DELAWARE HEALTH AND SOCIAL SERVICES

DIVISION OF MEDICAID & MEDICAL ASSISTANCE

Delaware Medical Assistance Program

Prior Authorization Metrics Reports for 2025 are Now Available!

On January 17, 2024, CMS released the CMS Interoperability and Prior Authorization final rule (CMS-0057-F). One of the new requirements is that state Medicaid programs are required to publicly report certain prior authorization metrics for the previous year by March 31st each year.

Some of the items required to be reported are:

- A list of all items and services that require prior authorization.
- The percentages of standard and urgent prior authorization requests that were approved and denied.
- The average and median time between submission and determination for standard and urgent prior authorization requests.

See the new reports on the DMAP Document Repository.

In This Edition:

gainwell

How-To & What's New

DMAP Now Covers Lactation Counseling Services

Lactation counseling services support families by providing breastfeeding assistance to expectant and nursing mothers. Local birthing centers, hospitals, pregnancy centers, or health departments may have experts on staff called Lactation Consultants or Breastfeeding Counselors who work frequently with new moms and are trained to help with initial breastfeeding support and issues.

Licensed Physicians, Nurse Practitioners, Physician Assistants, Nurse Midwifes, and Registered Nurses are eligible to provide lactation counseling services for eligible members. Providers must be licensed and have either:

- A certification from the Academy of Lactation Policy and Practice (ALPP) as a Certified Lactation Consultant (CLC), or
- A certification from the International Board of Lactation Consultant Examiners (IBLCE) as an International Board-Certified Lactation Consultant (IBCLC).

For more information about services, provider qualifications, limitations, and billing, please refer to "Section 19.0 Lactation Counseling Services" of the Practitioner Provider Specific Policy Manual and your Managed Care Organization(s) provider resources.

New and Updated How-To Documents

How-To: Disclosure Statement of Information to be Completed by Providers and Fiscal Agents

How-To: Enrollment Guide for Fee-for-Service Providers

How-To: Submit a Dental Prior Authorization Request through the Portal

How-To: Submit an Inpatient Claim with TPL on the Portal

How-To: Submit an Inpatient Crossover Claim on the Portal

How-To: Submit a Medical Prior Authorization Request through the Portal

How-To: Update Provider Service Location Information

Helpful Titles

- How-To: Submit a Pharmacy Prior Authorization Request through the Portal
- How-To: View and Verify a Member's Eligibility through the Provider Portal
- How-To: Utilize Treatment History Panels
- How-To: Provide a Third-Party Liability Lead through the Portal

Top Tips

- Provider Enrollment
- Provider Health Insurance Portability and Accountability Act

***Remittance Advice Reminder:** RAs are available on the Provider Portal every **Monday** after 12:00 noon ET.

Delaware Cancer Treatment Program (DCTP)

The Delaware Cancer Treatment Program (DCTP) is available to Delaware residents who:

- Were residents of Delaware when diagnosed with cancer,
- Were diagnosed with cancer on or after July 1, 2004,
- Have no comprehensive health insurance,
- Do not receive benefits through the Medicaid Breast and Cervical Cancer Treatment Program,
- Meet income guidelines (up to 650 percent of the Federal Poverty Level), and
- Are not eligible for health insurance.

DCTP is also available to Delaware residents with comprehensive health insurance who:

- Were residents of Delaware when diagnosed with cancer,
- Were diagnosed with cancer on or after July 1, 2004,
- Do not receive benefits through the Medicaid Breast and Cervical Cancer Treatment Program,
- Meet income guidelines (up to 650 percent of the Federal Poverty Level), and
- Meet maximum out-of-pocket expense for health insurance equal to or more than 15 percent of their household income (does NOT include premiums) *.

***Applicants must submit documentation from their insurance carrier notating the maximum out-of-pocket expense in order to determine eligibility**.

The DCTP application is available online at healthydelaware.org. Please click HERE for more information and to download both the English and Spanish application packet. For more information on DCTP, please call 1-844-245-9580 (TTY 711).

Vaccines for Children (VFC) Program

The Vaccines for Children (VFC) program in Delaware is a federally funded initiative designed to ensure that eligible children receive recommended immunizations at no cost. Administered by the Delaware Division of Public Health, the program provides vaccines purchased by the Centers for Disease Control and Prevention (CDC) to registered healthcare providers throughout the state. These vaccines are available to children who are Medicaid-eligible, uninsured, underinsured, or American Indian/Alaska Native, as defined by the CDC. By removing financial barriers, the VFC program helps protect vulnerable populations from preventable diseases and supports public health efforts to maintain high immunization coverage.

Delaware healthcare providers who participate in the VFC program benefit from reduced out-of-pocket costs and the ability to offer comprehensive immunization services to their pediatric patients. Providers must complete an enrollment process, including a site visit to ensure proper vaccine storage and handling, and are allowed to charge a nominal administrative fee to offset operational expenses. Becoming a VFC provider also enhances the ability to serve children receiving Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services, reinforcing the importance of delivering immunizations within the child's medical home.

Interested providers should visit the Vaccines for Children (VFC) Provider website for more details.

Managed Care Organization (MCOs) for 2026

The Delaware Department of Health and Social Services (DHSS) selected three MCOs to operate its Medicaid Managed Care Program.

For more information or to enroll with an MCO, members should login to their DMAP Member Portal or call the Health Benefits Manager at 1-800-996-9969 (TTY 771) (M-Th 8AM – 6PM; F 8AM – 5PM).

For information about provider enrollment, please reach out to the MCOs at the contact numbers below.

AmeriHealth Caritas Delaware	delaware first health	HIGHMARK HEALTH OPTIONS
AmeriHealth Caritas	**Delaware First Health**	**Highmark Health Options**
1-855-707-5818 DentaQuest: 1-800-372-2022	1-877-236-1341 Centene Dental: 1-833-236-1886	1-844-325-6251 United Concordia: 1-800-372-2024

Technical Denial

What is a technical denial?

A technical denial is issued when a provider fails to respond to a Division of Medicaid and Medical Assistance (DMMA) Surveillance Utilization Review (SUR) Unit request for information. The information is used to substantiate the care provided to a member. A technical denial results in the recoupment of the entire paid amount of funds paid for the claim.

Reasons for a technical denial include:

- Failure to provide the entire medical record,
- Failure to provide parts of the medical record required to conduct a review, or
- Failure to respond to a request to conduct a Self-Audit.

What happens if a provider fails to respond to a DMMA SUR documentation request?

If the requested records are not received within 45 days by the DMMA SUR Unit and the provider has not contacted the SUR Unit regarding a delay, the SUR Unit will attempt to contact the provider. The attempt will be made to the phone number or e-mail on file associated with the billing NPI. If this additional contact attempt is unsuccessful, the claims involved in the audit will be subject to a technical denial, and the claims will be recouped within 7 days.

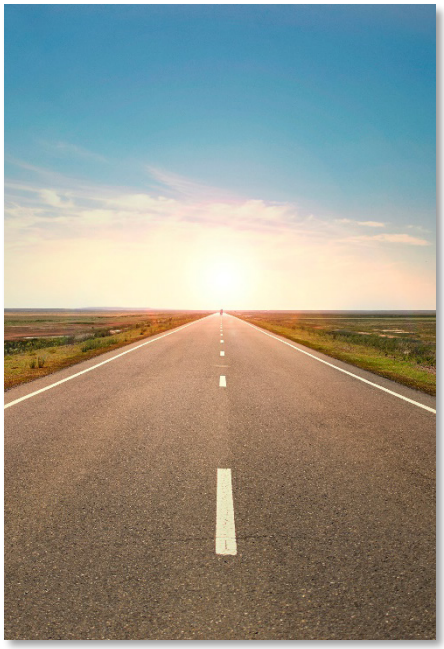
What happens when a technical denial is issued?

Technical denials are issued when there is a failure to provide requested information. Technical denials result in the recoupment of the funds paid for the claim. The provider has ten (10) days from the date of the technical denial letter to provide the missing/incomplete documentation. If the requested documentation is received after the technical denial is issued, medical records and/or related documentation may be reviewed on a case-by-case basis as outlined in the DMMA Provider Post-Payment Audit Policy.

Upon completion of the technical denial review, a findings letter will be issued. Information on how to request a timely Re-Determination Review is located in Appendix A of the DMAP General Policy Manual.

If you have any further questions regarding fraud, waste, or abuse, please contact the DMMA Surveillance Utilization and Review (SUR) Unit at:
Toll-Free Telephone: 1-800-372-2022 (TTY 711)
Hotline (After-Hours Voicemail Only): 1-800-372-2022, select option 1.
Email: SURreferrals@delaware.gov

A New EVV Horizon Awaits!



We continue the "soft edit" phase for EVV paid claims where provider partners have been receiving remittance advice messages explaining that non-matching claims will be rejected once the "hard edit" phase begins. In an effort to provide as much time as possible to address any lingering issues, the hard edit date has been extended from March 31, 2026, to **October 1, 2026**. **After this date, claims will be denied without a valid authorization/visit/paid claims match.**

The EVV team is still working diligently with our provider partners to provide as much education and assistance as possible. Providers receiving claim rejection warning(s) should contact their MCO partners, HHAeXchange (formerly Sandata), and/or the State (where appropriate) to avoid any future claims denials. Please stay tuned for any potential updates as they come. Continued thanks to our partners as always for their patience, dedication, and cooperation!

EVV Highlights from Q4:

- 150 unique providers who provide services subject to EVV have registered with HHAeXchange.
- 2,479,479 visits from 120 different providers are reflected in the production environment. Of these, 98% are in a verified/processed status (claims/visits matched).
- Progress continues in engaging with providers and our MCO partners with resolving issues related to EVV, including MCD ID alignment, proper HHAeXchange registration, and other EVV hangups.
- The EVV team has been very successful in helping our provider partners iron out lingering issues with MCD ID registration(s) and other related issues. The team has been conducting provider calls with all MCOs and HHAeXchange representation.
- The EVV team continues to collaborate with our MCO partners, addressing both common and unique concerns/issues and coordinate effective provider outreach.
- The MCOs have also continued outreach to providers who we have identified as high-risk for claims matching issues. We would like to again send many thanks for the continued cooperation!

Provider Reminders:

The EVV requirement is federally mandated. All Personal Care Services (PCS) and Home Health Care Services (HHCS) providers **MUST** register with our EVV vendor HHAeXchange or an alternate EVV vendor of their choosing. To register, please visit the EVV Provider Self-Registration Portal. You **MUST** have your Medicaid Provider Identification Number (MCD ID) to register. If you need help with identifying your MCD ID, please contact DMAP Provider Services from 8:00 AM ET to 4:30 PM ET at 1-800-999-3371 (TTY 711), select option 0, option 4.

Once the registration process is complete, providers may begin accessing the Sandata training resources.

- Providers who are utilizing HHAeXchange/Sandata as their EVV solution: Sandata Learn
- Providers utilizing an alternate EVV vendor: DE Aggregator Training

Provider Forums:

DMAP has hosted several provider forums. Slides from past forums are available on the DMMA EVV webpage. For more information and learn about future forums, visit the DMMA EVV webpage.

Contact Us:

For questions or more information, contact the EVV Provider Service Team at DHSS_DMMA_EVV@delaware.gov.

Children's Dental Program

Effective **January 1, 2025**, the Division of Medicaid and Medical Assistance (DMMA) has contracted with Managed Care Organizations (MCOs) to provide dental services to children. Listed below is the Dental Benefit Manager (DBM) for each MCO:

AmeriHealth Caritas	Delaware First Health	Highmark Health Options
DentaQuest	Centene Dental	United Concordia
1-800-372-2022 1-877-378-5295	1-833-236-1886	1-800-372-2024

Dental providers wishing to provide dental services to children must enroll in DMAP prior to credentialing with an MCO using the taxonomies below:

Provider Description	Taxonomy Code	Enrollment Type (Group and/or Individual)
Dentist	122300000X	Both
Dental Anesthesiologist	1223D0004X	Both
Endodontics	1223E0200X	Both
General Practice	1223G0001X	Both
Oral & Maxillofacial Pathology	1223P0106X	Both
Oral & Maxillofacial Surgery	1223S0112X	Both
Orthodontics and Dentofacial Orthopedics	1223X0400X	Both
Pediatric Dentistry	1223P0221X	Both
Periodontics	1223P0300X	Both
Prosthodontics	1223P0700X	Both

Adult Dental Program

Join us to meet the growing demands of the Adult Dental Program. For additional information regarding the DMMA Adult Dental Program, click HERE. Dental providers wishing to provide adult dental services **must** be enrolled in DMAP and must credential with an MCO.

Provider Description	Taxonomy Code	Enrollment Type (Group and/or Individual)
Dentist	122300000X	Both
Dental Anesthesiologist	1223D0004X	Both
Endodontics	1223E0200X	Individual
Oral & Maxillofacial Surgery	1223S0112X	Individual
Periodontics	1223P0300X	Individual
Prosthodontics	1223P0700X	Individual

Dental Fee Schedule

The Dental Fee Schedule is on the DMAP Document Repository.
Effective date is **April 1, 2025**.

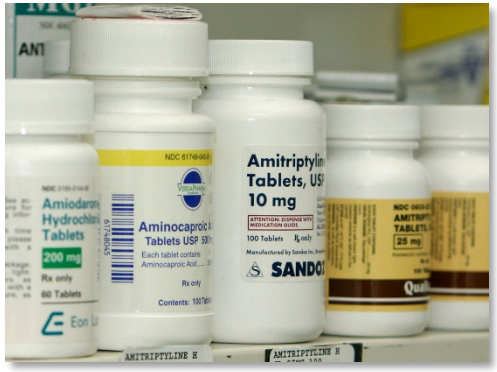
FDA Approves iPLEDGE REMS Modifications

The U.S. Food and Drug Administration (FDA) approved modifications to the iPLEDGE Risk Evaluation and Mitigation Strategy (REMS) on February 9, 2026. The changes will go into effect 180 days after the approval date (August 8, 2026). Some of the changes include:

- Prescribers may opt to allow patients to complete pregnancy tests outside of a medical setting (e.g., at-home pregnancy tests) during and after treatment. However, patients must continue to complete their pre-treatment pregnancy tests in a medical setting. Prescribers will need to develop procedures to mitigate misinterpretation or falsification of pregnancy tests completed outside of a medical setting.
- There is no longer a 30-day prescription window for patients who cannot get pregnant. Pharmacies may need to adapt their workflow practices to ensure that if a patient does not pick up the prescription, the authorization is reversed in the REMS and the prescription is returned to stock.
- If a person who can get pregnant does not pick up their prescription within the 7-day window, a repeat pregnancy test may be done immediately without an additional waiting period. If the patient has not received their first dose of isotretinoin, the repeat pregnancy test must be done in a medical setting.

See the full description of changes at: https://www.fda.gov/drugs/postmarket-drug-safety-information-patients-and-providers/ipledge-risk-evaluation-and-mitigation-strategy-rems.

New National Drug Code (NDC) Format Final Rule Approved



The FDA's final rule, Revising the National Drug Code Format and Drug Label Barcode Requirements, establishes a single, standardized 12-digit format for the National Drug Code (NDC). The NDC is the FDA's system for uniquely identifying drugs marketed in the United States. Today, FDA-assigned NDCs are 10 digits long and appear in multiple different configurations.

The new rule becomes effective on March 7, 2033. On that date, the FDA will begin assigning only 12-digit NDCs and will convert all existing 10-digit NDCs into the new uniform format. This transition applies to FDA-assigned NDCs for human drugs, including biological products, as well as animal drugs. The rule does not change NDC formats used for non-FDA purposes, such as the 11-digit HIPAA standard used for reimbursement.

During the 7-year transition period (March 5, 2026, through March 6, 2033), the FDA will continue issuing 10-digit NDCs in the current formats. Manufacturers, distributors, repackagers, relabelers, pharmacies, health care providers, payors, and other supply-chain stakeholders should use this time to update their systems, processes, and infrastructure to accommodate the 12-digit format by the March 7, 2033, deadline.

For more information, read the rule at: https://www.federalregister.gov/documents/2026/03/05/2026-04368/revising-the-national-drug-code-format-and-drug-label-barcode-requirements.

Early Periodic Screening, Diagnosis & Treatment (EPSDT) Corner

EPSDT and the Comprehensive Cancer Control Program

The Comprehensive Cancer Control Program aims to reduce the incidence of cancer, lower mortality rates, and improve cancer care in Delaware. The Department of Health and Social Services (DHSS), through the Division of Public Health (DPH), has developed a Comprehensive Cancer Control Program with funding by the Delaware Health Fund and the U.S. Centers for Disease Control and Prevention (CDC). Cancer prevention and control is a top priority.

Under this program, DHSS and the Division of Public Health (DPH) provide the following for eligible residents:

- Cancer control services,
- Comprehensive cancer prevention programs,
- Comprehensive cancer screening programs,
- Support services for those diagnosed with cancer, such as cancer care coordinators.

In accordance with EPSDT guidelines, Delaware continues to promote EPSDT awareness and accessibility and to improve care for children with specialized needs. DMMA and DMAP play a crucial role in the Comprehensive Cancer Control Program by ensuring that Medicaid-eligible individuals and families have access to necessary healthcare services by:

- Providing comprehensive medical assistance to those who cannot afford healthcare costs.
- Covering a wide range of medical services, including cancer treatment, ensuring that vulnerable populations receive quality medical services.
- Working to improve health outcomes by providing cost-effective medical services to Delawareans, which includes addressing cancer care needs.

For more information on Delaware's Cancer Prevention and Control Program, visit https://dhss.delaware.gov/dph/dpc/cancer/.

USPSTF Recommendations

Delaware Medicaid provides coverage and reimbursement of all preventative services assigned either grade A or B by the United States Preventive Services Task Force (USPSTF). Click HERE for the comprehensive listing of USPSTF recommendations.

Recommendations with a grade of either A or B

Topic	Description	Grade	Release Date of Current Recommendation
Intimate Partner Violence and Caregiver Abuse of Older or Vulnerable Adults: Screening: women of reproductive age, including pregnant and postpartum women	The USPSTF recommends that clinicians screen for intimate partner violence (IPV) in women of reproductive age, including those who are pregnant and postpartum.	B	June 2025
Syphilis Infection During Pregnancy: Screening: asymptomatic pregnant women	The USPSTF recommends early, universal screening for syphilis infection during pregnancy; if an individual is not screened early in pregnancy, the USPSTF recommends screening at the first available opportunity.	A	May 2025
Breastfeeding: Primary Care Behavioral Counseling Interventions: pregnant and postpartum women	The USPSTF recommends providing interventions or referrals, during pregnancy and after birth, to support breastfeeding.	B	April 2025

Opportunities for Public Comment

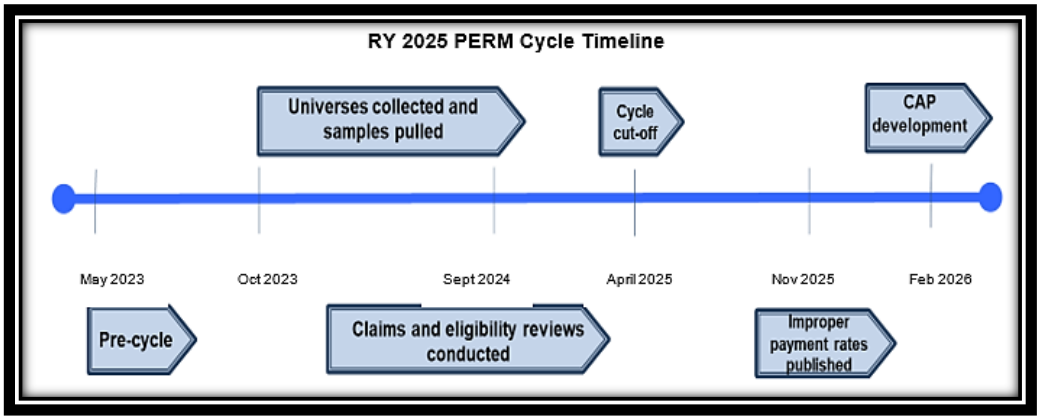
The U.S. Preventive Services Task Force (USPSTF) provides healthcare providers with an opportunity to influence the future of preventive care through its public comment process. Firsthand clinical experience and expertise are vital in ensuring that recommendations are evidence-based, practical, and applicable to diverse patient populations. The process begins when the USPSTF publishes a draft recommendation statement, accompanied by an evidence review. These drafts are made available for a defined public comment period, typically lasting a few weeks. During this time, providers and other stakeholders can submit feedback through the USPSTF website. Comments can address potential gaps, raise implementation concerns, or offer suggestions to enhance the recommendations' relevance and effectiveness.

After the comment period closes, all input is reviewed and carefully considered by the Task Force before finalizing the recommendation. This collaborative process allows healthcare providers to advocate for their patients and contribute to shaping guidelines that impact clinical practice nationwide.

Stay informed about open comment periods through the USPSTF website and take advantage of the opportunity to strengthen preventive care and shape health policy.

Payment Error Rate Measurement (PERM)

PERM Cycle RY25 Updates



CMS has completed its review of a sample of Delaware's Medicaid and Children's Health Insurance Program (CHIP) payments made during Reporting Year (RY) 2025 (July 1, 2023 – June 30, 2024) as part of the Payment Error Rate Measurement (PERM) program. This review fulfills federal requirements under the Payment Integrity Information Act (PIIA) of 2019.

The PERM program estimates improper payment rates for Medicaid and CHIP through a three-year cycle. Each state is reviewed once per cycle; Delaware is part of Cycle 1. The review includes:

- Fee-for-Service (FFS) claims
- Managed care capitation payments
- Payments resulting from eligibility determinations

PERM findings help CMS generate both national and state-specific improper payment rates, and the results help states correct the identified issues and drive program improvements. CMS will collect the Federal Financial Portion (FFP) back from the State for claims where proper documentation is not submitted by providers timely. Consequently, DMMA will recoup the payment from a liable party as a PERM Recovery.

IMPORTANT: Providers must submit proper medical record documentation supporting the paid claim(s) selected for the audit. The required documentation must include sufficient information to validate that provided services were medically necessary and were consistent with the specified diagnosis during the time of the claim payment. If providers have questions about documentation, they should refer to the provider-specific policy manual. Additionally, providers must comply with all federal and state laws, regulations, and billing instructions provided under the Delaware Medicaid program, pursuant to Section 1.6 Provider Contractual/Programmatic Responsibilities in the General Policy Manual, which include:

- 1.6.1 – "A provider who signs a contract with the Delaware Medical Assistance Program (DMAP) is responsible to meet certain conditions in order to remain an eligible provider and receive payment for services rendered."
- 1.6.2 – "Providers are responsible for the accuracy, truthfulness, and completeness of all claims submitted to DMAP. The provider is further responsible for all costs associated with the preparation for the submission of claims, whether prepared or submitted by the provider or by an outside agency or service."
- Refer to Section 1.6 of the General Policy Manual for additional information regarding provider responsibilities.

CMS will collect the Federal Financial Portion (FFP) back from the State for claims where proper documentation is not submitted by providers timely. Consequently, DMMA will recoup the payment from a liable party as a PERM Recovery.

Questions?

If you have any questions or concerns regarding this program, please contact DeeGee Peterson at DeeGee.Peterson@delaware.gov or Joel Riley at Joel.Riley@delaware.gov.

How To Update Provider Contact Information on the Provider Portal

Enrolled providers can update their contact information (i.e., phone number, mailing address) and demographic information (i.e., accepting new patients, language spoken, etc.) on the DMAP Provider Portal. Accurate contact and demographic information are invaluable to DMAP members in need of medical services.

1. Log into the Secure Portal.
2. Select Characteristics.
3. Select the plus sign (+) next to the address to be updated.
   a. The "Mail To", "Pay To", and "Home Address" can be updated on the Portal.
   b. If the Service Location changes, a new application will be required to enroll the new Service Location.
   c. Contact Information can be updated for a Service Location.
4. Select Edit.
5. Make the necessary updates and select Save.
   a. Ensure the "Mail To" address is up to date to receive DMAP administrative notifications, such as welcome letters, revalidation notifications, and administrative updates.

Delaware Medicaid Retroactive Coverage Fact Sheet

The Division of Medicaid and Medical Assistance (DMMA) expanded the groups of individuals who are eligible for retroactive Medicaid coverage. Individuals eligible under the Delaware Healthy Children Program (DHCP) are not eligible for retroactive Medicaid. Click HERE for information about retroactive coverage, eligible members, effective dates, and reimbursement for providers.

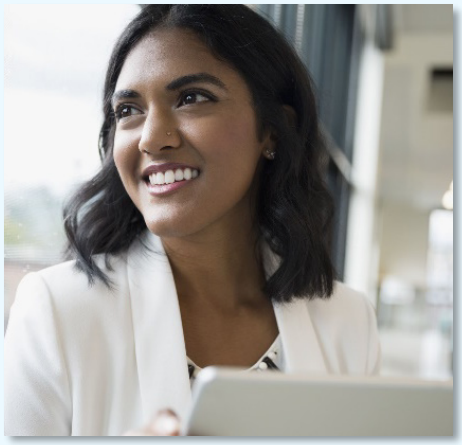
Vaccine for Children (VFC) – Encounter for Immunization

Diagnosis code Z23 (ENCOUNTER FOR IMMUNIZATION) may be used as a primary diagnosis code for immunizations in a physician setting when the member is in the VFC Program.

How-To: Subscribe to Provider Notify Me E-Mail Notifications

For providers who have NOT enrolled for an account on the Delaware Medical Assistance Portal:

1. Go to the Delaware Medical Assistance Portal: https://medicaid.dhss.delaware.gov/.
2. Select the "Notify Me" link in the left panel.
3. Enter and confirm your e-mail address. Choose which types of notifications you want to receive via e-mail.
4. When you receive a confirmation e-mail, click on the link in the e-mail to finish subscribing.



For providers who HAVE enrolled for an account on the Delaware Medical Assistance Portal:

1. Go to the Delaware Medical Assistance Portal: https://medicaid.dhss.delaware.gov/.
2. Log into the Provider Portal using your User ID and Password.
3. After signing in, users with an unverified e-mail address will be directed to the "Subscribe for E-mail Notifications" panel. A confirmation dialog box prompt will appear. Click OK.
4. Verify that the e-mail address on record is correct. If desired, add additional types of notifications.
5. When you receive a confirmation e-mail, click on the link in the e-mail to finish subscribing.

Need Assistance?

Phone & Fax Contacts

Provider Contacts

1-800-999-3371

Provider Pharmacy — **option 0, option 1**
***Fax 302-454-0224**

Provider Services — **option 0, option 2**
(***1 – Member Eligibility; 2 – Claim Status***)
***Fax 302-454-7603**

Provider Enrollment — **option 0, option 4**
***Fax 302-454-7603**

Member Contacts

1-800-996-9969

Health Benefits Manager

Delaware Cancer Treatment Program (DCTP)*
***Fax ONLY 302-454-0223**

Managed Care

Highmark Health Options

Members: 1-844-325-6251
Pharmacies: 1-844-325-6251
Providers: 1-844-325-6251
Dental Benefit Manager:
United Concordia: 1-800-372-2024

AmeriHealth Caritas Delaware

Members DSHP: 1-844-211-0966
Members DSHP Plus: 1-855-777-6617
Pharmacies DSHP: 1-855-251-0966
Pharmacies DSHP Plus: 1-888-987-6396
Providers: 1-855-707-5818
Dental Benefit Manager:
DentaQuest: 1-800-372-2022
or 1-877-378-5295
Prior Authorizations: 1-855-260-9544

Delaware First Health

Members: 1-877-236-1341
Pharmacies: 1-833-236-1887
Dental Benefit Manager:
Centene Dental: 1-833-236-1886
Provider: 1-877-236-1341

Contact Us

Secure Correspondence

Log in to the Provider Portal

Email* Us

delawarepret@gainwelltechnologies.com

**Reminder: Do not send any correspondence that has protected health information (PHI) to this mailbox.*

Electronic Data Interchange (EDI) Department*

DelawareECSGroup@gainwelltechnologies.com

1-800-999-3371, Option 0, Option 2

Stop Medicaid Fraud Now!

To Submit Anonymously

Call 1-800-372-2022

Or click HERE

Stay Connected!

Sign up for **Notify Me** to receive e-mail notifications about mass adjustments, special program information, program reminders, policy updates, holiday closing, and inclement weather updates.

Click **HERE** to sign up for Provider notifications.

Click **HERE** to sign up for Member notifications.

NOTE: If you are a Registered Provider/Delegate/Trading Partner, log into the Portal to update your Notify Me Subscription.