STATE OF NEW YORK
DEPARTMENT OF HEALTH

REQUEST: January 6, 2016
[redacted]
AGENCY: MAP
FH #: 7212695N

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 January 29, 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 (Centers Plan for Healthy Living)

Jillian Harrison, Fair Hearing Representative;
Naret Arzi, Fair Hearing Representative

ISSUE

Was the December 28, 2015, determination, of the Managed Long Term Care Plan, Centers Plan for Healthy Living, to reduce the Appellant's Personal Care Services from 84 hours per week to 70 hours per 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 92 has been in receipt of a Medical Assistance authorization of Medicaid, Managed Long Term Care services.

2. The Appellant is enrolled in a Managed Long Term Care Plan, Centers Plan for Healthy Living.

3. The Appellant has been in receipt of personal care services in the amount of 84 hours per week.

4. On June 3, 2015, a nursing assessor completed a Uniform Assessment System New York (UANSY) Assessment (Comprehensive) Report of the Appellant's personal care needs.

5. On December 4, 2015 a nursing assessor completed a Uniform Assessment System New York (UANSY) Assessment (Comprehensive) Report of the Appellant's personal care needs.

6. By "Initial Adverse Determination" notice dated December 28, 2015, Centers Plan for Healthy Living advised the Appellant of its determination to reduce the Appellant's personal care services from 84 hours per week to 70 hours per week on the grounds that "health care services is not medically necessary."

7. By "MLTC Appeal Upheld Acknowledgment/Resolution" dated January 8, 2016, Centers Plan for Healthy Living advised the Appellant that after receipt of a verbal request for a standard appeal on January 4, 2016, it "has made the determination that coverage for this service will be reduced. This adverse determination will take effect on January 7, 2016. The plan is taking this adverse determination because the health care service is not medically necessary."

8. On January 6, 2016, the Appellant requested this fair hearing.

APPLICABLE LAW

Regulations at 18 NYCRR 358-3.7(a) provide that an appellant has the right to examine the contents of the case record at the fair hearing. At the fair hearing, the agency is required to provide complete copies of its documentary evidence to the hearing officer. In addition, such documents must be provided to the appellant and appellant's authorized representative where such documents were not provided otherwise to the appellant or appellant's authorized representative in accordance with 18 NYCRR 358-3.7. 18 NYCRR 358-4.3(a). In addition, a representative of the agency must appear at the hearing along with the case record and a written summary of the case and be prepared to present evidence in support of its determination. 18 NYCRR 358-4.3(b). Except as otherwise established in law or regulation, in fair hearings concerning the discontinuance, reduction or suspension of Medical Assistance or Services, the Agency must establish that its actions were correct. 18 NYCRR 358-5.9(a)

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 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 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...

NYS DEPARTMENT OF HEATLH
OFFICE OF HEALTH INSURANCE PROGRAMS

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

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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.

Section 505.14(a)(1) of the Regulations defines "Personal Care Services" to mean some or total assistance with personal hygiene, dressing and feeding; and nutritional and environmental support functions. 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 further provides, in part, that:

(2) **Some or total assistance** shall be defined as follows:

(i) Some assistance shall mean that a specific function or task is performed and completed by the patient with help from another individual.

(ii) Total assistance shall mean that a specific function or task is performed and completed for the patient.

MLTC Policy memo 13.09(a): Transition of Semi-Annual Assessment of Members to Uniform Assessment System for New York, dated September 24, 2013 reminds Plans of MLTC Policy 13.09: Transition of Semi-Annual Assessment of Members to the Uniform Assessment System for New York which in turn indicates that effective October 1, 2013, the Uniform Assessment System for New York (UAS-NY) will replace the Semi-Annual Assessment of Members (SAAM). As per the statewide implementation plan, Plans must use the UAS-NY for all new members who are scheduled to enroll effective October 1, 2013; the SAAM assessment must not be used for these new enrollees. Additionally, the UAS-NY must be used for all reassessments beginning October 1, 2013.

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.

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

The Managed Long Term Care Model Contract provides that "New York has elected to require that a member exhaust the plan's internal appeal process before an enrollee may request a State Fair Hearing."

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.

This change in policy has the following effects:
1) enrollees are no longer required to exhaust their plan's internal appeals processes before obtaining a State fair hearing;
2) aid-continuing is no longer available if the enrollee asks only for an internal appeal of a plan's proposed reduction or discontinuance of services and does not also timely request a State fair hearing;
3) to obtain aid-continuing, enrollees must request a State fair hearing within 10 days of the date of the Managed Long Term Care Action Taken notice;
4) enrollees do not need to specifically request aid-continuing to obtain it, but they may tell OTDA that they specifically decline it; and
5) the 60 day deadline to request a State fair hearing begins on the date of the Managed Long Term Care Action Taken notice.

NYS DEPARTMENT OF HEATLH
OFFICE OF HEALTH INSURANCE PROGRAMS

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

e. Terminations and Reductions…

iii. 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.

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 438.404(b) of 42 CFR Subpart F provides in part:

(b) Content of notice. **The notice must explain** the following:

(1) The action the MCO or PIHP or its contractor has taken or intends to take;

(2) **The reasons for the action**...

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.

In Rodriguez v. City of New York, 197 F. 3rd 611 (Federal Court of Appeals, 2nd Circuit 1999), cert. denied 531 U.S. 864, the Plaintiffs were Personal Care Services recipients who alleged that they would be in receipt of inadequate service not meeting legal requirements, without the provision of safety monitoring as an independent task in their Personal Care Services authorizations. The district court had ruled in favor of the Plaintiffs, but the Court of Appeals held that the Agency is not required to provide safety monitoring as an independent Personal Care Services task in evaluating the needs of applicants for and recipients of Personal Care Services. Local Agencies were advised of this decision in GIS message 99/MA/036.

GIS 03 MA/03 was released to clarify and elaborate on the assessment of Personal Care Services pursuant to the Court's ruling in Rodriguez v. Novello and in accordance with existing Department regulations and policies. In relevant portion, this GIS Message states:

Social services districts should authorize assistance with recognized, medically necessary personal care services tasks. As previously advised, 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**.**

DISCUSSION

The credible evidence establishes that the Appellant, age 92, has been enrolled in a Medicaid Managed Long Term Care plan through Centers Plan for Healthy Living and has been in receipt of a Personal Care Services authorization in the amount of 84 hours per week. The credible evidence further establishes that by Initial Adverse Determination dated December 28, 2015, the plan determined to reduce the Appellant's Personal Care Services authorization from 84 hours per week to 70 hours per week.

The regulations pertaining to personal care services require that all notices must reflect the reasons for reduction, of a personal care services. Appropriate reasons for reducing personal care services include but are not limited to: the client's medical, mental, economic or social circumstances have changed and the Managed Care Plan 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. All notices must reflect the reasons for reduction, discontinuation or denial of a reauthorization for personal care services. Appropriate reasons for reducing, discontinuing or denying a reauthorization of personal care services include but are not limited to: a mistake occurred in the previous personal care services authorization.

In this present case, the December 28, 2015, Notice of Initial Adverse Determination stated in relevant part, "The plan is taking this action because the health care services is not medically necessary."

On January 8, 2016, the Plan upheld the Initial Adverse determination for the following clinical reason(s):

"...has significant past medical history of high blood pressure, gastroesophageal reflux disease (GERD), hyperlipidemia, arthropathy, and chronic pain. You underwent a follow-up face-to-face clinical assessment on December 16, 2015...that demonstrated that: you were independent (requiring setup help only) for eating; your required limited assistance for bathing, dressing (upper body) and toilet use; you required extensive assistance for bathing, dressing (lower body) and walking/locomotion; you required maximal assistance for medication management; and you were totally dependent for meal preparation and ordinary housework. It was noted that your daughter's family lives next door (on the first floor) and is willing to assist

you..."

The January 8, 2016 Notice further states, "Based upon your most recent assessment on December 16, 2015 that demonstrated a significant improvement in your physical functioning, it had been proposed that your physical needs could be met by decreasing your PCA hours to 70 hours/week (10 hours/day x 7 days/week).

In support of this determination the plan included the December 4, 2015 and June 3, 2015 Uniform Assessment System New York (UANSY) Assessment (Comprehensive) Reports of the Appellant's personal care needs. These Assessments were reviewed to assess whether Center's Plan for Healthy Living's determination to reduce the Appellant's personal care services from 84 hours per week to 70 hours per week on the grounds that "not medically necessary" was correct.

A review of the June 3, 2015 Uniform Assessment System New York (UANSY) Assessment found that the Appellant required "Total dependence, Full performance by others during entire period" in the Functional Status section of Meal Preparation, Ordinary housework, Stairs and Shopping. The Appellant required maximal assistance in managing medication. The Appellant required extensive assistance with bathing and dressing upper and lower body, walking, personal hygiene, and toilet use. A "Declined" and "Deteriorated" were found in the Appellant's ADL status and overall self-sufficiency "as compared to 90 days, or since last assessment if less than 90 days.

A review of the December 4, 2015, Uniform Assessment System New York (UANSY) Assessment found that the Appellant required "Total dependence, Full performance by others during entire period" in the Functional Status section of Meal Preparation, Ordinary housework, Stairs and Shopping. The Appellant required maximal assistance in managing medication. The Appellant required extensive assistance with bathing and dressing lower body, walking, personal hygiene, and toilet use. Most significantly, from the last assessment of June 3, 2015 to the recent assessment of December 4, 2015, "No Change was found in the Appellant's ADL status and overall self-sufficiency "as compared to 90 days, or since last assessment if less than 90 days.

The finding of "No Change" in Appellant's ADLs in the December 4, 2015 UAS, clearly contradicts the Plan's assessment on December 16, 2015 of "a significant improvement in your physical functioning, it had been proposed that your physical needs could be met by decreasing your PCA hours to 70 hours/week (10 hours/day x 7 days/week)."

At the hearing, the Appellant's daughter and representative, rebutted the Plan's testimony and documentation. The Appellant's daughter stated that a physical therapist did not meet with her mother and that a proper assessment of her mother was never done. She added emphatically, that her mother has never had the benefit of a nurse assessment in a manner that was detailed, constructive or meaningful, and that rather, assessments if done at all, were conducted over the telephone. The Appellant's daughter stated that rather than reduce the Appellant's hours, the Plan was informed that the Appellant fell in 2015 and broke her arm and as a result needed more, not reduced hours. To support her testimony, Appellant's daughter submitted into evidence a January 28, 2016 Medical Letter that confirms that the Appellant lives alone, suffers from multiple issues including debility, dementia, and severe osteoarthritis. In addition, Appellant's daughter

submitted a January 28, 2016 Letter that confirmed that the Appellant suffered a fracture of her left wrist that has to treated with non-operative management consisting of several weeks of immobilization and that as a result, has developed restricted use of her left upper extremity.

In conclusion, a comparative review of the June 3, 2015 and December 4, 2015 Uniform Assessment System New York (UANSY) Assessment (Comprehensive) Reports of the Appellant's personal care needs rebuts the Plan's reasons for its determination to reduce the Appellant's personal care services from 84 hours per week to 70 hours per week on the grounds that "not medically necessary". The record of progressive decline of the Appellant and the increased need for maximal assistance found the December 4, 2015 directly contradicts the Plan's conclusion that Appellant has made significant improvement in health and ADLs.

For the foregoing reasons, the December 28, 2015, determination by the Appellant's Managed Long Term Care plan, Centers Plan for Healthy Living to reduce the Appellant's Personal Care Services authorization from 84 hours per week to 70hours per week, is not correct and cannot be sustained.

DECISION AND ORDER

The December 28, 2015, determination by the Appellant's Managed Long Term Care plan, Centers Plan for Healthy Living, to reduce the Appellant's Personal Care Services authorization from 84 hours per week to 70 hours per week is not correct and is reversed.

1. The Managed Long Term Care Plan, Centers Plan for Healthy Living, is directed to immediately restore the Appellant's Personal Care Services authorization back to the amount of 84hours per week and to take no further action upon the December 28, 2015, Initial Adverse Determination.

2. The Managed Long Term Care Plan, Centers Plan for Healthy Living, is directed to continue to provide the Appellant with a Personal Care Services authorization in the amount of 84 hours weekly.

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 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 to the Managed Long Term Care plan promptly to facilitate such compliance.

As required by 18 NYCRR 358-6.4, the Managed Long Term Care plan must comply immediately with the directives set forth above.

DATED: Albany, New York
02/18/2016

NEW YORK STATE
DEPARTMENT OF HEALTH

By

Commissioner's Designee