STATE OF NEW YORK
DEPARTMENT OF HEALTH

REQUEST: February 28, 2019
[redacted]
AGENCY: MAP
FH #: 7918861M

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 April 26, 2019, in New York City, before an Administrative Law Judge. The following persons appeared at the hearing:

For the Appellant

[redacted]

For the Medicaid Managed Long-Term Care Plan Centers Plan for Healthy Living

Debora Ferguson, Fair Hearing Representative

ISSUE

Was the Managed Long-Term Care Plan's determination to deny the Appellant's request for an increase from Personal Care Services Level 2 in the amount of 8.5 hours per day x 7 days per week (total 59.5 hours per week) to Personal Care Services Level 2 in the amount of 10 hours per day x 7 days per week (total 70 hours per week) correct?

FACT FINDINGS

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 90, resides with her adult daughter, [redacted], and has been in receipt of Medical Assistance benefits from the Medicaid Managed Long-Term Care Plan, Centers for Healthy Living ("the Medical Plan" or "the Plan").

2. On June 7, 2018, the Medical Plan completed a Uniform Assessment System- New York, Comprehensive Community Assessment Report ("the June 7, 2018 UAS").

3. The Appellant's medical diagnoses include, Alzheimer's disease, atherosclerotic heart disease, hypertension, iron deficiency, anemia, insomnia, fatigue, pain, osteoarthritis, abnormalities of gait and mobility, incontinence of bladder and vitamin deficiency.

4. On October 10, 2018, the Medical Plan completed a Uniform Assessment System-New York, Comprehensive Community Assessment Report ("the October 10, 2018 UAS").

5. The Appellant has been authorized to receive Personal Care Services Level 2 for 8.5 hours per day x 7 days per week (total 59.5 hours per week).

6. On December 18, 2018 the Appellant requested an increase from Personal Care Services Level 2 in the amount of 8.5 hours per day x 7 days per week (total 59.5 hours per week) to Personal Care Services Level 2 in the amount of 10 hours per day x 7 days per week (total 70 hours per week).

7. By notice dated December 31, 2018, the Medical Plan informed the Appellant of its initial adverse determination to deny the Appellant's request for an increase from Personal Care Services Level 2 in the amount of 8.5 hours per day x 7 days per week (total 59.5 hours per week) to Personal Care Services Level 2 in the amount of 10 hours per day x 7 days per week (total 70 hours per week).

8. The Appellant requested an internal appeal of the Medical Plan's initial adverse determination.

9. By notice dated January 3, 2019, the Medical Plan informed the Appellant of its final adverse determination to uphold its initial adverse determination.

10. On February 28, 2019, the Appellant requested this hearing to contest the Medical Plan's determination to deny the Appellant's request for an increase from Personal Care Services Level 2 in the amount of 8.5 hours per day x 7 days per week (total 59.5 hours per week) to Personal Care Services Level 2 in the amount of 10 hours per day x 7 days per week (total 70 hours per week).

APPLICABLE LAW

Section 358-3.1 of the Regulations provides, in part:

(a) An applicant or recipient has the right to challenge certain determinations or actions of a social services agency or such agency's failure to act with reasonable promptness or within the time periods required by other provisions of this Title, by requesting that the Department provide a fair hearing. The right to request a fair

hearing cannot be limited or interfered with in any way.

(b) If you are an applicant or a recipient of assistance, benefits or services you have a right to a fair hearing if:

(3) your public assistance, medical assistance, SNAP or services have been discontinued, suspended or reduced...

(6) your public assistance, medical assistance, HEAP or services are inadequate...

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

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

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

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

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

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

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

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

(iii) May place appropriate limits on a service

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

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

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

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

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

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

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

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

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

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

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

(i) Have in effect mechanisms to ensure consistent application of review criteria for authorization decisions; and

(ii) Consult with the requesting provider when appropriate.

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

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

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

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

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

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

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

(4) Are reviewed and updated periodically as appropriate.

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

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

Section 438.400 of 42 CFR Subpart F provides in part:

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

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

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

(3) Section 1932(b)(4) requires Medicaid managed care organizations to establish internal grievance procedures under which Medicaid enrollees, or providers acting on their

behalf, may challenge the denial of coverage of, or payment for, medical assistance.

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

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

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

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

Section 438.402 of 42 CFR Subpart F provides in part:

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

Section 438.406 of 42 CFR Subpart F provides in part:

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

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

(2) Acknowledge receipt of each grievance and appeal.

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

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

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

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

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

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

(b) Special requirements for appeals. The process for appeals must:

(1) Provide that oral inquiries seeking to appeal an action are treated as appeals (to establish the earliest possible filing date for the appeal) and must be confirmed in writing, unless the enrollee or the provider requests expedited resolution.

(2) Provide the enrollee a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing. (The MCO or PIHP must inform the enrollee of the limited time available for this in the case of expedited resolution.)

(3) Provide the enrollee and his or her representative opportunity, before and during the appeals

process, to examine the enrollee's case file, including medical records, and any other documents and records considered during the appeals process.

(4) Include, as parties to the appeal—

(i) The enrollee and his or her representative;

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

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

OBLIGATIONS OF THE CONTRACTOR

A. Provision of Benefits

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

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

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

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

Appeal - a request for a review of an action taken by the Contractor.

Section B of Appendix K of the Managed Long Term Care Contract, provides in part:

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 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.
(3) **Continuous personal care services** means the provision of uninterrupted care, by more than one person, for more than 16 hours per day for a patient who, because of the patient's medical condition and disabilities, requires total assistance with toileting, walking, transferring or feeding at times that cannot be predicted.
(5) **Live-in 24-hour personal care services** means the provision of care by one person for a patient who, because of the patient's medical condition and disabilities, requires some or total assistance with one or more personal care functions during the day and night and whose need for assistance during the night is infrequent or can be predicted.

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(6) 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.

Note: Effective April 1, 2011 Social Services Law §365-a(2)(e)(iv), which is reflected in this regulation, was amended to provide that personal care services pursuant to this paragraph shall not exceed eight hours per week for individuals whose needs are limited to nutritional and environmental support functions.

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(ii) Level II shall include the performance of nutritional and environmental support functions and personal care functions.
(a) Personal care functions shall include some or total 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) preparing meals in accordance with modified diets, including low sugar, low fat, low salt and low residue diets;
(8) feeding;

(9) 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;
(10) providing routine skin care;
(11) using medical supplies and equipment such as walkers and wheelchairs; and
(12) changing of simple dressings.

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The regulations promote the efficient use of resources designed to enhance the independence of individuals in support of their desire to remain in the community. To that end, the regulations require that personal care services and consumer directed personal assistance shall not be authorized if the patient's need for assistance can be met by:

adaptive or specialized equipment or supplies including, but not limited to, beside commodes, urinals, walkers and wheelchairs, when such equipment or supplies can be provided safely, and, by promoting the consumer's independence in the home or other location, services provided would also be cost-effective; or

voluntary assistance available from informal caregivers including, but not limited to, the patient's family, friends or other responsible adult; or formal services provided by an entity or agency. [§§ 505.14(a)(4)(iii) and 505.28(e)(1)]

With regard to adaptive or specialized equipment (the "efficiencies"), the nursing assessment shall include a professional evaluation whether such adaptive or specialized equipment or supplies can meet the recipient's need for assistance and whether such equipment or supplies can be provided safely and cost-effectively when compared to the provision of aide services. Such adaptive or specialized equipment or supplies include, but are not limited to, bedside commodes, adult diapers, urinals, walkers and wheelchairs

[§§ 505.14(b)(3)(iii)(b)(5) and (b)(3)(iv)(a)(7)and §505.28(d)(3)(ii)(f)].
With regard to informal caregivers, such support cannot be required but should be evaluated and discussed with the patient and the potential caregivers.

General Information Service message GIS 97 MA 033 includes a reminder that the contribution of family members or friends (to the care of a Personal Care Services recipient) is voluntary and cannot be coerced or required in any manner whatsoever.

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**.**

18 NYCRR 358-5.9(a) provides:

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

DISCUSSION

The uncontroverted evidence established that the Appellant, age 90, resides with her adult daughter, Denise Hetsburg, and has been in receipt of Medical Assistance benefits from the Medicaid Managed Long-Term Care Plan Centers for Healthy Living ("the Medical Plan" or "the Plan"). The Appellant's medical diagnoses include, Alzheimer's disease, atherosclerotic heart disease, hypertension, iron deficiency, anemia, insomnia, fatigue, pain, osteoarthritis, abnormalities of gait and mobility, incontinence of bladder and vitamin deficiency. The Appellant has been authorized to receive Personal Care Services (PCS) Level 2 in the amount of 8.5 hours per day x 7 days per week (total 59.5 hours per week). On December 18, 2018 the Appellant requested an increase from 59.5 hours per week to Personal Care Services Level 2 in the amount of 10 hours per day x 7 days per week (total 70 hours per week).

By notice dated January 3, 2019, the Medical Plan informed the Appellant of its final adverse determination to uphold its initial adverse determination to deny the Appellant's request for an increase from Personal Care Services Level 2 in the amount of 8.5 hours per day x 7 days per week (total 59.5 hours per week) to Personal Care Services Level 2 in the amount of 10 hours per day x 7 days per week (total 70 hours per week).

At the hearing, the Appellant's daughter acting as Appellant's Representative stated that the Appellant requires an increase in Personal Care Services primarily because her mother's medical

conditions have worsened, specifically in regard to her incontinence, decreased ability to ambulate, decreased vision and decreased hearing as well as decreasing ability to communicate. The Appellant's daughter added that she works and she is unable to meet her mother's increased Personal Care needs.

A review of the Uniform Assessment System Comprehensive Community Assessment Report ("UAS"), dated October 10, 2018 shows that the Appellant needs assistance from others to perform her activities of daily living (ADLs) as follows: total dependence with meal preparations, ordinary housework, managing finances, managing medications, phone use, shopping, maximal assistance with stairs, transportation, bathing, dressing upper and lower body, locomotion, transfer toilet, toilet use, and extensive assistance with bed mobility. (Medical Plan Exhibit 3 UAS October 10, 2018 at 3-8 of 23).

A review of the Medical Plan's January 3, 2019 final adverse determination to deny the Appellant's request for an increase in PCS weekly hours was for the following reasons:

> You live with your daughter, on the 4th floor of a studio apartment, in a building with access to an elevator. You recently underwent a follow-up face-to-face clinical assessment on October 10, 2018 utilizing the New York State Department of Health's Uniform Assessment Tool that showed most of your abilities to perform physical functioning stayed the same since your prior assessment that was completed by Centers Plan for Healthy Living on June 7, 2018.
>
> Your abilities to perform physical functioning stayed the same for dressing upper and lower body, personal hygiene (cleaning yourself), walking, bathing, transfer toilet (getting on and off the toilet), toilet use, eating, meal preparation, medication management and ordinary housework.
>
> In summary, most of your abilities to perform physical functioning stayed the same; therefore, your hours stay the same at 8.5 hours per day, 7 days a week, for a total of 59.5 hours per week.
>
> This decision is based on the NYS Department Health Uniform Assessment System (UAS-NY) and the plan's client tasking tool. This decision was made under 42 CFR Sections 438.210 and 438.404; NYS Social Services Law Sections 364-j(4)(k) and 365-a(2); 18 NYCRR Section 360-10.8;

Medical Plan Exhibit 4 at 1-5 of 9.

In response to the findings in the Medical Plan's Determination, the Appellant's Representative argued her mother is 90 years old, and the Appellant's decreasing ability to communicate along with her decreasing physical abilities have led to an increase in her needs for personal care assistance.

The Appellant presented into the record documentation, marked Appellant's Exhibit A, dated April 4, 2019, from the Appellant's treating physician [redacted], M.D. and stated that she did not provide to the Medical Plan to consider prior to the Medical Plan making

its determination. The Appellant's Exhibit A, indicated in pertinent part regarding:

> Ms. [redacted] ….. requires assistance and supervision with all of her daily living activities, including bathing, dressing, grooming, personal hygiene, and walking. She is unable to clean herself after using the bathroom, and she is incontinent. She has poor balance, and she uses a walker for mobility. She …. has difficulty to find the right words to verbalize her needs. She is hard of hearing, and has vision problems; left eye is completely shut.
>
> We believe the level of home care is insufficient, and we are asking for a re-evaluation of home care hours to adequately meet Ms. [redacted]'s needs…

(Appellant's Exhibit A).

The record shows the Medical Plan reasonably relied on the information that the Medical Plan had (the UAS dated June 7, 2018 and the UAS dated October 10, 2018) at the time it made its January 3, 2019 determination to deny the Appellant's request for an increase from Personal Care Services Level 2 in the amount of 8.5 hours per day x 7 days per week (total 59.5 hours per week) to Personal Care Services Level 2 in the amount of 10 hours per day x 7 days per week (total 70 hours per week) and therefor the Medical Plan's determination was correct when made.

At a hearing concerning the adequacy of services, the Appellant must establish that the Agency erred in its determination. The evidence has been carefully reviewed and the arguments carefully considered and it is found that the Appellant's Representative met her burden of proof to establish the Appellant requires an increase from Personal Care Services Level 2 in the amount of 8.5 hours per day x 7 days per week (total 59.5 hours per week) to Personal Care Services Level 2 in the amount of 10 hours per day x 7 days per week (total 70 hours per week).

The record does establish the Appellant needs Personal Care Services for a longer period during the day to assist her as reported by her treating physician with all ADLS to include bathing, dressing, grooming, caring for her personal hygiene, transferring and using toilet and ambulating.

A review of the hearing record which included newly presented evidence (Appellant's daughter's testimony and Appellant's treating physician's report dated April 4, 2019) shows that Appellant is incontinent, needs assistance with all ADLs including: (1) bathing, (2) dressing, (3) grooming, (4) caring for her personal hygiene, (5) transferring and (6) using toilet and ambulating and that her treating physician recommends an increase in PCS weekly hours. Accordingly, an increase of one hour per day x 7 days (10 additional minutes x 6 tasks daily) is appropriate based upon the record.

Based upon the aforementioned reasons, the Plan's determination to deny the Appellant's request for an increase from Personal Care Services Level 2 in the amount of 8.5 hours per day x 7 days per week (total 59.5 hours per week) to Personal Care Services Level 2 in the amount of 10 hours per day x 7 days per week (total 70 hours per week) was correct when made, but is not sustained, and the Medical Plan is directed to increase the Appellant's Consumer Directed

Personal Care Services authorization to 10 hours per day x 7 days per week (total 70 hours per week) (an increase of one hour per day x 7 days) (10 minutes x 6 tasks daily increase).

DECISION AND ORDER

The Medical Plan's determination to deny the Appellant's request for an increase from Personal Care Services Level 2 in the amount of 8.5 hours per day x 7 days per week (total 59.5 hours per week) to Personal Care Services Level 2 in the amount of 10 hours per day x 7 days per week (total 70 hours per week) is correct when made. However, the Medical Plan is directed to:

1. Increase the Appellant's Consumer Directed Personal Care Services Authorization Level 2: to 10 hours per day x 7 days per week (total 70 hours per week).

2. Notify the Appellant in writing of the Medical Plans new determination.

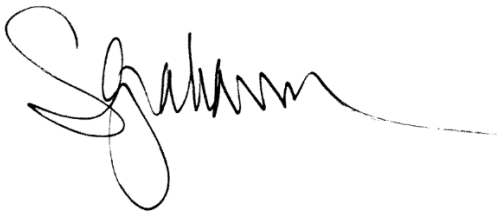
Should the Medical Plan need additional information from the Appellant in order to comply with the above directives, it is directed to notify the Appellant and the Appellant's Representative promptly in writing as to what documentation is needed. If such information is required, the Appellant or the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

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

DATED: Albany, New York
05/08/2019

NEW YORK STATE
DEPARTMENT OF HEALTH

By



Commissioner's Designee