STATE OF NEW YORK
DEPARTMENT OF HEALTH

REQUEST: December 20, 2018
[redacted]
AGENCY: MAP
FH #: 7881410Q

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 February 20, 2019, 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)

Deborah Ferguson, Fair Hearing Representative

ISSUES

Was the Appellant's request for a fair hearing to review the Appellant's Managed Long-Term Care Plan, Centers Plan for Healthy Living, to deny the request, on the Appellant's behalf, for an increase in personal care services from 84 hours per week (12 hours daily, 7 days weekly) to 24 hours daily, 7 days weekly, provided on a "Live-in" basis timely?

Assuming the request was timely, was the determination of the Appellant's Managed Long-Term Care Plan, Centers Plan for Healthy Living, to deny the request, on the Appellant's behalf, for an increase in personal care services from 84 hours per week (12 hours daily, 7 days weekly) to 24 hours daily, 7 days weekly, provided on a "Live-in" basis, 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 79, has been enrolled in and has received care and services, including Personal Care Services, through a Managed Long-Term Care Plan operated by Centers Plan for Healthy Living.

2. The Appellant has been in receipt of Personal Care Services in the amount of 84 hours weekly (12 hours daily, 7 days weekly).

3. On May 8, 2018, a nursing assessor completed a Uniform Assessment System-New York Comprehensive Community Assessment Report of the Appellant's personal care needs which reports in part, that Appellant requires mostly maximal to extensive assistance for all ADLs.

4. A request was made on behalf of the Appellant for increase in Personal Care Aide hours from 84 hours per week to 24 hours daily, 7 days weekly, provided on a "Live-in" basis.

5. On July 12, 2018, a nursing assessor completed a Uniform Assessment System-New York Comprehensive Community Assessment Report of the Appellant's personal care needs which reports in part, that Appellant requires mostly maximal to extensive assistance for all ADLs.

6. By Initial Adverse Determination Letter dated July 30, 2018, Centers Plan for Healthy Living, denied the Appellant's request for an increase, in part because-

"The comparison of the UAS-NY assessments completed on 5/8/2018 and 7/12/2018, showed you have demonstrated some changes in your abilities to perform Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs)."

7. After an internal appeal of the determination by the Appellant, by FINAL ADVERSE DETERMINATION letter dated August 3, 2018, Centers Plan for Healthy Living upheld the determination to deny the request for an increase in personal from 84 hours per week to 24 hours daily, 7 days weekly, provided on a "Live-in" basis.

8. The notice advised the Appellant that a fair hearing must be requested within sixty days of the date of the Agency's action.

9. The Agency mailed the notice to the Appellant at his address of record.

10. On December 20, 2018, the Appellant's representative requested this fair hearing to contest the Managed Long-Term Care Plan's determination.

9. On February 5, 2019, following an hospitalization, a nursing assessor completed a Uniform Assessment System-New York Comprehensive Community Assessment Report of the Appellant's personal care needs, which reports in part, that Appellant requires mostly maximal to extensive assistance for all ADLs.

APPLICABLE LAW

Section 22 of the Social Services Law provides that applicants for and recipients of Public Assistance, Emergency Assistance to Needy Families with Children, Emergency Assistance for Aged, Blind and Disabled Persons, Veteran Assistance, Medical Assistance and for any services authorized or required to be made available in the geographic area where the person resides must request a fair hearing within sixty days after the date of the action or failure to act complained of. In addition, any person aggrieved by the decision of a social services official to remove a child from an institution or family home may request a hearing within sixty days. Persons may request a fair hearing on any action of the social services district relating to SNAP benefits or the loss of SNAP benefits which occurred in the ninety days preceding the request for a hearing. Such action may include a denial of a request for restoration of any benefits lost more than ninety days but less than one year prior to the request. In addition, at any time within the period for which a person is certified to receive SNAP benefits, such person may request a fair hearing to dispute the current level of benefits.

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 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.

Section 505.14(a)(1) of the Regulations defines "Personal Care Services" to mean assistance with nutritional and environmental support functions and personal care functions, as specified in clauses (5)(i)(a) and (5)(ii)(a) of this subdivision. Such services must be essential to the maintenance of the patient's health and safety in his or her own home, as determined by the social services district in accordance with this section; ordered by the attending physician; based on an assessment of the patient's needs and of the appropriateness and cost-effectiveness of services specified in subparagraph (b)(3)(iv) of this section; provided by a qualified person in accordance with a plan of care; and supervised by a registered professional nurse.

Section 505.14(a) of the Regulations provides:

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

(3) Personal care services, as defined in this section, can be provided only if the services are medically necessary and the social services district reasonably expects that the patient's health and safety in the home can be maintained by the provision of such services, as determined in accordance with this section.

(4) Live-in 24-hour personal care services means the provision of care by one personal care aide for a patient who, because of the patient’s medical condition, needs assistance during a

calendar day with toileting, walking, transferring, turning and positioning, or feeding and whose need for assistance is sufficiently infrequent that a live-in 24-hour personal care aide would be likely to obtain, on a regular basis, five hours daily of uninterrupted sleep during the aide's eight hour period of sleep.

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

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

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

(1) making and changing beds;

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

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

(4) dishwashing;

(5) listing needed supplies;

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

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

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

(9) preparing meals, including simple modified diets.

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

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

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

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

(2) dressing;

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

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

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

(6) transferring from bed to chair or wheelchair;

(7) turning and positioning;

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

(9) feeding;

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

(11) providing routine skin care;

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

(13) changing of simple dressings.

MLTC Policy 15.09: Changes to the Regulations for Personal Care Services (PCS) and Consumer Directed Personal Assistance (CDPA), effective December 23, 2015, provides: The purpose of this policy directive is to inform Managed Long-Term Care Plans (MLTCPs) of revisions to the Personal Care Services (PCS) and Consumer Directed Personal Assistance (CDPA) regulations at 18 NYCRR § 505.14 and 18 NYCRR § 505.28, respectively. These revised regulations are effective on December 23, 2015.

These changes to the PCS and CDPA regulations include, among other provisions, changes to the definitions and eligibility requirements for continuous ("split-shift") PCS and CDPA as well as live-in 24-hour PCS and CDPA. Consequently, MLTCPs must be aware of, and apply, effective immediately, the revised definitions and eligibility requirements when conducting PCA and CDPA assessments and reassessments. In addition, the revised regulations set forth revised criteria for notices that deny, reduce or discontinue these services. See the attached detailed summary of these changes and the Notice of Adoption, as published in the New York State Register on December 23, 2015.

Regulatory changes for PCS and CDPA applicable to MLTCP's include:

1. 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.

2. "Turning and positioning" is added as a specific Level II personal care function and as a CDPA function.

3. 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.

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

d. *Live-in 24-hour consumer directed personal assistance* means the provision of care by one consumer directed personal assistant for a consumer who, because of the consumer's medical condition, needs assistance during a calendar day with toileting, walking, transferring, turning and positioning, feeding, home health aide services, or skilled nursing tasks and whose need for assistance is sufficiently infrequent that a live-in 24-hour consumer directed personal assistant would be likely to obtain, on a regular basis, five hours daily of uninterrupted sleep during the aide's eight hour period of sleep.

GIS 12 MA/026 entitled "Availability of 24-Hour Split-Shift Personal Care Services" provides, in part, the intent of 18 NYCRR 505.14 is to allow the identification of situations in which a person's needs can be met by a live-in aide and still allow the aide to have an uninterrupted five hours for sleeping.

GIS 12 MA/026 provides as follows concerning the availability of 24 hour, split-shift personal care services in connection with the case of Strouchler v. Shah:

It is the Department's policy that 24-hour split-shift care should be authorized only when a person's nighttime needs cannot be met by a live-in aide or through either or both of the following: (1)adaptive or specialized equipment or supplies including, but not limited to, bedside commodes, urinals, walkers, wheelchairs, and insulin pens, when the social services district determines that such equipment or supplies can be provided safely and cost-effectively; and (2)voluntary assistance available from informal caregivers or formal services provided by an entity or agency.

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.

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

On August 3, 2018, Centers Plan for Healthy Living notified the Appellant that it had upheld the determination to deny the request for an increase in personal from 84 hours per week to 24 hours daily, 7 days weekly, provided on a "Live-in" basis.

Although the notice advised the Appellant that a fair hearing must be requested within sixty days of its action, the Appellant failed to request this fair hearing until December 20, 2018, which was more than sixty days after the Agency's determination. However, pursuant to **Bryant v. Perales**, N.Y.A.D. 4 Dept., 1990, where a hearing involves a Notice of intent, any defect in the Notice tolls the statute of limitations. With regard to the Notice at issue, the Notice failed to cite to any laws or regulations, among other defects, as required by Regulations and was, therefore, void. The statute of limitations is tolled.

Still at the hearing, the record establishes that Appellant has been in receipt of Personal Care Services in the amount of 84 hours weekly (12 hours daily, 7 days weekly). The Appellant's representative requested an increase in Appellant's Personal Care Aide hours from 84 hours per week to 24 hours daily, 7 days weekly, provided on a "Live-in" basis. By notice dated July 30, 2018, the Appellant's Managed Long-Term Care Plan, Centers Plan for Healthy Living, denied the Appellant's request in part because-" The comparison of the UAS-NY assessments completed on 5/8/2018 and 7/12/2018, showed you have demonstrated some changes in your abilities to perform Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs)." The Appellant's representative sought an internal appeal of the determination, and by FINAL ADVERSE DETERMINATION letter dated August 3, 2018, Centers Plan for Healthy Living upheld the determination to deny the request for an increase in personal from 84 hours per week to 24 hours daily, 7 days weekly, provided on a "Live-in" basis

According to the hearing record, the Appellant suffers from multiple medical conditions which include, severe cognitive impairment, diabetes, hypertension, hypothyroidism, prostatic hyperplasia, mood disorder, poor balance and unsteady gait. He is occasionally incontinent of bladder and bowel control and requires maximal assistance with toileting, locomotion, walking and eating.

At the hearing, the Appellant's counsel argued that Appellant's medical condition has declined rapidly, and the Plan's own assessments finds that Appellant needs extensive to maximal assistance for toileting, transferring, and locomotion which requires a span of time over 24 hours a day and not task based. Appellant's counsel stated further that Appellant does not have assistance overnight and the Plan does not have any plan or explanation as to how the Appellant's overnight needs are supposed to be met and that the Plan's actions violates the MLTC policy regarding span of time.

The above testimony by Appellant's counsel and representative is supported by the evidence presented by Centers Plan for Healthy Living at the hearing. Centers Plan for Healthy Living produced three Uniform Assessment System ("UAS") reports dated May 8, 2018, July 12, 2018, and the latest one conducted on February 5, 2019. These assessments showed the steady decline in Appellant's medical condition, beginning with the May 8, 2018 assessment. Centers Plan for Healthy Living's reason for denying Appellant's request because-" The comparison of the UAS-NY assessments completed on 5/8/2018 and 7/12/2018, showed you have demonstrated some changes in your abilities to perform Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs)," is preposterous, especially when the Uniform Assessment System ("UAS") report dated July 12, 2018 reports in part that Appellant, who suffers from severe cognitive impairment, was found "wandering outside on 7/6/18 after PCA left the home and was found unconscious on the streets" before been taken to the hospital. The Uniform Assessment System ("UAS") report dated February 5, 2019 also reports an hospitalization on January 29, 2019 due to syncope and collapse. All the three Uniform Assessment System ("UAS") clearly reports that Appellant requires maximal to extensive assistance with toileting, locomotion and transferring and even feeding. These are all unscheduled needs, which require span of time care, according to Regulations, which Centers Plan for Healthy Living own evidence in the form of the Uniform Assessments System indicates that the Appellant has these needs.

As to the issue of family members providing assistance as needed, Centers Plan for Healthy Living is reminded that GIS 97 MA 033 advises that the contribution of family members to the care of a personal care services applicant or recipient is voluntary and cannot be coerced or required in any manner whatsoever

The regulations require that at a fair hearing concerning the denial of an application for or the adequacy of Medical Assistance, the Appellant must establish that the denial of assistance or benefits was not correct or that the Appellant is eligible for a greater amount of assistance or benefits. The record has been carefully considered, and the weight of the evidence does not support Centers Plan for Healthy Living's determination to deny Appellant's request for an increase in personal care hours. Review of the record establishes that the Appellant has unscheduled needs during the day and night, and Centers Plan for Healthy Living's determination to deny the Appellant's request for an increase of Personal Care Services Authorization from 84 hours weekly to 24 hours daily, 7 days weekly, provided on a "Live-in" basis, cannot be sustained.

DECISION AND ORDER

The determination of the Appellant's Managed Long-Term Care Plan, Centers Plan for Healthy Living, to deny the request, on the Appellant's behalf, for an increase in personal care services from 84 hours per week to 24 hours daily, 7 days weekly, provided on a "Live-in" basis, was not correct and is reversed.

1. Centers Plan for Healthy Living is directed to increase Appellant's Personal Care Services to 24 hours daily, 7 days weekly, provided on a "Live-in" basis and notify the Appellant and Appellant's representative, in writing, of its compliance with this Decision.

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 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 Centers Plan for Healthy Living 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
03/05/2019

NEW YORK STATE
DEPARTMENT OF HEALTH

By

Commissioner's Designee