STATE OF NEW YORK
DEPARTMENT OF HEALTH

REQUEST: May 24, 2018
[redacted]
AGENCY: MAP
FH #: 7763705L

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 20, 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

Personal appearance of the Plan waived by the Office of Administrative Hearings

ISSUE

Was the April 5, 2018, determination by the Managed Long-Term Care plan, Center's Plan for Healthy Living, to deny a request that the Plan authorize an increase in the Appellant's Personal Care Services from sixty-three (63) hours per week (9 hours per day x 7 days) to twenty-four (24) hour daily "split-shift" services by more than one Personal Care Aide, with regard to the adequacy of Medical Assistance, 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 ninety-six (96), has been in receipt of a Medical Assistance authorization, Medicaid benefits, and has been enrolled in a Medicaid Managed Long-Term Care Plan with Centers Plan for Healthy Living.

2. The Appellant resides alone.

3. The Appellant has been in receipt of an authorization of Personal Care Services in the amount of sixty-three (63) hours per week (9 hours per day x 7 days).

4. The Appellant requested that the Plan authorize an increase in Personal Care Services to twenty-four (24) hour daily "split-shift" services by more than one Personal Care Aide.

5. On March 22, 2018, a registered nurse assessor completed a Uniform Assessment System (UAS)- New York Assessment Report of the Appellant's personal care needs based upon an in-person evaluation of the Appellant by the registered nurse assessor on said date.

6. On March 22, 2018, the Plan also completed a Centers Plan for Healthy Living "Client Task Sheet," and, based on said assessment, the Plan authorized an increase of the Appellant's Personal Care Services from fifty-six (56) hours (8 hours per day x 7 days) to the current sixty-three (63) hours per week (9 hours per day x 7 days).

7. The Appellant has been diagnosed with the following medical conditions: age related cognitive decline, age related physical disability, anemia, dizziness and giddiness, fecal urgency, hypertensive heart disease with heart failure, long term (current) use of aspirin, muscle weakness, abnormalities of gait and mobility, fatigue, presence of an implanted cardiac defibrillator, presence of a cardiac pacemaker, shortness of breath, dementia without behavioral disturbance, hearing loss, macular degeneration, osteoarthritis, urinary incontinence, urinary tract infection, and vitamin D deficiency.

8. By notice dated May 15, 2018, Center's Plan for Healthy Living advised the Appellant that the Agency was denying the request that the Plan authorize an increase in the Appellant's Personal Care Services from sixty-three (63) hours per week (8 hours per day x 7 days) to twenty-four (24) hour daily "split-shift" services by more than one Personal Care Aide on the grounds that "the health care service is not medically necessary."

9. On May 24, 2018, the Appellant requested this fair hearing.

APPLICABLE LAW

Section 358-5.9 of the Regulations provides that, at a fair hearing concerning the denial of an application for or the adequacy of Medical Assistance 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.

The Department's Managed Care Personal Care Services (PCS) Guidelines dated May 2013 advises that requests for PCS must be reviewed for benefit coverage and medical necessity of the service in accordance with Public Health Law (PHL) Article 49, 18 NYCRR 505.14 (a), the Medicaid Managed Care (MMC) Model Contract and these guidelines. As such, denial or

reduction in services must clearly set forth a clinical rationale that shows review of the enrollee's specific clinical data and medical condition; the basis on which request was not medically necessary or does not meet specific benefit coverage criteria; and be sufficient to enable judgment for possible appeal. If the determination results in a termination or reduction, the reason for denial must clearly state what circumstances or condition has changed to warrant reduction or termination of previously approved services.

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.

18 NYCRR 505.14(a)(5) provides that:

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…

(ii) Level II shall include the performance of nutritional and environmental support functions 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 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.

The authorization of a personal care services authorization must be based, in relevant part, a physician's order, social assessment and a nursing assessment. 18 NYCRR 505.14(b)(2). The guidelines for Medicaid Managed Care also provide in part:

I. Scope of the Personal Care Benefit

a. As required by federal regulations, the personal care services benefit afforded to MCO enrollees must be furnished in an amount, duration, and scope that is no less than the services furnished to Medicaid fee-for-service recipients. [42 CFR §438.210]…

i. The assessment process should evaluate and document when and to what degree the member requires assistance with personal care services tasks and whether needed assistance with tasks can be scheduled or may occur at unpredictable times during the day or night. The assessment process should also evaluate the availability of informal supports who may be willing and available to provide assistance with needed tasks and whether the member's day or nighttime needs can totally or partially be met through the use of efficiencies and specialized medical equipment including, but not limited to, commode, urinal, walker, wheelchair, etc. A care plan must be developed that meets the member's scheduled and unscheduled day and nighttime personal needs.

When the district, in accordance with 505.14(a)(4), determined the patient is appropriate for the Personal Care Services Program, a care plan must be developed that meets the patient's scheduled and unscheduled day and nighttime personal care needs. In determining the appropriate amount of hours to authorize, the district must review the physician's order and the nursing and social assessments to assure that the authorization and scheduling of hours in combination with any informal support contributions, efficiencies and specialized medical equipment, is sufficient to meet the patient's personal care needs.

The assessment process should also evaluate the availability of informal supports who may be willing and available to provide assistance with needed tasks and whether the patient's day or nighttime needs can totally or partially be met through the use of efficiencies and specialized medical equipment including, but not limited to, commode, urinal, walker, wheelchair, etc.

Social services districts should authorize assistance with recognized, medically necessary personal care services tasks. Social services districts are NOT required to allot time for safety monitoring as a separate task as part of the total personal care services hours authorized (see GIS

99 MA/013, GIS 99 MA/036). However, districts are reminded that a clear and legitimate distinction exists between “safety monitoring” as a non-required independent stand-alone function while no Level II personal care services task is being provided, and the appropriate monitoring of the patient while providing assistance with the performance of a Level II personal care services task, such as transferring, toileting, or walking, to assure the task is being safely completed.

Completing accurate and comprehensive assessments is essential to safe and adequate care plan development and appropriate service authorization. Adhering to Department assessments requirements will help assure patient quality of care and district compliance with the administration of the Personal Care Services Program.

General Information System message GIS 97 MA 033 notified local districts as follows:

The purpose of this GIS is to provide further instructions regarding the Mayer v. Wing court case, which applies to social services districts' reductions or discontinuations of personal care services. [Mayer v. Wing, 922 F. Supp. 902 (SDNY, 1996)]. The Mayer case is now final, and the Department is issuing these additional instructions to comply with the court's final order in this case.

Districts were first advised of the Mayer case in May 1996. (Please refer to GIS 96 MA/019, issued May 28, 1996.) As described in that GIS message, the Mayer case prohibits social services districts from using task-based assessment plans ("TBA plans") to reduce the hours of any personal care services recipient whom the district has determined needs 24-hour care, including continuous 24-hour services ("split-shift"), 24-hour live-in services ("live-in") or the equivalent provided by informal or formal supports. This GIS message identifies the policies and procedures districts must follow in order to comply with this particular provision of the Mayer case.

This particular provision of the Mayer case applies only when the district has first determined that the MA recipient is medically eligible for split-shift or live-in services. To determine whether the recipient is medically eligible for split-shift services or live-in services, the district must continue to follow existing Department regulations and policies. As is currently required, the district must assure that the nursing and social assessments fully document and support the determination that the recipient is, or is not, medically eligible for split-shift or live-in services.

When the district has determined that the MA recipient is medically eligible for split-shift or live-in services, it must next determine the availability of informal supports such as family members or friends and formal supports such as Protective Services for Adults, a certified home health agency or another agency or entity. This requirement is no different from current practice. And, as under current practice, the district must assure that the nursing and social assessments fully document and support its determination that the recipient does, or does not, have informal or formal supports that are willing and able to provide hours of care.

Remember that the contribution of family members or friends is voluntary and cannot be coerced or required in any manner whatsoever. A district may choose to implement so-called "statements of understanding" to reflect a family member's or friend's voluntary agreement to provide hours of care to a recipient whom the district has determined is medically eligible for split-shift or live-in services. (See 95 LCM-76, section III, issued July 18, 1995, for a description of statements of understanding.)

In addition to clarifying requirements for client notices under Mayer, the Department's regulations also reflect a Court ruling in Mayer regarding the use of task based assessments [18 NYCRR 505.14(b)(5)(v)(d)]. Specifically, social services districts are prohibited from using task-based assessments when authorizing or reauthorizing personal care services for any recipient whom the district has determined needs 24-hour care, including continuous 24-hour services (split-shift), 24-hour live-in services or the equivalent provided by a combination of formal and informal supports or caregivers. In addition, the district's determination whether the recipient needs such 24-hour personal care must be made without regard to the availability of formal or informal supports or caregivers to assist in the provision of such care. GIS 01 MA/044, issued on December 24, 2001.

Once the district has determined that the recipient is medically eligible for split-shift or live-in services and determined whether the recipient has informal or formal supports that are willing and able to provide hours of care, the district can assure that it is complying with the Mayer case by following the appropriate guidelines set forth below:

1. Recipient is medically eligible for split-shift services but has no informal or formal supports:

The district should authorize 24-hour split-shift services for this recipient if the recipient otherwise meets the fiscal assessment requirements. The district must not use a TBA plan to reduce this recipient's personal care services.

2. Recipient is medically eligible for split-shift services and has informal or formal supports:

The district should authorize services in an amount that is less than 24-hour split-shift services if the recipient otherwise meets the fiscal assessment requirements. The amount that is authorized, when combined with the amount that informal or formal supports are willing and able to provide, would equal 24 hours. The district must not use a TBA plan to reduce this recipient's services because the recipient is receiving the "equivalent" of split-shift services: part of the services are funded by the MA program and part of the services are provided by the informal or formal supports.

3. Recipient is medically eligible for live-in services but has no informal or formal supports:

The district should authorize 24-hour live-in services for this recipient if the recipient otherwise meets the fiscal assessment requirements. The district must not use a TBA plan to reduce this recipient's personal care services.

4. Recipient is medically eligible for live-in services and has formal or informal supports:

The assessment process should evaluate and document when and to what degree the patient requires assistance with personal care services tasks and whether needed assistance with tasks can be scheduled or may occur at unpredictable times during the day or night.

In accordance with GIS 12 MA/026, published October 3, 2012, pursuant to the directives of the U.S. District Court for the Southern District of New York, in connection with the case of Strouchler v. Shah, the GIS directs that, when determining whether a person requires 24-hour split-shift care or live-in care, the local professional director must consider whether the physician's order and other required assessments document the following:

- The existence of a medical condition that directly causes the person to need frequent assistance with personal care services tasks during the night;
- The specific task or tasks with which the person requires frequent assistance during the night;
- The frequency at which the person requires assistance with these tasks during the night;
- Whether the person requires similar assistance with these tasks during the daylight hours and, if not, why not;
- The informal supports or formal services that are willing, able and available to provide assistance with the person's nighttime tasks;
- The person's ability to use adaptive or specialized equipment or supplies to meet his or her documented medical need for assistance with nighttime tasks; and whether the person's physician has documented that, due to the person's medical condition, he or she could not safely use the equipment or supplies; and
- Whether a live-in aide would likely be able to obtain an uninterrupted five hours of sleep were live-in services to be authorized.

18 NYCRR 505.14(a)(4) provides a new definition of "Live-in 24-Hour Personal Care Services" as follows: 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.

18 NYCRR 505.14(a)(2) provides a new definition of "Continuous Personal Care Services" ("Split-Shift Care") as follows: 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.

GIS 15 MA/24, published on December 31, 2015, advises of the revisions to the Personal Care Services (PCS) and Consumer Directed Personal Assistance (CDPA) regulations at 18 NYCRR section 505.14 and 18 NYCRR section 505.28, and notes the following changes:

The definitions of "some assistance" and "total assistance" are repealed in their entirety. This means, in part, that a "total assistance" need with certain activities of daily living is no longer an eligibility requirement for continuous personal care services or continuous consumer directed personal assistance.

The definitions and eligibility requirements for "continuous personal care services," "live-in 24-hour personal care services," "continuous consumer directed personal assistance" and "live-in 24-hour consumer directed personal assistance" are revised as follows:

a. 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.

b. 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 Services shall not be authorized to the extent that the individual's need for assistance can be met by voluntary assistance from informal caregivers, by formal services other than the Medicaid program, or by adaptive or specialized equipment or supplies that can be provided safely and cost-effectively.

The nursing assessment is no longer required to include an evaluation of the degree of assistance required for each function or task, since the definitions of "some assistance" and "total assistance" are repealed.

The nursing assessment in continuous personal care services and live-in 24-hour personal care services cases must document certain factors, such as whether the physician's order has documented a medical condition that causes the patient to need frequent assistance during a calendar day with toileting, walking, transferring, turning and positioning, or feeding. The regulations set forth other factors that nursing assessments must document in all continuous PCS

and live-in 24-hour PCS cases. Similar requirements also apply in continuous consumer directed personal assistance and live-in 24-hour consumer directed personal assistance cases.

The social assessment in live-in 24-hour PCS and CDPA cases must evaluate whether the individual's home has sleeping accommodations for an aide. If not, continuous PCS or CDPA must be authorized; however, should the individual's circumstances change and sleeping accommodations for an aide become available in the individual's home, the case must be promptly reviewed. If a reduction of the continuous services to live-in 24-hour services is appropriate, timely and adequate notice of the proposed reduction must be sent to the individual.

Pursuant to Office of Health Insurance Programs MLTC Policy 16.07, "Guidance on Task-based Assessment Tools for Personal Care Services and Consumer Directed Personal Assistance Services," issued on November 17, 2016, the New York State Department of Health has not approved the use of any particular task-based assessment tool. Managed Long Term Care plans, however, are allowed to choose to use such tools as guidelines for determining an enrollee's plan of care. In any event, if the plan chooses to use a task-based assessment tool, including an electronic task-based assessment tool, it must do so in accordance with the following guidance:

- Task-based assessment tools cannot be used to establish inflexible or "one size fits all" limits on the amount of time that may be authorized for an IADL or ADL or the frequency at which such tasks can be performed. Plans must conduct individualized assessments of each enrollee's need for assistance with IADLs and ADLs. This means that plans must permit the assessments of time, as well as frequency, for completion of a task to deviate from the time, frequency, or other guidelines set forth in the tool whenever necessary to accommodate the enrollee's individualized need for assistance.
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- When an enrollee requires safety monitoring, supervision or cognitive prompting to assure the safe completion of one or more IADLs or ADLs, the task-based assessment tool must reflect sufficient time for such safety monitoring, supervision or cognitive prompting for the performance of those particular IADLs or ADLs. Safety monitoring, supervision and cognitive prompting are not, by themselves, independent or "stand-alone" IADLs, ADLs, or tasks. Ideally, all time that is necessary for the performance of any needed safety monitoring,
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- All plans, including those that use task-based assessment tools, must evaluate and document when and to what extent the enrollee requires assistance with IADLs and ADLs and whether needed assistance can be scheduled or may occur at unpredictable times during the day or night. All plans must assure that the plan of care that is developed can meet any unscheduled or recurring daytime or nighttime needs that the enrollee may have for assistance. The plan must first determine whether the enrollee, because of the enrollee's medical condition, would be otherwise eligible for PCS or CDPAS, including continuous or live-in 24-hour services. For enrollees who would be otherwise eligible for services, the plan must then determine whether, and the extent to which, the enrollee's

need for assistance can be met by voluntary assistance from informal caregivers, by formal services, or by adaptive or specialized equipment or supplies.

The federal Center for Medicare and Medicaid Services State Medicaid Manual states, in part, at section 4480 regarding Personal Care Services (speaking of activities of daily living, or "ADL's"):

1. Cognitive Impairments.--An individual may be physically capable of performing ADLs and IADLs but may have limitations in performing these activities because of a cognitive impairment. Personal care services may be required because a cognitive impairment prevents an individual from knowing when or how to carry out the task. For example, an individual may no longer be able to dress without someone to cue him or her on how to do so. In such cases, personal assistance may include cuing along with supervision to ensure that the individual performs the task properly.

DISCUSSION

The record in this matter establishes that the Appellant, now age ninety-six (96), has been in receipt of an authorization of Personal Care Services in the amount of sixty-three (63) hours per week (9 hours per day x 7 days). The record also establishes that the Plan denied the Appellant's request for an authorization of Personal Care Services in the amount of twenty-four (24) hour daily assistance via "split-shift" services.

Review of the UAS report shows that the nurse who evaluated the Appellant's Personal Care Services needs had reported that the Appellant needs total assistance with meal preparation, ordinary housework and locomotion, and maximal assistance with bathing, dressing upper and lower body, walking, toilet transfer, toilet use, bed mobility and eating. The nurse reported that the Appellant is frequently incontinent of bladder and of bowel. The nurse also noted that Appellant's ADL status had declined since the last assessment and that her overall self-sufficiency has changed significantly, or "deteriorated," and that Appellant cannot be left alone safely. Appellant also exhibited difficulty sleeping. The Plan also submitted a Medical Review Form, dated March 28, 2018, which states that Appellant "requires assistance throughout the day and night."

At the hearing, the Plan also submitted a letter from the Appellant's physician which is dated March 19, 2018, and which states that the Appellant cannot clean herself after toileting and requires "assistance with her ongoing, unpredictable toileting needs around the clock." Said letter also mentions that the Appellant is "very confused and has issues with her balance." It is noted that an increase to twenty-four-hour daily assistance via "split-shift" services cannot be based solely upon safety supervision.

In rebuttal of the Plan's denial, the Appellant's niece, [redacted], testified that she has called Appellant's aide in the mornings and the aide has reported that the Appellant was found to have soiled herself, to have ripped off her diaper and that the aide would have to clean up the

mess in the home. Ms. [redacted] also testified that she herself began to stay overnight with the Appellant and could not get five hours of uninterrupted sleep because she had to assist Appellant with frequent toileting throughout the night. Ms. [redacted] stated that she is unable to spend every night in Appellant's home.

The Appellant's daughter-in-law, [redacted], also testified that she has stayed overnight with Appellant. She stated that Appellant needed help with toileting overnight more than once per hour. She also testified that the Appellant would try to get out of bed, and that Appellant has suffered at least one fall within the last 90 days. Ms. [redacted] further testified that she herself was not able to get five hours of uninterrupted sleep due to Appellant's frequent toileting throughout the night. She also testified that she works full time and that she also is unable to spend every night at Appellant's home.

Although duly notified of the date, time and location of the hearing as well as the issue(s) to be addressed at same, the Plan did not present further evidence which might rebut the aforesaid credible and plausible testimony, respectively, of the Appellant's niece and daughter-in-law. The record establishes that, based upon the plausible and credible evidence presented by the Appellant's witnesses, an aide would not be able to get five uninterrupted hours of sleep in the overnight hours. Despite the obvious concerns that the Appellant's safety must be overseen with regard to her cognitive decline and issues with her balance, the record shows that the overnight assists by the Appellant's home care aide are all related to the Appellant's activities of daily living, particularly with regard to toileting and clean up from same. The record in this matter establishes that the Appellant requires assistance with all activities of her daily living. The record also shows that the Appellant requires assistance with walking, locomotion and toileting and that her overnight needs are such that a "live-in" home attendant could not be expected to receive at least five hours of sleep per night. Nor does the record establish that the Appellant's niece or daughter-in-law are able to continue attending to the Appellant's personal care needs at night as informal supports.

Based upon the medical documentation as presented by the parties in this matter, the advanced age of the Appellant and the plausibility regarding overnight assists particularly related to incontinence and toileting needs for same, the Plan's determination not to authorize an increase in Personal Care Services to twenty-four (24) hour daily "split-shift" services cannot be sustained.

DECISION AND ORDER

The April 5, 2018, determination by Centers Plan for Healthy Living to deny a request that the Plan authorize an increase of the Appellant's Personal Care Services to twenty-four (24) hour daily "split-shift" services by more than one Personal Care Aide, is not correct and is reversed.

Center's Plan for Healthy Living is directed to:

1. Immediately provide the Appellant with an authorization of Personal Care Services in the amount of twenty-four-hour daily care via two twelve-hour shifts ("split-shift" services).
2. Continue to provide the Appellant with an authorization of "split-shift" services unchanged.

Should Centers Plan for Healthy Living 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 required, the Appellant's Representative must provide it to the Managed Long-Term Care plan promptly to facilitate such compliance.

As required by Section 358-6.4 of the Regulations, Centers Plan for Healthy Living must comply immediately with the directives set forth above.

DATED: Albany, New York
06/26/2018

NEW YORK STATE
DEPARTMENT OF HEALTH

By

Commissioner's Designee