemented in **March 2016**. With the Phase 1 Go-Live date set, the Department also announced that the enrollment of children in Health Homes and the implementation of Phase 2 MAPP HHTS will now begin in **September 2016**.

The new MAPP implementation schedule will result in the following changes:

- Former OMH and COBRA Targeted Case Management (TCM) and OASAS Managed Addiction Treatment Services (MATS) providers may continue to bill Medicaid directly for Health Home services using legacy rates for service dates up to and including **August 2016**.
- The HML monthly assessment/questionnaire will be available in MAPP in March 2016 and will be required to be completed for service dates beginning April 2016.
- The transition to HARP/non-HARP HML payment for Health Home services will begin with **September 2016** service dates.
- Health Home billing readiness attestations required to be submitted by existing Health Homes (including those designated to serve children) certifying they have procedures in place, and have tested their ability to bill Plans for Health Home services and pass Health Home payments to downstream care managers will be due on **May 1, 2016.**
- Information about MAPP training for Children's Health Homes will be made available after Phase 1 is launched. The Department will continue to work with contingently designated Health Homes on readiness activities, including obtaining network provider lists and other information necessary to operationalize MAPP modifications for children.

The Department anticipates that the Health Home performance dashboards will be made available to MAPP users prior to the March 2016 MAPP Go-Live date (possibly as early as December 2015). Additional information on how to access the Health Home performance dashboards will be provided as soon as soon as MAPP is configured to display the dashboards.

Phase 1 of the MAPP Health Home Tracking System (HHTS) will provide users with the following functionality that is not in the current Health Home Tracking System:

- Care Management Agencies will have access to the MAPP HHTS
- Actions within MAPP can be performed individually or in bulk through online screen entry or through file transfer
- The creation, acceptance, and rejection of assignments made from the Managed Care Plan to the Health Home to the Care Management Agency will be tracked in MAPP HHTS
- A new concept of "accepting" of assignments, transfers, and referrals by all users and of Health Homes "accepting" assignment, outreach, and enrollment submitted by Care Management Agencies
- Allowing seamless "warm" transfer of enrolled Health Home members between health homes
- Using status types and new end date reason codes for members in Assignment, Outreach, and Enrollment to better track members in outreach hiatus, incarcerated and lapsed Medicaid eligibility

Phase 2 of the MAPP Health Home Tracking System (HHTS) will add functionality to MAPP to support the design of the Health Home model for children, including:

- CANS-NY Assessment tool will be integrated into MAPP
- Billing, rate information and CANS-NY algorithms (High, Medium, Low)
- Referral Portal for Children (under 21)
- Community Referral (by LGU/SPOA and LDSS, and eventually others) for Assignment
- Assignment and Enrollment by Health Homes, Plans and Care Managers
- Consent Management
- Consent to Refer
- Consent to Enroll
- Consent to Share Information (Protected Services)

Additional information on access to the MAPP HHTS test environment for Phase 1 will be provided next month. The MAPP HHTS Specifications Document can be found here.

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August 2015 Global Cap Report

The August 2015 Global Cap Report was recently posted on the Medicaid Redesign Team (MRT) website. The 2016 state budget extended the Global Spending Cap through March 2017. Pursuant to legislation, the Global Spending Cap has increased from $17.0 billion in FY 2015 to $17.7 billion (including the Basic Health Program) in FY 2016, an increase of 4.6 percent.

Total State Medicaid expenditures under the Medical Global Spending Cap for FY 2016 through August were $4 million (.1%) *under* projections. Spending for FY 2016 resulted in total expenditures of $7.663 billion compared to the projection of $7.667 billion.

Medicaid spending in major Managed Care categories was $45 million *over* projections. Mainstream Medicaid Managed Care was $30 million (0.8%) *over* projections through August. Long Term Managed Care spending was $15 million *over* projections. Medicaid spending in major fee-for-service categories was $67 million (1.7%) *below* projections.

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Regulatory Updates

Department of Health

Transgender Related Care Services

The Department of Health recently issued a notice of proposed rulemaking that would revise the existing regulations providing for Medicaid coverage of treatments to address gender dysphoria. The proposed amendments would: (1) change the minimum age from 21 to 18 for coverage of gender reassignment surgery (GRS), even in instances where sterilization would result; and (2) add psychiatric nurse practitioners to the list of medical professionals who can provide letters establishing the appropriateness of GRS. These proposed regulations follow the Department's adoption of regulations last March reversing its longstanding prohibition against coverage of hormone treatment and GRS for individuals with gender dysphoria under the Medicaid program.

The Department is accepting comments on the proposed regulation through **December 21, 2015.**

Statewide Health Information Network for New York (SHIN-NY)

The Department of Health Recently issued a notice of proposed rulemaking that would allow the Department to establish and adopt policy and processes for the operation of the Statewide Health Information Network for New York (SHIN-NY). The SHIN-NY is designed to enable widespread, non-duplicative interoperability among disparate health information systems, including electronic health records, personal health records, health care claims, payment and other administrative data, and public health information systems, while ensuring privacy and security. The proposed regulations would also establish requirements for Qualified Entities (QEs) and QE participants to participate and share information over the SHIN-NY.

The Department is accepting comments on the proposed regulation through **December 21, 2015.**

It is important to note that these proposed amendments differ from the Department's former proposed rulemaking published in the September 3, 2014 edition of the NYS Register. That proposed rulemaking has expired and was removed from consideration in the September 23, 2015 edition of the NYS Register.

Hospital Observation Services

The Department of Health Recently issued a notice of adopted rulemaking that amend regulations governing operational standards for hospital observation units. The adopted amendments implement statutory requirements for hospital observation services and are consistent with DOH guidance issued in 2013 relating to the provision and billing of observation services. The amendments extend the maximum observation stay to 48 hours, allow observation services to be rendered in a distinct unit or in inpatient beds, and remove limitations on the number of observation beds.

The regulations include one substantive change to the proposed amendments published in the October 29, 2014 edition of the *NYS Register*. The regulation has been amended to allow direct referrals of patients to a hospital for observation services without receiving emergency room or critical care services on the day observation begins by community providers who are not members of the medical staff of the receiving hospital.

Office of People with Developmental Disabilities

Day and Residential Habilitation Changes

The Office of People with Developmental Disabilities (OPWDD) published a notice of adopted rulemaking that amends requirements for day and residential habilitation services provided under the Home and Community Based Services (HCBS) Medicaid Waiver program. The regulations, beginning October 1, 2015, prohibit supportive individualized residential alternatives (IRAs), supportive community residences (CRs), and family care homes from separately billing Medicaid for home health or personal care services, supplemental group day services, and certain clinical services (i.e., nutrition and psychological services). Residential providers are responsible to pay for any supplemental group day habilitation services. Billing for personal care services for individuals in IRAs, CRs and family care homes, and certain clinical services in supervised IRAs and supervised CRs are allowable as residential habilitation. The adopted regulation contains non-substantive changes from the proposed rule, which was published in the August 19, 2015 edition of the NYS Register.

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Legislative Spotlight

Provided below is notable legislation that was ***delivered*** to the Governor:

- **A.7060/S.5086 (Gottfried/Griffo):** This bill would allow for expedited access to medical marihuana in certain cases. Patients that receive "special certification" from an authorized practitioner certifying that the patient's condition is progressive and degenerative or that delay in the patient's certified medical use of marihuana poses a serious risk to the patient's life or health. It would also expedite the registration of organizations wishing to become "registered organizations" for purposes of the production and sale of marihuana by permitting the Commissioner to waive or modify

registration requirements. The bill would also specify certain criteria which will give an applicant preference for expedited registration.

- **A.8258/S.5989 (Gottfried/Griffo):** This bill is a "chapter amendment" which would make technical corrections to statutory references enacted by A.7060 Gottfried/S.5086 Griffo.

The following healthcare related legislation was recently signed ***into law*** by the Governor:

- **A.1327-A/S.4922-A (Cahill/Hannon):** This bill would require expedited utilization review and expedited external appeals for certain substance abuse and behavioral services which may be subject to a court order. It would require commercial health insurers to allow an individual who certifies that they may be subject to a court order requiring mental health and/or substance use disorder services, to avail the claim to the existing expedited utilization review process to determine if the court ordered services under consideration will ultimately be covered. The request would be eligible for an expedited external appeal if the initial review results in an adverse determination.
- **A.4140/S.2300 (Gottfried/Hannon):** This bill would make technical amendments to various sections of law (the education law, general business law, vehicle and traffic law) to remove the phrase "written collaborative agreement" and replace it with "nurse practitioner acting in his or her lawful scope of practice" in order to allow for a nurse practitioner to practice pursuant to a written practice agreement when applicable and in accordance with a collaborative relationship when applicable.
- **A.7641/S.5738 (Brennan/Ranzenhofer):** This bill would change the effective date from January 1, 2016 to January 1, 2017 of the prohibition on not-for-profit employees serving as chairperson of the board of directors of a corporation. The Not-For-Profit Revitalization Act of 2013 contained a provision that prohibited employees of a not-for-profit corporation from serving as chair of the not-for-profit's board of directors. As a result of this legislation, this provision would go into effect on January 1, 2017.
- **S.676B/A.1323B (Hannon/Rosenthal):** This bill would establish the CARE Act, which would require a general hospital to allow a patient an opportunity to designate, upon admission to a hospital, a caregiver in the patient's medical record. Hospitals would be required to notify and offer to meet with the designated caregiver to discuss the patient's plan of care prior to the patient's discharge or transfer to another facility. In addition, hospitals would be required to offer to adequately train the designated caregiver in certain aftercare tasks upon a patient's discharge to his or her current residence.
- **S.4324A/A.791C (Hannon/Gunther):** This bill would require immunization against meningococcal disease for students entering, repeating or transferring into the seventh and twelfth grades and adds meningococcal disease to the list of school vaccination requirements.

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Upcoming Calendar

Monday, November 9 & Tuesday, November 10	DSRIP Project Approval and Oversight Panel (PAOP) Meeting with the Upstate-based PPS Monday, November 9 – All day Tuesday, November 19 – Half day The Egg Convention Center, Hart Theatre Lounge, Albany, NY
Wednesday,	Committee on Health Planning of the Public Health and Health

November 18	Planning Council 1:00 p.m. to 5:00 p.m. 875 Central Avenue, Albany, NY 12206
Thursday, November 19	Committees of the Public Health and Health Planning Council 10:00 a.m. Empire State Plaza, Concourse Level, Meeting Room 6, Albany, NY
Thursday, November 19	Drug Utilization Review Board (DURB) 9:00 a.m. to 4:00 p.m. Empire State Plaza, Concourse Level, Meeting Room 3, Albany, NY
Monday, November 30	Nursing Home Transition and Diversion (NHTD) and Traumatic Brain Injury (TBI) Waiver Transition Workgroup 1:00 p.m. – 3:00 p.m. Empire State Plaza, Concourse Level, Meeting Room 6, Albany, NY
Thursday, December 3	Early Intervention Coordinating Council 10:15 a.m. to 3:00 p.m. Empire State Plaza Convention Center, Meeting Room 1, Albany, NY
Thursday, December 10	Public Health and Health Planning Council 10:00 a.m. Empire State Plaza, Concourse Level, Meeting Room 6, Albany, NY

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