STATE OF NEW YORK
DEPARTMENT OF HEALTH

REQUEST: August 16, 2019
[redacted]
AGENCY: MAP
FH #: 8013990N

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 September 18, 2019, in New York City, before an Administrative Law Judge. The following persons appeared at the hearing:

For the Appellant

[redacted]

For the Agency

D. Ferguson for Centers Plan for Healthy Living

ISSUE

Did the Agency correctly deny the Appellant's request for PCS 24-hour split shift?

FINDINGS OF FACT

All parties had an opportunity to present their evidence and after careful consideration, the following facts have been established:

1. The Appellant, age 89, receives personal care services ("PCS) provided by Centers Plan for Healthy Living ("Agency"). She has been diagnosed with kidney insufficiency, hypertensive heart disease, valvular heart disease, sinoatrial dysfunction, chronic rhinitis, anticoagulant therapy, atrial fibrillation, dyslipidemia, diastolic heart failure, diabetes type 2, obesity, constipation, memory deterioration, insomnia, osteoarthritis, frequently incontinent and has lower back pain.

2. The Appellant currently receives PCS in the amount of 8.5 hours a day, 7 days a week.

3. The Appellant requested an increase in PCS to 24-hour split shift coverage.

4. On July 16, 2019, the Agency's nurse conducted an assessment and concluded the Appellant's medical needs were being met with the current PCS provided.

5. The Agency advised Appellant that her request for 24-hour split shift coverage was denied.

6. The Appellant challenged the Agency's denial and requested an internal appeal.

7. On July 24, 2019, the Agency issued a Final Adverse Determination upholding the Agency's original denial.

7. On August 16, 2019, the Appellant requested this fair hearing.

APPLICABLE LAW

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.

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.

MLTC Policy 15.03: End of Exhaustion Requirement for MLTC Partial Capitation Plan Enrollees dated July 2, 2015, provides:

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.

Until further notice, this policy change applies only to enrollees in MLTC partial capitation plans. Enrollees in other MLTC products, such as MAP and PACE plans, must continue to exhaust their plan's internal appeals processes before obtaining a State fair hearing.

Personal care services means assistance with nutritional and environmental support functions and personal care functions, as specified in 18 NYCRR §§ 505.14(a)(5)(i)(a) and 505.14(a)(5)(ii)(a). 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 Section 505.14; 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 18 NYCRR § 505.14(b)(3)(iv); provided by a qualified person in accordance with a plan of care; and supervised by a registered professional nurse.

MLTC Policy 15.09: Changes to the Regulations for Personal Care Services (PCS) and Consumer Directed Personal Assistance (CDPA), dated December 30, 2015, effective December 23, 2015, provided:

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.

4. 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.

5. 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.

6. 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.

7. The social assessment in live-in 24-hour PCS and CDPA cases would have to 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.

8. The regulations also revise the Department's regulations governing the content of notices for denials, reductions or discontinuances of PCS and CDPA. In subparagraph 505.14(b)(5)(v), the provisions governing social services districts' notices to recipients for whom districts have determined to deny, reduce or discontinue PCS are revised and reorganized. Paragraph 505.28(h)(5) is amended to provide additional detail regarding the content of social services district notices when the district denies, reduces or discontinues CDPA. All MLTCPs must ensure that their notices denying, reducing or discontinuing PCS or CDPA are consistent with these regulations and, in particular, include the specific reason for the action and, if applicable, the clinical rationale. All MLTCPs should ensure that their policies and procedures are appropriately and expeditiously updated to reflect these new requirements.

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. 18 NYCRR 505.14(a)(2)

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)(4)

The social services district must first determine whether the patient, because of the patient's medical condition, would be otherwise eligible for personal care services, including continuous personal care services or live-in 24-hour personal care services. For patients who would be otherwise eligible for personal care services, the district must then determine whether, and the extent to which, the patient's need for assistance can be met by voluntary assistance from informal caregivers, by formal services, or by adaptive or specialized equipment or supplies, as specified in subclauses (a)(1) through (a)(3) of this subparagraph. 18 NYCRR 505.14 (a)(3)(iii)(b)

MLTC Policy 16.07: Guidance on Task-based Assessment Tools for Personal Care Services and Consumer Directed Personal Assistance Services, issued November 17, 2016, provides in relevant part that:

Plans cannot use task-based assessment tools to authorize or reauthorize services for enrollees who need 24-hour services, including continuous services, live-in 24-hour services, or the equivalent provided by formal services or informal caregivers. The reason for this is that task-based assessment tools generally quantify the amount of time that is determined necessary for the completion of particular IADLs or ADLs and the frequency of that assistance, rather than reflect assistance that may be needed on a more continuous or "as needed" basis, such as might occur when an enrollee's medical condition causes the enrollee to have frequent or recurring needs for assistance during the day or night**.** A task-based assessment tool may thus be suitable for use for enrollees who are not eligible for 24-hour services but is inappropriate for enrollees who are eligible for 24-hour care. [See MLTC Policy Directive 15.09, advising plans of recently adopted regulations affecting the eligibility requirements for continuous and live-in 24 hour services as well as revised notice requirements.]

GIS message GIS 12 MA/ 026, dated October 3, 2012, provides that the Department has been directed by the U.S. District Court for the Southern District of New York, in connection with the case of Strouchler v. Shah, to clarify the proper interpretation and application of 18 NYCRR 505.14 with respect to the availability of 24-hour, split-shift personal care services for needs that are predicted and for Medicaid recipients whose only nighttime need is turning and positioning.

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.

When a person's nighttime needs cannot be met by the use of adaptive or specialized equipment or supplies or voluntary assistance from informal caregivers or formal services, a determination must be made whether the person needs 24-hour split-shift care (included within the regulatory definition of "continuous personal care services") or live-in 24-hour personal care services. Under Section 505.14, this depends on whether the person needs "some" or "total" assistance with toileting, walking, transferring, or feeding, and whether these needs are "frequent" or "infrequent", and able to be "scheduled" or "predicted".
The intent of the regulation 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. The Department is considering changes to the regulations to better achieve this goal.

In the meantime, the Department provides the following clarifications:
1. The fact that a person's needs are predictable does not preclude the receipt of 24-hour split-shift care, if the person has a documented medical need for the tasks to be performed with a

frequency that would not allow a live-in aide to perform them and still obtain an uninterrupted five hours of sleep.
2. The need for turning and positioning and/or the need for diaper changes, by themselves, neither preclude nor justify the receipt of 24-hour split shift care. In order to receive 24-hour split-shift care, the person must have a documented medical need for those tasks to be performed so frequently that a live-in aide cannot provide them and still obtain an uninterrupted five hours of sleep.
3. A person with a documented medical need for turning and positioning may, if otherwise appropriate, qualify for either 24-hour split-shift care or live-in care depending on the frequency at which turning and positioning is required at night, regardless of whether the person has a nighttime need for transferring.
4. 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.

MLTC Policy 13.09(b): Frequently Asked Questions on Uniform Assessment System for New York, dated December 10, 2013, provides in relevant part:
1. Is it permissible for an MLTC Plan to have the nurse complete the 22 items to calculate the Nursing Facility Level of Care in order to determine if the individual meets the initial eligibility for one of the MLTC products? If the individual scores below a 5, the individual would not be assessed using the full UAS-NY Community Assessment.
No. All MLTC Plans (Partial Capitation, PACE and MAP) are required to conduct the full UAS-NY Community Assessment. The purpose of this tool, in use across all long-term care programs and provider types, is to obtain consistent information related to Medicaid recipient care needs. The Department of Health will use this information to effectively inform future community based long term care policy for its entire population. Additionally, this assessment will be used by MLTC Plans to demonstrate reasons for denial of enrollment at Fair Hearings and as such will need to present a clear and consistent representation of the Medicaid recipient's total health care needs to justify their action.

It is important to note that the Nursing Facility Level of Care is not a determining factor for all Partial Capitation MLTC eligibility. Please refer to the MLTC contract for the full eligibility criteria.

2. The Plan conducted an initial assessment on August 20 for a person to be enrolled October 1. Is the six-month reassessment date based on the date of the assessment or based on the enrollment date?

The reassessment date is calculated based on the date of assessment not on the date of enrollment. Reassessments must be conducted every six-months or following a significant change in condition.

6. Currently, when a referral is received the UAS-NY Community Assessment is completed within 30 days of the referral. If the enrollment is deferred for various reasons past 42 days, is a reassessment required before enrollment? How long is a UAS-NY assessment "valid" for before enrollment?

Managed Long-Term Care (MLTC) Plans are required to conduct a UAS-NY Community Assessment prior to enrollment and every six months or sooner if there is a significant change in condition. In certain cases, an individual may not be enrolled in an MLTC Plan within 30 days from the date of the assessment. In these situations, the MLTC Plan must review the UAS-NY Community Assessment with the applicant and verify the information is unchanged.

If there are no changes, the MLTC Plan will document this review by logging into the UAS-NY and signing the completed assessment as a "reviewer or consulting participant."

If changes in patient condition are noted that would affect care planning and the delivery of services, the MLTC Plan will conduct a new UAS-NY Community Assessment.

If the individual does not enroll in an MLTC Plan within six months of the assessment, a new UAS-NY Community Assessment must be completed.

7. In the UAS-NY Community Assessment, Intake/History, should the reason for a deferred assessment be entered as routine or return?

As stated in the MLTC Policy 13.09 dated April 26, 2013, the UAS-NY does not have the option to indicate that a reassessment was deferred. If a reassessment is completed in variance to MLTC policy rules (within the month the reassessment is due), the member's record should indicate the reason for the late reassessment. The nurse should record these comments in the "Sign/Finalize" section of the UAS-NY.

The reason used for the assessment must follow the definitions included in the UAS-NY Community Assessment Reference Manual.

Routine reassessment – A regularly scheduled follow-up assessment to ensure that the care/service plan is appropriate and current.

Return assessment — An assessment conducted when the person returns from the hospital or otherwise re-enters the same organization after a discharge or disenrollment.

MLTC Policy 14.04: MLTCP Potential Enrollee Assessments, dated May 22, 2014, provides: This policy guidance is intended to clarify the current required potential enrollee assessment process conducted by a Managed Long Term Care Plan (MLTCP) prior to a consumer's actual enrollment.

A Potential Enrollee means a Medicaid recipient who is eligible to enroll in a managed long term care plan, but is not yet an Enrollee of a Managed Long Term Care Plan.

An initial assessment may be conducted at an institutional residence, such as a residential health care facility (nursing home).

When a MLTCP receives a prospective enrollment referral from a nursing home on behalf of a Medicaid recipient, the MLTCP must assess the consumer in a timely manner, within 30 days of receiving the referral. The MLTCP should assess the consumer where the consumer is located at the time of the referral, i.e., the nursing home. The assessment conducted in the nursing home setting will include and consider: diagnoses; current Plan of Care; discharge plan; proposed community residence; tentative discharge date; and need for community based long term care services.
In addition to the assessment conducted in the nursing home, the MLTCP must also assess the potential enrollee's proposed community residence which must be available for viewing prior to the date of discharge. A home visit by the MLTCP is required to determine the potential enrollee's health and safety in the actual residence, identify any risk factors, and develop an effective and efficient Plan of Care. The potential enrollee does not need to be at the proposed residence during the home visit.

As the MLTCP is responsible for the consumer's health and safety beginning on the enrollment date, the assessment process must be completed, the final definitive Plan of Care established, and MLTCP services must be in place for the consumer on day of discharge to the community setting.

At a fair hearing concerning the denial of an application for or the adequacy of Public Assistance, Medical Assistance, HEAP, SNAP 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. Except where otherwise established by law or regulation, in fair hearings concerning the discontinuance, reduction or suspension of Public Assistance, Medical Assistance, SNAP benefits or services, the social services agency must establish that its actions were correct. 18 NYCRR 358-5.9(a).

DISCUSSION

The Appellant, age 89, receives PCS provided by Centers Plan for Healthy Living ("Agency"). She lives alone and has been diagnosed with kidney insufficiency, hypertensive heart disease, valvular heart disease, sinoatrial dysfunction, chronic rhinitis, anticoagulant therapy, atrial fibrillation, dyslipidemia, diastolic heart failure, diabetes type 2, obesity, constipation, memory deterioration, insomnia, osteoarthritis, frequently incontinent and has lower back pain. Her spouse passed away in May 2019; who was providing some assistance.

The basic premise for the Agency's denial of 24-hour split shift coverage is the Appellant's needs are met with her current 8.5 hours a day, 7 days a week. No night-time assessment was performed by the Agency (none was requested.)

The Agency submitted a Uniform Assessment System Report dated July 16, 2019. The evidence clearly establishes the Appellant has cognitive difficulties that affect her ability to perform daily activities and relies on maximal assistance with walking and transferring and toileting and dressing and eating and mobility. The Appellant has nighttime needs that are not

addressed by the Agency; and nothing in the record supports any claim that request for additional hours of assistance are for safety monitoring as a stand-alone task.

Nothing in the Agency's assessments support their conclusion the Appellant's day and nighttime needs are met with her current PCS of 8.5 hours a day, 7 days a week. Based on the evidence presented, the Appellant requires 24-hour split shift assistance. The Appellant has submitted documentation and testimony and other evidence that the denial of the request for split-shift care is not correct; and therefore the Agency's determination cannot be sustained.

DECISION AND ORDER

The Agency incorrectly denied the Appellant's request for 24-hour split shift Personal Care Services.

1. The Agency is directed to authorize Personal Care Services to the Appellant for twelve-hours split shift personal care aides.

As required by Section 358-6.4 of the Regulations, the Agency must immediately comply with the directive set forth above.

DATED: Albany, New York
09/30/2019

NEW YORK STATE
DEPARTMENT OF HEALTH

By

Commissioner's Designee

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