STATE OF NEW YORK
DEPARTMENT OF HEALTH

REQUEST: February 25, 2016
[redacted]
AGENCY: MAP
FH #: 7248076H

In the Matter of the Appeal of [redacted]	:	**DECISION AFTER FAIR HEARING**
from a determination by the New York City Department of Social Services	:	

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 June 14, 2016, 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

Joanne Hinkson, Grievances and Appeals Manager (3/21/2016 and 6/14/2016 only)

ISSUE

Was the Managed Long-Term Care Plan's determination to deny the Appellant's physician's authorization request for a motorized wheelchair for the Appellant 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 61 and certified disabled, is enrolled in a partially capitated managed long-term care plan operated by Centers Plan for Healthy Living (hereinafter, the "MLTC Plan").

2. On January 6, 2016, the Appellant's vascular surgeon submitted a prior authorization request to the MLTC Plan for a motorized wheelchair for the Appellant.

3. On January 8, 2016, the Appellant's vascular surgeon submitted a formal prior authorization request to the MLTC Plan for a motorized wheelchair, which included the Appellant's progress notes, a diagnosis of "right lower extremity amputation", and also states: "Motorized wheelchair requested in order for Ms. [redacted] to ambulate for daily living re doctor's app[ointment]ts[,] routine errands etc."

4. By notice dated January 22, 2016, the MLTC Plan advised the Appellant of its determination to deny the prior authorization request for a motorized or power wheelchair because the Appellant is "a 60[-]year[-]old female with a significant past medical history of high blood pressure, elevated cholesterol and peripheral vascular disease complicated by right lower extremity amputation 3 years ago and angioplasty/stenting of the left lower extremity for whom a request has been submitted (by prescription) for a motorized wheelchair. The request for this device reflects that you need this device to conduct your day-to-day activities (e.g. routine errands, doctor visits). A clinical follow-up note completed on 01/06/16 reflects that you are doing well following your angioplasty without chest pain or shortness of breath with exercise and have no other musculoskeletal complaints or conditions. No clinical documentation is provided, however, inclusive of a comprehensive Physical Therapy evaluation that reflects any of the remaining physical limitations that you may have had that would require a motorized device or that would, specifically, preclude the use of a manually-operated wheelchair to meet your needs…"

5. On February 25, 2016, the Appellant requested this fair hearing to contest the Plan's determination to deny the authorization request for a motorized wheelchair.

APPLICABLE LAW

Section 365-a of the Social Services Law provides in part:

> 2. "Medical Assistance" shall mean payment of part or all of the cost of care, services and supplies 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 his capacity for normal activity, or threaten some significant handicap and which are furnished an eligible person in accordance with this title, and the regulations ...

Section 364.2 of the Social Services Law provides in part, as follows:

The Department of Health shall be responsible for . . .

> (b) establishing and maintaining standards for all non-institutional health care and services rendered pursuant to this title, . . .

* * *

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. The NYS Department of Health has entered into a contract with VNS Choice.

Section 438.210 of 42 CFR Subpart D provides in part:

Section 438.210 Coverage and authorization of services.

(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 part:

Section 438.236 Practice guidelines.

(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 438.402 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 4403-f of the Public Health Law pertains to Managed Long Term Care Plans.

Subsection 1 of said statute, definitions, states, in part:

As used in this section:

(a) "Managed long term care plan" means an entity that has received a certificate of authority pursuant to this section to provide, or arrange for, health and long term care services, on a capitated basis in accordance with this section, for a population which the plan is authorized to enroll.

Subsection 5 of said statute states, in part:

Applicability of other laws. (a) A managed long term care plan or approved managed long term care demonstration shall be subject to the provisions of the insurance law and regulations applicable to health maintenance organizations, this article and regulations promulgated pursuant thereto. To the extent that the provisions of this section are inconsistent with the provisions of this chapter or the provisions of the insurance law, the provisions of this section shall prevail.

Article V of the Managed Long-Term Care Model Contract for New York State provides:

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 42 CFR 438.210; comply with professionally recognized standards of health care and implement practice guidelines consistent with 42 CFR 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.

According to Appendix G of the just-cited Model Contract, one of the services for which the State will pay a Plan as part of capitation payments, if the Plan elects to provide such service, is Durable Medical Equipment.

Appendix K of the just-cited Model Contract summarizes the participant's statutory rights to appeal determinations of the Managed Long-Term Care Plan, including the right to a fair hearing. Pursuant to the New York State Department of Health Office of Health Insurance Programs MLTC Policy 15.03, for all MLTC partial capitation plan decisions made on or after July 1, 2015 that deny, reduce or discontinue enrollees' services, enrollees may request a State fair hearing from the NYS Office of Temporary and Disability Assistance ("OTDA") immediately without first requesting an internal appeal of the determination.

Social Services Law §365-a(2) provides that "Medical assistance" 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.

Social Services Law §365-a(2)(k) provides that such care, services and supplies shall include care and services furnished by an entity offering a comprehensive health services plan, including an entity that has received a certificate of authority pursuant to sections forty-four hundred three, forty-four hundred three-a or forty-four hundred eight-a of the public health law (as added by chapter six hundred thirty-nine of the laws of nineteen hundred ninety-six) or a

health maintenance organization authorized under article forty-three of the insurance law, to eligible individuals residing in the geographic area served by such entity, when such services are furnished in accordance with an agreement approved by the department which meets the requirements of federal law and regulations.

According to 18 NYCRR section 505.5(d), the Medical Assistance Program covers medical and surgical supplies, a term which is defined at section 505.5(a)(2).

The New York State Department of Health has implemented electronic prior approval request mechanisms for certain medical and surgical supplies. Pursuant to the EMedNY durable medical equipment handbook, based upon Department guidelines, the prior approval coding for most adult incontinence products is "6," meaning that "electronic prior authorization through the Medicaid Eligibility Verification System (MEVS) Dispensing Validation (DVS) is required."

The New York State Managed Long-Term Care Partial Capitation Contract, effective September 1, 2012, Appendix G, lists durable medical equipment, including medical/surgical supplies, as a covered benefit.

The newly-amended New York State (EMedNY) Medicaid Manual for DME includes the following clinical criteria for Wheeled Mobility Equipment, a term that encompasses manual wheelchairs, power mobility devices (including power wheelchairs), power operated vehicles, and push rim-activated power assist devices:

General Clinical Criteria for Wheeled Mobility Equipment:

●Wheeled mobility equipment is covered if the beneficiary's medical condition(s) and mobility limitation(s) are such that without the use of the WME, the beneficiary's ability to perform mobility related activities of daily living (MRADL) in the home and/or community is significantly impaired and the beneficiary is not ambulatory or functionally ambulatory.
●When a beneficiary presents for a medical evaluation for WME and SPC (Seating and Positioning Components), the sequential consideration of the questions below by ordering and treating practitioners provides clinical guidance for the ordering of an appropriate device to meet the medical need of treating and restoring the beneficiary's ability to perform MRADLs. MRADLs include dining, personal hygiene tasks and activities specified in a medical treatment plan completed in customary locations in the home and community.

1. Does the beneficiary have a mobility limitation that significantly impairs his/her ability to participate in one or more MRADLs? A mobility limitation is one that:
(a). Prevents the beneficiary from accomplishing the MRADLs entirely, or,
(b). Places the beneficiary at a reasonably determined heightened risk of morbidity or mortality secondary to attempts to participate in MRADLs, or,
(c). Prevents the beneficiary from completing the MRADLs within a reasonable time frame.
2. Are there other conditions that limit the beneficiary's ability to participate in MRADLs?
(a). Some examples are significant impairment of cognition or judgment and/or vision.

(b). For these beneficiaries, the provision of WME and SPC might not enable them to participate in MRADLs if the co-morbidity prevents effective use of the wheelchair or reasonable completion of the tasks even with WME and SPC.
3. If these other limitations exist, can they be ameliorated or compensated sufficiently such that the additional provision of WME and SPC will be reasonably expected to significantly improve the beneficiary's ability to perform or obtain assistance to participate in MRADLs?
(a). A caregiver, for example a family member, may be compensatory, if consistently available and willing and able to safely operate and transfer the beneficiary to and from the wheelchair and to transport the beneficiary using the wheelchair. The caregiver's need to use a wheelchair to assist the beneficiary in the MRADLs is to be considered in this determination.
(b). If the amelioration or compensation requires the beneficiary's compliance with treatment, for example medications or therapy, substantive non-compliance, whether willing or involuntary, can be grounds for denial of WME and SPC coverage if it results in the beneficiary continuing to have a significant limitation. It may be determined that partial compliance results in adequate amelioration or compensation for the appropriate use of WME and SPC.
4. Does the beneficiary or caregiver demonstrate the capability and the willingness to consistently operate the WME and SPC safely and independently?
(a). Safety considerations include personal risk to the beneficiary as well as risk to others. The determination of safety may need to occur several times during the process as the consideration focuses on a specific device.
(b). A history of unsafe behavior may be considered.
5. Can the functional mobility deficit be sufficiently resolved by the prescription of a cane or walker?
(a). The cane or walker should be appropriately fitted to the beneficiary for this evaluation.
(b). Assess the beneficiary's ability to safely use a cane or walker.
6. Does the beneficiary's typical environment support the use of WME and SPC?
(a). Determine whether the beneficiary's environment will support the use of these types of WME and SPC.
(b). Keep in mind such factors as physical layout, surfaces, and obstacles, which may render WME and SPC unusable.
7. Does the beneficiary have sufficient upper extremity function to propel a manual wheelchair to participate in MRADLs during a typical day? The manual wheelchair should be optimally configured (seating and positioning components, wheelbase, device weight, and other appropriate accessories) for this determination.
(a). Limitations of strength, endurance, range of motion, coordination, and absence or deformity in one or both upper extremities are relevant.
(b). A beneficiary with sufficient upper extremity function may qualify for a manual wheelchair. The appropriate type of manual wheelchair, i.e. light weight, etc., should be determined based on the beneficiary's physical characteristics and anticipated intensity of use.
(c). The beneficiary's home should provide adequate access, maneuvering space and surfaces for the operation of a manual wheelchair.
(d). Assess the beneficiary's ability to safely use a manual wheelchair.
NOTE: If the beneficiary is unable to self-propel a manual wheelchair, and if there is a caregiver who is available, willing, and able to provide assistance, a manual wheelchair may be appropriate.

8. Does the beneficiary have sufficient strength and postural stability to operate a POV/scooter?
(a). A covered POV is a 4-wheeled device with tiller steering and limited seat modification capabilities. The beneficiary must be able to maintain stability and position for adequate operation without additional SPC (a 3-wheeled device is not covered).
(b). The beneficiary's home should provide adequate access, maneuvering space and surfaces for the operation of a POV.
(c). Assess the beneficiary's ability to safely use a POV/scooter.
9. Are the additional features provided by a power wheelchair or powered SPC needed to allow the beneficiary to participate in one or more MRADLs?
(a). The pertinent features of a power wheelchair compared to a POV are typically control by a joystick or alternative input device, lower seat height for slide transfers, and the ability to accommodate a variety of seating needs.
(b). The type of wheelchair and options provided should be appropriate for the degree of the beneficiary's functional impairments.
(c). The beneficiary's home should provide adequate access, maneuvering space and surfaces for the operation of a power wheelchair.
(d). Assess the beneficiary's ability to safely and independently use a power wheelchair and powered SPC.
NOTE: If the beneficiary is unable to use a power wheelchair or power SPC and if there is a caregiver who is available, willing and able to provide assistance, a manual wheelchair and manual SPC is appropriate.
General Coverage Criteria for WME:
●The coverage criteria for Medicaid reimbursement of WME is based on a stepwise progression of medical necessity listed in the clinical criteria above and the specific criteria in this section
●In order for these criteria to be met, the beneficiary must have an evaluation that was performed by a qualified practitioner who has specific training and/or experience in wheelchair evaluation and ordering.
●The practitioner must document, to the extent required by the coverage criteria for the specific WME, how the beneficiary's medical condition supports Medicaid reimbursement.
●The practitioner must have no financial relationship with the supplier.
●If coverage criteria for the WME that is requested or provided are not met and if there is another device that meets the beneficiary's medical needs, payment will be based on the allowance for the least costly medically appropriate alternative.
●Determination of least costly alternatives will take into account the beneficiary's weight, seating needs, amount and type of use and needs for other medically necessary features.
●Maintaining documentation of least costly alternatives reviewed and attempted is the responsibility of the ordering practitioner and DMEPOS provider.
●Documentation must be submitted or provided at the time of manual review of a prior approval request, claim, or audit.

Regulation 358-5.9(a) provides, in part:

> At a fair hearing concerning the denial of an application for or the adequacy of

medical assistance, 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 hearing record establishes that the Appellant, who is 61 years old and certified disabled, is enrolled with Centers Plan for Healthy Living, a managed long-term care plan. The Appellant is diagnosed with asthma, Chronic Obstructive Pulmonary Disease (COPD), emphysema, shortness of breath with minimal exertion, HIV, and severe peripheral artery disease (Appellant Exhibits 1 and 4; Plan Exhibit 1). The Appellant's right leg was amputated below the knee several years ago, and she continues to experience debilitating pain in the remaining portion of her leg. Additionally, the Appellant continues to receive treatment from her vascular surgeon for poor circulation in both legs. For these reasons, she is able to ambulate only with the use of a wheelchair.

On January 6, 2016, the Appellant's vascular surgeon submitted a prior authorization request to the MLTC Plan for a motorized wheelchair for the Appellant. On January 8, 2016, the Appellant's vascular surgeon submitted a formal prior authorization request to the MLTC Plan for a motorized wheelchair, which included the Appellant's progress notes, a diagnosis of "right lower extremity amputation", and also states: "Motorized wheelchair requested in order for Ms. [redacted] to ambulate for daily living re doctor's app[ointment]ts[,] routine errands etc." The progress notes document the stents and angioplasty in the Appellant's arteries within her legs, as well as her reports of "rest pain" in her left leg, and tingling in her left foot.

By notice dated January 22, 2016, the MLTC Plan advised the Appellant of its determination to deny the prior authorization request for a motorized or power wheelchair because the Appellant is "a 60[-]year[-]old female with a significant past medical history of high blood pressure, elevated cholesterol and peripheral vascular disease complicated by right lower extremity amputation 3 years ago and angioplasty/stenting of the left lower extremity for whom a request has been submitted (by prescription) for a motorized wheelchair. The request for this device reflects that you need this device to conduct your day-to-day activities (e.g. routine errands, doctor visits). A clinical follow-up note completed on 01/06/16 reflects that you are doing well following your angioplasty without chest pain or shortness of breath with exercise and have no other musculoskeletal complaints or conditions. No clinical documentation is provided, however, inclusive of a comprehensive Physical Therapy evaluation that reflects any of the remaining physical limitations that you may have had that would require a motorized device or that would, specifically, preclude the use of a manually-operated wheelchair to meet your needs…"

On the first scheduled date of this hearing, the Appellant explained that she has been borrowing a friend's spare motorized wheelchair that has a very low battery, and which she has been asked to return to her friend. The Appellant stated that she was given a manual wheelchair approximately two years ago. However, the Appellant asserted that she simply cannot ambulate with a manual wheelchair because of her respiratory ailments. She contended that she

experiences shortness of breath quite frequently, with minimal effort. When she attempted to use her manual wheelchair, the Appellant explained, she quickly became short of breath, which very quickly caused asthma attacks, some of which were so severe that she needed to be hospitalized.

In reviewing the documentation submitted by the Appellant's vascular surgeon to the MLTC Plan as part of the authorized request, the Appellant contested the surgeon's failure to include information pertaining to her respiratory ailments. Additionally, she submitted into evidence a new letter dated March 18, 2016 from the requesting vascular surgeon, which states in pertinent part:

> This letter is to verify that Ms. [redacted], has been under my care for a leg amputation.
>
> Ms. [redacted] is in immediate need of a motorized wheelchair. She has poor circulation on her remaining leg and it is extremely difficult for her to ambulate. In addition, she also suffers from asthma and takes Spiriva and Albuterol inhalers to assist with breathing. In order to remain active and keep all important medical and physical therapy appointments, it is imperative that she receive a motorized wheelchair to assist her with these medical matters…

[Appellant Exhibit 1]

In response to the Appellant's submission of this letter, the MLTC Plan representative contended that a vascular surgeon lacks specialized knowledge concerning respiratory ailments. For that reason, the Appellant requested an adjournment to obtain information concerning her respiratory problems directly from her internist.

However, on the second scheduled date of the hearing, the Appellant explained that she was hospitalized for several days beginning on or before April 21, 2016, because of severe pain in her legs. She was then discharged on April 23, 2016 to a Skilled Nursing Facility, where she remained for over one week. In support of these statements, she submitted her Patient Discharge Instructions from the treating hospital into evidence (Appellant Exhibit 3). At the Appellant's request, she was granted a final adjournment to obtain information from her internist.

On the third scheduled date of this hearing, the Appellant submitted into evidence a letter from her internist dated May 18, 2016, which states, in pertinent part: "[redacted] is my patient in [the] Chest Clinic. Patient has COPD/Emphysema. She is wheelchair[-]bound. She gets shortness of breath with minimal exertion. She needs [a] powered wheelchair…" (Appellant Exhibit 4).

In response to the Appellant's introduction of the May 18, 2016 letter into evidence, the Plan's representative asserted that the Plan is unaware of the Appellant's respiratory ailments. The Plan's contention has been considered and upon due deliberation, is held to be without merit. The MLTC Plan has authorized the Appellant to receive Personal Care Services, and is therefore responsible for conducting periodic assessments of the Appellant's overall abilities

with respect to performance of activities of daily living. One component of the assessment entails reviewing the Appellant's medical history, and current medical conditions. The Plan is therefore required to ensure that the Appellant receives care that is adequate and appropriate considering the Appellant's unique medical needs. Therefore, before rendering any determination to authorize or deny a service, it is the Plan's obligation to review the Appellant's health conditions. In fact, the MLTC Plan's January 22, 2016 notice upon which this fair hearing was requested appears to indicate that the Plan had considered the Appellant's medical needs and history before rendering its determination.

The evidence has been considered. The hearing record clearly establishes that the Appellant has a severe mobility limitation that inhibits her ability to perform activities of daily living. Her limitation may only be alleviated with the use of a wheelchair, specifically, a motorized wheelchair because she is prone to shortness of breath and exacerbating her respiratory ailments upon minimal exertion. The Appellant has established that the requested motorized wheelchair is medically necessary. Therefore, the MLTC Plan's determination cannot be sustained.

DECISION AND ORDER

The Managed Long-Term Care Plan's determination to deny the Appellant's physician's authorization request for a motorized wheelchair for the Appellant was not correct and is reversed.

The Managed Long-Term Care Plan is directed to:

1. Approve the Appellant's physician's request for a motorized/power wheelchair.

2. Notify the Appellant and her physician in writing when it has complied with this directive.

Should the Managed Long-Term Care Plan need additional information from the Appellant in order to comply with the above directives, it is directed to notify the Appellant promptly in writing as to what documentation is needed. If such information is requested, the Appellant must provide it to the Managed Long-Term Care Plan promptly to facilitate such compliance.

As required by 18 NYCRR 358-6.4, the Agency must comply immediately with the directives set forth above.

DATED: Albany, New York
07/07/2016

NEW YORK STATE
DEPARTMENT OF HEALTH

By

Commissioner's Designee