STATE OF NEW YORK
DEPARTMENT OF HEALTH

REQUEST: April 3, 2018
[redacted]
AGENCY: MAP
FH #: 7733981J

In the Matter of the Appeal of

[redacted]

from a determination by the New York City Department of Social Services

DECISION AFTER FAIR HEARING

JURISDICTION

Pursuant to Section 22 of the New York State Social Services Law (hereinafter Social Services Law) and Part 358 of Title 18 NYCRR, (hereinafter Regulations), a fair hearing was held on May 18, 2018, in New York City, before an Administrative Law Judge. The following persons appeared at the hearing:

For the Appellant

[redacted]

For the Managed Long Term Care Plan

Appearance waived by the Office of Administrative Hearings

ISSUES

Was the Managed Long Term Care Plan's determination as to the amount of hours of Personal Care Services authorized for Appellant upon transfer to the present Managed Long Term Care Plan and for 60 days thereafter correct?

Was the Managed Long Term Care Plan's determination to reduce the amount of hours of Personal Care Services authorized for Appellant from 35 hours a week, 5 hours a day, 7 days a week, to 23 hours a week, 3 hours a day, 6 days a week, 5 hours a day, 1 day a week, correct?

FINDINGS OF FACT

An opportunity to be heard having been afforded to all interested parties and evidence having been taken and due deliberation having been had, it is hereby found that:

1. The Appellant, age 66, has been in receipt of an authorization for Medical Assistance.

2. Prior to April 1, 2018, Appellant had been enrolled in a partial capitation Managed Long Term Care Plan operated by Centers Plan for Healthy Living.

3. Effective as of April 1, 2018, Appellant has been enrolled in a partial capitation Managed Long Term Care Plan operated by Fidelis Care.

4. Appellant has requested continued Personal Care Services for herself.

5. On March 19, 2018. Fidelis conducted a UAS-NY assessment of Appellant.

6. Appellant was initially approved for 35 hours a week of Personal Care Services, 5 hours a day, 7 days a week, effective April 1, 2018 upon her transfer to Fidelis.

7. On April 24, 2018, Appellant was approved for Medical Day Care for 6 days a week.

8. By initial adverse determination notice dated April 27, 2018, Fidelis informed Appellant that effective May 8, 2018, Appellant was approved for only 23 hours a week of Personal Care Services , 3 hours a day, 6 days a week, 5 hours a day, 1 day a week. “Due to your Medical Day Care attendance, this will necessitate a reduction in your aide services to prevent duplication of services.”

9. On April 3, 2018, the Appellant requested this fair hearing.

APPLICABLE LAW

Social Services Law section 365-a (2) states, in part, that the amount, nature and manner of providing medical assistance for needy persons shall be determined by the public welfare official with the advice of a physician and in accordance with the local medical plan, this title, and the regulations of the department.

> 1. "Benchmark coverage" shall mean payment of part or all of the cost of medically necessary medical, dental, and remedial care, services, and supplies described in subdivision two of this section, and to the extent not included therein, any essential benefits as defined in 42 U.S.C. 18022(b), with the exception of institutional long term care services; such care, services and supplies shall be provided consistent with the managed care program described in section three hundred sixty-four-j of this title.

2. "Standard coverage" shall mean payment of part or all of the cost of medically necessary medical, dental and remedial care, services and supplies, as authorized in this title or the regulations of the department, which are necessary to prevent, diagnose, correct or cure conditions in the person that cause acute suffering, endanger life, result in illness or infirmity, interfere with such person's capacity for normal activity, or threaten some significant handicap and which are furnished an eligible person in accordance with this title and the regulations of the department.

Part 438 of 42 Code of Federal Regulations (CFR) pertains to provision of Medicaid medical care, services and supplies through Managed Care Organizations (MCOs), Prepaid Inpatient Health Plans (PIHPs), Prepaid Ambulatory Health Plans (PAHPs) and Primary Care Case Managers (PCCMs), and the requirements for contracts for services so provided.

Section 438.210 of 42 CFR Subpart D provides, in pertinent part:

(a) Coverage - Each contract with an MCO, PIHP, or PAHP must do the following:

(1) Identify, define, and specify the amount, duration, and scope of each service that the MCO, PIHP, or PAHP is required to offer.

(2) Require that the services identified in paragraph (a)(1) of this section be furnished in an amount, duration, and scope that is no less than the amount, duration, and scope for the same services furnished to beneficiaries under fee-for-service Medicaid, as set forth in Sec. 440.230.

(3) Provide that the MCO, PIHP, or PAHP--

(i) Must ensure that the services are sufficient in amount, duration, or scope to reasonably be expected to achieve the purpose for which the services are furnished.

(ii) May not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness, or condition of the beneficiary;

(iii) May place appropriate limits on a service

(A) On the basis of criteria applied under the State plan, such as medical necessity; or

(B) For the purpose of utilization control, provided the services furnished can reasonably be expected to achieve their purpose, as required in paragraph (a)(3)(i) of this section;

and

(4) Specify what constitutes "medically necessary services"' in a manner that:

(i) Is no more restrictive than that used in the State Medicaid program as indicated in State statutes and regulations, the State Plan, and other State policy and procedures; and

(ii) Addresses the extent to which the MCO, PIHP, or PAHP is responsible for covering services related to the following:

(A) The prevention, diagnosis, and treatment of health impairments.

(B) The ability to achieve age-appropriate growth and development.

(C) The ability to attain, maintain, or regain functional capacity.

(b) Authorization of services. For the processing of requests for initial and continuing authorizations of services, each contract must require:

(1) That the MCO, PIHP, or PAHP and its subcontractors have in place, and follow, written policies and procedures.

(2) That the MCO, PIHP, or PAHP:

(i) Have in effect mechanisms to ensure consistent application of review criteria for authorization decisions; and
(ii) Consult with the requesting provider when appropriate.

(3) That any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, be made by a health care professional who has appropriate clinical expertise in treating the enrollee's condition or disease....

Section 438.236 of 42 CFR Subpart D provides, in pertinent part:

(a) Basic rule: The State must ensure, through its contracts, that each MCO and, when applicable, each PIHP and PAHP meets the requirements of this section.

(b) Adoption of practice guidelines. Each MCO and, when applicable, each PIHP and PAHP adopts practice guidelines that meet the following requirements:

(1) Are based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field.

(2) Consider the needs of the MCO's, PIHP's, or PAHP's enrollees.

(3) Are adopted in consultation with contracting health care professionals.

(4) Are reviewed and updated periodically as appropriate.

(c) Dissemination of guidelines. Each MCO, PIHP, and PAHP disseminates the guidelines to all affected providers and, upon request, to enrollees and potential enrollees.

(d) Application of guidelines. Decisions for utilization management, enrollee education, coverage of services, and other areas to which the guidelines apply are consistent with the guidelines.

Section 438.400 of 42 CFR Subpart F provides in part:

(a) Statutory basis. This subpart is based on sections 1902(a)(3), 1902(a)(4), and 1932(b)(4) of the Act.

(1) Section 1902(a)(3) requires that a State plan provide an opportunity for a fair hearing to any person whose claim for assistance is denied or not acted upon promptly.

(2) Section 1902(a)(4) requires that the State plan provide for methods of administration that the Secretary finds necessary for the proper and efficient operation of the plan.

(3) Section 1932(b)(4) requires Medicaid managed care organizations to establish internal grievance procedures under which Medicaid enrollees, or providers acting on their behalf, may challenge the denial of coverage of, or payment for, medical assistance.

(b) Definitions. As used in this subpart, the following terms have the indicated meanings:
In the case of an MCO or PIHP-“Action” means--

(1) The denial or limited authorization of a requested service, including the type or level of service;

(2) The reduction, suspension, or termination of a previously authorized service;

(3) The denial, in whole or in part, of payment for a service...

Section 438.402 of 42 CFR Subpart F provides in part:

(a) The grievance system. Each MCO [Managed Care Organization] and PIHP [Prepaid Inpatient Health Plan] must have a system in place, for enrollees, that includes a grievance process, an appeal process, and access to the State's fair hearing system...

Section 438.406 of 42 CFR Subpart F provides in part:

(a) General requirements. In handling grievances and appeals, each MCO and each PIHP must meet the following requirements:

(1) Give enrollees any reasonable assistance in completing forms and taking other procedural steps. This includes, but is not limited to, providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability.

(2) Acknowledge receipt of each grievance and appeal.

(3) Ensure that the individuals who make decisions on grievances and appeals are individuals--

(i) Who were not involved in any previous level of review or decision-making; and

(ii) Who, if deciding any of the following, are health care professionals who have the appropriate clinical expertise, as determined by the State, in treating the enrollee's condition or disease.

(A) An appeal of a denial that is based on lack of medical necessity.

(B) A grievance regarding denial of expedited resolution of an appeal.

(C) A grievance or appeal that involves clinical issues.

Section 4403-f of the Public Health Law pertains to Managed Long Term Care Plans.

Article 49 of the Public Health Law pertains to Utilization Review and External Appeal.

OBLIGATIONS OF THE CONTRACTOR

A. Provision of Benefits

1. The Contractor agrees to provide covered services set forth in Appendix G in accordance with the coverage and authorization requirements of 42CFR 438.210; comply with professionally recognized standards of health care and implement practice guidelines consistent with 42CFR 438.236; and comply with the requirements of 438.114 regarding emergency and post-stabilization services to the extent that services required to treat an emergency medical condition are within the scope of covered services in Appendix G.

2. Benefit package services provided by the Contractor under this Contract shall comply with all standards of the State Medicaid Plan established pursuant to State Social Services Law Section 363-a and shall satisfy all applicable requirements of the State Public Health and Social Services Law. Non-covered services for which the Enrollee is eligible under the Medicaid Program will be paid by the Department on a fee-for-service basis directly to the provider of service.

3. The Contractor agrees to allow each Enrollee the choice of Participating Provider of covered service to the extent possible and appropriate.

4. The Contractor agrees to maintain and demonstrate to the Department's satisfaction, a sufficient and adequate network for the delivery of all covered services either directly or through subcontracts. The Contractor shall meet the standards required by 42CFR 438.206 for availability of services; and 42CFR 438.207 for assurances of adequate capacity; and applicable sections of Public Health Law and regulations. If the network is unable to provide necessary services under this Contract for a particular Enrollee, the Contractor agrees to adequately and timely furnish these services outside of the Contractor's network for as long as the Contractor is unable to provide them within the network.

Section 505.14(a)(1) of the Regulations defines "Personal Care Services" to mean assistance with nutritional and environmental support functions and personal care functions, as specified in clauses (5)(i)(a) and (5)(ii)(a) of this subdivision. Such services must be essential to the maintenance of the patient's health and safety in his or her own home...".

Section 505.14(a) of the Regulations provides in part that:

(2) Continuous personal care services means the provision of uninterrupted care, by more than one personal care aide, for more than 16 hours in a calendar day for a patient who, because of the patient's medical condition, needs assistance during such calendar day with toileting, walking, transferring, turning and positioning, or feeding and needs assistance with such frequency that a live-in 24-hour personal care aide would be unlikely to obtain, on a regular basis, five hours daily of uninterrupted sleep during the aide's eight hour period of sleep.

(4) Live-in 24-hour personal care services means the provision of care by one personal care aide for a patient who, because of the patient's medical condition, needs assistance during a calendar day with toileting, walking, transferring, turning and positioning, or feeding and whose need for assistance is sufficiently infrequent that a

live-in 24-hour personal care aide would be likely to obtain, on a regular basis, five hours daily of uninterrupted sleep during the aide's eight hour period of sleep.

(5) Personal care services shall include the following two levels of care, and be provided in accordance with the following standards:

(i) Level I shall be limited to the performance of nutritional and environmental support functions.

(a) Nutritional and environmental support functions include assistance with the following:

(1) making and changing beds;

(2) dusting and vacuuming the rooms which the patient uses;

(3) light cleaning of the kitchen, bedroom and bathroom;

(4) dishwashing;

(5) listing needed supplies;

(6) shopping for the patient if no other arrangements are possible;

(7) patient's laundering, including necessary ironing and mending;

(8) payment of bills and other essential errands; and

(9) preparing meals, including simple modified diets.

(b) The authorization for Level I services shall not exceed eight hours per week.

(ii) Level II shall include the performance of nutritional and environmental support functions specified in clause (i)(a) of this paragraph and personal care functions.

(a) Personal care functions include assistance with the following:

(1) bathing of the patient in the bed, the tub or in the shower;

(2) dressing;

(3) grooming, including care of hair, shaving and ordinary care of nails, teeth and mouth;

(4) toileting; this may include assisting the patient on and off the bedpan, commode

or toilet;

(5) walking, beyond that provided by durable medical equipment, within the home and outside the home;

(6) transferring from bed to chair or wheelchair;

(7) turning and positioning;

(8) preparing of meals in accordance with modified diets, including low sugar, low fat, low salt and low residue diets;

(9) feeding;

(10) administration of medication by the patient, including prompting the patient as to time, identifying the medication for the patient, bringing the medication and any necessary supplies or equipment to the patient, opening the container for the patient, positioning the patient for medication and administration, disposing of used supplies and materials and storing the medication properly;

(11) providing routine skin care;

(12) using medical supplies and equipment such as walkers and wheelchairs; and

(13) changing of simple dressings.

Section 505.14(a)(4)(iii) of the regulations provides personal care services shall not be authorized if the patient's need for assistance can be met by either or both of the following:

(a) voluntary assistance available from informal caregivers including, but not limited to, the patient's family, friends or other responsible adult; or formal services provided by an entity or agency; or

(b) adaptive or specialized equipment or supplies including, but not limited to, bedside commodes, urinals, walkers and wheelchairs, when such equipment or supplies can be provided safely and cost-effectively.

18 NYCRR 505.14(g) provides, in part:

(g) Case management.

(1) All patients receiving personal care services must be provided with case management services according to this subdivision...

(3) Case management includes the following activities...

> arranging for the delivery of personal care services according to subdivision (c) of this section….
> monitoring personal care services to ensure that such services are provided according to the authorization and that the patient's needs are appropriately met...

Subsection (b) of the just-cited section of Regulations provides, in part:

> The social services district must first determine whether the patient, because of the patient's medical condition, would be otherwise eligible for personal care services, including continuous personal care services or live-in 24-hour personal care services. For patients who would be otherwise eligible for personal care services, the district must then determine whether, and the extent to which, the patient's need for assistance can be met by voluntary assistance from informal caregivers, by formal services, or by adaptive or specialized equipment or supplies, as specified in subclauses (a)(1) through (a)(3) of this subparagraph.

Under Section 505.14(a)(4) of the Regulations, personal care services, as defined in this section, can be provided only if the services are medically necessary and the social services district reasonably expects that the patient's health and safety in the home can be maintained by the provision of such services, as determined in accordance with the regulations of the Department of Health.

18 NYCRR 505.28 (b) includes the following definitions:

…

(2) "consumer directed personal assistance" means the provision of some or total assistance with personal care services, home health aide services and skilled nursing tasks by a consumer directed personal assistant under the instruction, supervision and direction of a consumer or the consumer's designated directive.

…

(5) "designated representative" means an adult to whom a self-directing consumer has delegated authority to instruct, supervise and direct the consumer directed personal assist and to perform the consumer's responsibilities specified in subdivision (g) of this section who is willing and able to perform these responsibilities. With respect to a non-self-directing consumer, a "designated representative' means the consumer's parent, legal guardian or, subject to the social services district's approval, a responsible adult surrogate who is willing and able to perform such responsibilities on the consumer's behalf. The designated representative may not be the consumer directed personal assistant or a fiscal intermediary employee, representative or affiliated person.

…

(8) "personal care services" means the nutritional and environmental support functions, personal care functions, or both such functions, that are specified in Section 505.14 (a)(6) of this Part.

(d) Assessment process. When the social services district receives a request to participate in the consumer directed personal assistance program, the social service district must assess whether the individual is eligible for the program. The assessment process includes a physician's order, a social assessment and a nursing assessment and, when required under paragraph (5) of this subdivision, a referral to the local professional director or designee.

NYS DEPARTMENT OF HEALTH

Guidelines for the Provision of Personal Care Services in Medicaid Managed Care

I. Scope of the Personal Care Benefit

(a) vii. Personal care services includes some or total assistance with:

1. Level I functions as follows:
    a. Making and changing beds ;
    b. Dusting and vacuuming the rooms which the member uses;
    c. Light cleaning of the kitchen, bedroom and bathroom;
    d. Dishwashing;
    e. Listing needed supplies;
    f. Shopping for the member if no other arrangements are possible;
    g. Member's laundering, including necessary ironing and mending;
    h. Payment of bills and other essential errands; and
    i. Preparing meals, including simple modified diets.
2. Level II personal care services include Level I functions listed above and the following personal care functions:
    a. Bathing of the member in the bed, the tub or the shower;
    b. Dressing;
    c. Grooming, including care of hair, shaving and ordinary care of nails, teeth and mouth;
    d. Toileting, this may include assisting the patient on and off the bedpan, commode or toilet;
    e. Walking, beyond that provided by durable medical equipment, within the home and outside the home;
    f. Transferring from bed to chair or wheelchair;
    g. Preparing of meals in accordance with modified diets, including low sugar, low fat, and low residue diets;
    h. Feeding
    i. Administration of medication by the member, including prompting the member as to time, identifying the medication for the member, bringing the medication and any necessary supplies or equipment to the member, opening the container for the member, positioning the member for medication administration, disposing of used

equipment, supplies and materials and correct storage of medication;
j. Providing routine skin care;
k. Using medical supplies and equipment such as walkers and wheelchairs; and
l. Changing of simple dressings….

III. Authorization and Notice Requirements for Personal Care Services

e. Terminations and Reductions. Authorizations reduced by the MCO during the authorization period require a fair hearing and aid-to-continue language and must meet advance notice requirements of Appendix F.1(4)(a). Fair hearing and aid-to-continue rights are included in the "Managed Care Action Taken Termination or Reduction in Benefits" notice, which must be attached to the Notice of Action. Eligibility for aid-to-continue is determined by the Office of Administrative Hearings.

ii. If the authorization being amended was an LDSS authorization for PCS made pursuant to 18 NYCRR §505.14, an enrollee requesting a fair hearing has the right for aid-to-continue unchanged until the fair hearing decision is issued. (See 18 NYCRR § 358-3.6).

iii. If the authorization being amended was issued by an MCO (either current or previous MCO), an enrollee requesting a fair hearing has the right for aid-to-continue unchanged until the expiration of the current authorization period (see 42 CFR 438.420(c)(4) and 18 NYCRR §360-10.8). The Action takes effect on the start date of a new authorization period, if any, even if the fair hearing has not yet taken place.

iv. All notices must reflect the reasons for reduction, discontinuation or denial of a reauthorization for PCS. Appropriate reasons for reducing, discontinuing or denying a reauthorization of personal care services include but are not limited to:

1. the client's medical, mental, economic or social circumstances have changed and the MCO determines that the personal care services provided under the last authorization or reauthorization are no longer appropriate or can be provided in fewer hours than they were previously;
2. a mistake occurred in the previous personal care services authorization;
3. the member refused to cooperate with the required assessment of services;
4. a technological development renders certain services unnecessary or less time consuming;
5. **the member can be more appropriately and cost-effectively served through other Medicaid programs and services;**
6. the member's health and safety cannot be reasonably assured with the provision of personal care services;

7. the member's medical condition is not stable;
8. the member is not self-directing and has no one to assume those responsibilities;
9. the services the member needs exceed the personal care aide's scope of practice.

The Department's MLTC Policy 13.03:

The Partnership Plan terms and conditions (28 (d)) require:

Each enrollee who is receiving community-based long-term services and supports, as specified below, that qualifies for MLTC must continue to receive services under the enrollee's pre-existing service plan for at least 60 days after enrollment, or until a care assessment has been completed by the MCO/PIHP, whichever is later.
Any reduction, suspension, denial or termination of previously authorized services shall trigger the required notice under 42 C.F.R . § 438.404, mailed at least ten days before the proposed effective date of the change (as required by 42 C.F.R. § 431.211), that clearly articulates the enrollee's right to file an internal appeal (either expedited, if warranted, or standard), the right to have authorized services continue pending the resolution of the internal appeal, and the right to a fair hearing if the plan renders an adverse determination (either in whole or in part) on the internal appeal.

Social Services Law Section 365-a.8, as amended, states:

When a non-governmental entity is authorized by the department pursuant to contract or subcontract to make prior authorization or prior approval determinations that may be required for any item of medical assistance, a recipient may challenge any action taken or failure to act in connection with a prior authorization or prior approval determination as if such determination were made by a government entity, and shall be entitled to the same medical assistance benefits and standards and to the same notice and procedural due process rights, including a right to a fair hearing and aid continuing pursuant to section twenty-two of this chapter, as if the prior authorization or prior approval determination were made by a government entity, without regard to expiration of the prior service authorization.

Section 358-5.9 of the Regulations provide in part:

(a) At a fair hearing concerning the denial of an application for or the adequacy of public assistance, medical assistance, HEAP, SNAP benefits or services, the appellant must establish that the agency's denial of assistance or benefits was not correct or that the appellant is eligible for a greater amount of assistance or benefits.

DISCUSSION

The record discloses that Appellant, age 66, has been in receipt of an authorization for Medical Assistance. Effective as of April 1, 2018, Appellant has been enrolled in a partial capitation Managed Long Term Care Plan operated by Fidelis Care. Appellant was initially approved for 35 hours a week of Personal Care Services, 5 hours a day, 7 days a week, upon her transfer to Fidelis on April 1, 2018. By initial adverse determination notice dated April 27, 2018, Fidelis informed Appellant that effective May 8, 2018, Appellant was reduced to 23 hours a week of Personal Care Services , 3 hours a day, 6 days a week, 5 hours a day, 1 day a week. This hearing was requested for review of Fidelis' decision to reduce hours.

Appellant's sisters were insistent in their testimony that Appellant was receiving 58 hours of Personal Care Services from Centers Plan, immediately prior to her transfer to Fidelis. However, although given an adjournment to corroborate this, Appellant's sisters and representatives were not able to produce verification of their claim. Indeed, records provided from Centers Plan showed Appellant was only receiving 28 hours per week prior to the transfer. Nevertheless, Fidelis was not correct under MLTC Policy 13.03 to reduce Personal Care Services to under 28 hours a week as of May 8, which was prior to 60 days after the transfer.

NYS Department of Health Guidelines list nine appropriate reasons for reducing Personal Care Services authorized under Mainstream Managed Care or Managed Long-Term Care. Fidelis' rationale for the reduction to 23 hours qualifies as a listed reason--"Due to your Medical Day Care attendance, this will necessitate a reduction in your aide services to prevent duplication of services."

As per the March nurse assessment, Appellant was found to need maximal assistance with meal preparation and housework, extensive assistance with finances, toilet use, medication, shopping, equipment maintenance, bathing, hygiene, dressing upper and lower body, and limited assistance with walking, locomotion, and transfer toilet. Appellant has been diagnosed with bipolar disorder, COPD, coronary heart disease, advanced kidney disease, bowel incontinence, hypothyroidism, difficulty in walking, asthma, shortness of breath, and vitamin deficiency. A number of these are severe and chronic conditions.

The fact that Appellant has been found to need help with walking, toileting, and dressing could possibly qualify her for 24 hour care under applicable regulations and policy. Therefore, even though Appellant has been approved for 6 days of Adult Day Care, her needs are such that 35 hours a week of Personal Care Services remain reasonable and useful. As to the concept of duplication, it may be noted that performance of chores tasks in the home can be concentrated to emphasize times when Appellant attends Day Care. Fidelis can not be upheld in reducing hours.

DECISION AND ORDER

The Managed Long Term Care Plan's determination as to the amount of hours of Personal Care Services authorized for Appellant upon transfer to the present Managed Long Term Care Plan and for 60 days thereafter (authorization of 35 hours weekly) was correct.

The determination of Appellant's Managed Long Term Care Plan to reduce the Appellant's Personal Care Services authorization from 35 hours a week, 5 hours a day, 7 days a week, to 23 hours a week, 3 hours a day, 6 days a week, 5 hours a day, 1 day a week, is not correct and is reversed.

1. The MLTCP is directed to restore Appellant's Personal Care Services authorization to the amount of 35 hours a week, 5 hours a day, 7 days a week.

2. The MLTCP is directed to continue to authorize Personal Care Services to the Appellant in the amount of 35 hours a week, 5 hours a day, 7 days a week, and to notify Appellant upon compliance with this fair hearing decision.

Should the MLTCP need additional information from the Appellant in order to comply with the above directives, it is directed to notify the Appellant and the Appellant's representative promptly in writing as to what documentation is needed. If such information is required, the Appellant or the Appellant's representative must provide it promptly to facilitate such compliance.

As required by Section 358-6.4 of the Regulations, the Agency must comply immediately with the directives set forth above.

DATED: Albany, New York
06/06/2018

NEW YORK STATE
DEPARTMENT OF HEALTH

By

Commissioner's Designee