

MISCELLANEOUS NOTICES/HEARINGS

Notice of Abandoned Property Received by the State Comptroller

Pursuant to provisions of the Abandoned Property Law and related laws, the Office of the State Comptroller receives unclaimed monies and other property deemed abandoned. A list of the names and last known addresses of the entitled owners of this abandoned property is maintained by the office in accordance with Section 1401 of the Abandoned Property Law. Interested parties may inquire if they appear on the Abandoned Property Listing by contacting the Office of Unclaimed Funds, Monday through Friday from 7:00 a.m. to 5:00 p.m., at:

1-800-221-9311
or visit our web site at:
www.osc.state.ny.us

Claims for abandoned property must be filed with the New York State Comptroller's Office of Unclaimed Funds as provided in Section 1406 of the Abandoned Property Law. For further information contact: Office of the State Comptroller, Office of Unclaimed Funds, 110 State St., Albany, NY 12236

PUBLIC NOTICE Department of Civil Service

PURSUANT to the Open Meetings Law, the New York State Civil Service Commission hereby gives public notice of the following:

Please take notice that the regular monthly meeting of the State Civil Service Commission for March 2009 will be conducted on March 10 commencing at 9:30 a.m. and March 11 at 9:30 a.m. This meeting will be conducted at New York Network, Suite 146, South Concourse, Empire State Plaza, Albany, NY. Directions and parking information available at (www.nyn.suny.edu).

For further information, contact: Office of Commission Operations, Department of Civil Service, Alfred E. Smith State Office Building, Albany, NY 12239, (518) 473-6598

PUBLIC NOTICE Division of Criminal Justice Services Law Enforcement Agency Accreditation Council

Pursuant to Public Officers Law Section 104, the Division of Criminal Justice Services gives notice of a meeting of the Law Enforcement Agency Accreditation Council:

Date: Thursday, March 5, 2009
Time: 10:00 a.m.
Place: Four Tower Place
Albany, New York

For further information or if you need a reasonable accommodation to attend this meeting, contact: Henry Boland, Office of Public Safety, Division of Criminal Justice Services, Four Tower Place, Albany, NY 12203, (518) 485-7641

PUBLIC NOTICE Division of Criminal Justice Services Municipal Police Training Council

Pursuant to Public Officers Law Section 104, the Division of Criminal Justice Services gives notice of a meeting of the Municipal Police Training Council.

Date: Wednesday, March 4, 2009
Time: 10:00 a.m.
Place: Division of Criminal Justice Services
Four Tower Place
Albany, New York

For further information or if you need a reasonable accommodation to attend this meeting, contact: Lucy Verrigni, Office of Public Safety, Division of Criminal Justice Services, Four Tower Place, Albany, NY 12203-3702, (518) 457-6101

PUBLIC NOTICE Department of Health

Pursuant to 42 CFR Section 447.205, the Department of Health hereby gives public notice of the following:

The Department of Health proposes to amend the Title XIX (Medicaid) State Plan for inpatient hospital, long term care and non-institutional services to comply with recently proposed statutory provisions. The following significant changes are proposed:

Inpatient Hospital Services

- For the period April 1, 2009 through March 31, 2010, per diem and per discharge rates of payment for general hospital inpatient services will be subject to a uniform reduction to achieve an aggregate reduction of no less than \$154 million. The methodology used to achieve such reduction was previously noticed on March 26, 2008.
- Effective July 1, 2009, and thereafter, per diem rates for inpatient psychiatric services at a general hospital, or a distinct unit of a general hospital, shall be computed as follows:
 - For the period July 1, 2009 through December 31, 2009, the operating cost component will reflect 2005 operating costs as reported to the Department of Health prior to December 1, 2008, adjusted for inflation in accordance with existing statutory provisions and held to a ceiling of 110% of the regional average cost for all such services within the region the hospital is located.
 - For rate periods on and after January 1, 2010, the Commissioner will promulgate regulations that establish a reimbursement methodology that utilizes the 2005 operating costs in a case mix adjusted per diem payment, provide for post-discharge referral to outpatient services, and establish outpatient rates for evaluation and pre-admission referrals.
- Effective July 1, 2009, and thereafter, per diem rates for inpatient medical rehabilitation services and chemical dependency rehabilitation services will reflect the 2005 operating costs as reported to the Department prior to December 1, 2008, adjusted for infla-

tion in accordance with existing statutory provisions and held to a ceiling of 110% of the regional average cost for all such services within the region the hospital is located.

- Effective July 1, 2009, and thereafter, per diem rates for Critical Access Hospitals (CAH's) will reflect the 2005 operating costs as reported to the Department prior to December 1, 2008, adjusted for inflation in accordance with existing statutory provisions and held to a ceiling of 110% of the regional average cost for CAH's statewide.
 - Effective July 1, 2009, and thereafter, for inpatient services by specialty long term acute care hospitals, and cancer hospitals designated as of December 31, 2008, the operating cost component will reflect the 2005 operating costs of each such hospital as reported to the Department prior to December 1, 2008 and adjusted by inflation in accordance with existing statutory provisions. There is no ceiling on such costs.
 - Effective July 1, 2009, and thereafter, for exempt acute care children's hospitals designated as such by the federal DHHS, for which a discrete institutional cost report was filed for the 2006 calendar year, and which has reported Medicaid discharges greater than 50% of total discharges, the operating cost component will reflect the use of 2006 operating costs as reported to the Department prior to December 1, 2008 and adjusted by inflation in accordance with existing statutory provisions. The operating component may be on a per case or per diem basis as set forth in regulations promulgated by the Commissioner.
 - Effective July 1, 2009, and thereafter, such per diem rates for general hospitals or a distinct unit of a general hospital will exclude physician's costs. Claims for Medicaid fee-for-service payments for such physician's services may be submitted separately.
 - There is no change to the capital cost reimbursement methodology used to determine such per diem rates of payment.
 - For general hospitals or distinct units of a general hospital without adequate cost experience, the operating cost component of the applicable per diem rate will be based on the lower of the facility's or unit's inpatient budgeted operating costs per day, adjusted to actual, or the applicable regional ceiling, if any.
 - For discharges, effective July 1, 2009, and thereafter, case based rates of payment for general hospitals will reflect certain 2005 operating costs as reported by each facility to the Department prior to 2008. The rates will be computed based on the case mix neutral statewide base price applicable to each rate period, excluding adjustments for graduate medical education costs, high cost outlier costs, and cost related to patient transfers, and as periodically adjusted to reflect changes in provider coding patterns and case-mix. Rates of payment and case mix factors will reflect costs relating to services provided to Medicaid inpatients as determined by the applicable ratio of costs to charge methodology. Rates will reflect the application of hospital specific wage equalization factors and power equalization factors reflecting differences in wage rates and utility costs, and will be based on the All Patient Refined (APR) case mix methodology, utilizing diagnostic related groups with assigned weights that incorporate differing levels of severity of patient condition and associated risk of mortality, periodically updated by the Commissioner.
- Regulations will be proposed by the Commissioner of Health, establishing the methodology for the computation of general hospital case based inpatient rates. Such regulations may incorporate quality related measures pertaining to potentially preventable complications and re-admissions and will address adjustments based on the costs of high cost outlier patients.
- Case based rates of payment shall continue to reflect trend factor adjustments based on the consumer price index adjustment factor as provided in Section 2807(a)(10) of the Public Health Law (PHL) as otherwise modified by any applicable statute.
 - Cased based rates of payment for non-public, not-for-profit general hospitals which have not, as of the effective date, published an ancillary charges schedule will have their inlier payments

increased by an amount equal to the statewide average of cost outlier payments determined by regulations.

Regulations will provide for administrative rate appeals, only with regard to the correction of computational errors or omissions of data, including hospital specific computations relating to graduate medical education, wage equalization factor adjustments and power equalization factor adjustments, and capital cost reimbursement.

- Cased based rates of payment for teaching general hospitals will include reimbursement for direct and indirect graduate medical education as defined and calculated in accordance with regulations. Such regulations will specify the reports and information required by the Commissioner to assess the cost, quality and health system needs for medical education provided.
- The base period reported costs and statistics used for case based rate-setting operating cost components, including the weights assigned to diagnostic related groups, will be updated no less frequently than every four years and the new base period will be no more than four years prior to the first applicable rate period that utilizes such new base period.
- There is no change to the capital cost reimbursement methodology used to determine such case based rates.
- These provisions will not apply to general hospitals or distinct units whose inpatient reimbursement does not, as of June 30, 2009, reflect case based payment per diagnosis-related group (DRG) or whose reimbursement is, for periods on and after July 1, 2009, determined in the provisions noted above.
- For rate periods on and after July 1, 2009, additional adjustments to the inpatient rates of payment to eligible general hospitals, may be made to facilitate improvements in hospital operations and finances, in accordance with the following:
 - General hospitals eligible for distributions will be non-public hospitals which experience a reduction in their Medicaid inpatient revenue of a percentage determined by the Commissioner as a result of the above reform provisions.
 - Funds distributed will be allocated based on each eligible facility's relative need and will be available in aggregate payments of up to \$75 million for the period July 1, 2009 through March 31, 2010; up to \$75 million for the period April 1, 2010 through March 31, 2011; up to \$50 million for the period April 1, 2011 through March 31, 2012; and up to \$25 million for the period April 1, 2012 through March 31, 2013.
 - Payments made will not be subject to retroactive adjustment or reconciliation and may be added to rates of payment or made as lump sum payments.
 - Each hospital receiving funds will, as a condition for eligibility, adopt a resolution setting forth its current financial condition and a plan for reforming and improving such financial condition, including ongoing board oversight, and will, after two years, issue a report setting forth progress achieved regarding such improvement, provided, however, if such report is not issued and adopted, or if such report fails to set forth adequate progress, such facility may be deemed ineligible for further distributions, which may be redistributed to other eligible facilities. Copies of all resolutions and reports will be provided to the Commissioner.
- The revised inpatient per discharge methodology will result in a statewide decrease in aggregate Medicaid payments of no less than \$168 million for the period July 1, 2009 through March 31, 2010 and \$278 million for the period April 1, 2010 through March 31, 2011.
- The current authority to adjust Medicaid rates of payment for non-public general hospitals to include an adjustment for recruitment and retention of non-supervisory health care workers or any worker with direct patient care responsibility will be extended through June 30, 2009. Aggregate payments for the period April 1, 2009 through June 30, 2009, will be \$60.875 million.
- In accordance with previously noticed provisions, payments for patients discharged on and after December 1, 2008, who are determined to be in the diagnostic category of alcohol and

substance abuse (MDC 20, DRGs 743 through 751) will be made on a per diem basis. This includes inpatient detoxification, withdrawal, and observation services. The per diem rates of payment will be computed using 2006 costs and statistics as reported to the Department by general hospitals prior to 2008. Average cost per diem for the region in which the hospital is located will be calculated with regard to cost incurred for patients requiring medically managed detoxification services and medically supervised withdrawal services as defined by regulations adopted by the Office of Alcoholism and Substance Abuse. The per diem rates will be transitioned to 2006 costs and will be determined as follows:

- For the period December 1, 2008 through February 28, 2009, 75% of the operating cost component will reflect the operating cost component of rates of payment effective for December 31, 2007, as adjusted for inflation and otherwise modified by any applicable statutes, and 25% of such rates will reflect the use of the 2006 operating costs.
- For periods on and after March 1, 2009, 100% of the operating cost component of the rates will be based on the 2006 operating costs.
- For state fiscal years beginning April 1, 2009, and thereafter, additional medical assistance payments for inpatient hospital services may be made to public general hospitals operated by the State of New York or the State University of New York, or by a county which shall not include a city with a population over one million, and those public general hospitals located in the counties of Westchester, Erie, or Nassau, up to one hundred percent (100%) of each such public hospital's medical assistance and uninsured patient losses after all other medical assistance, including disproportionate share payments to such general hospitals. For state fiscal years beginning on and after April 1, 2009, initial payments will be based on reported 2000 reconciled data and be further reconciled to actual reported data for 2009 and to actual reported data for each respective succeeding year. Payments to eligible public general hospitals may be added to rates of payment or made as aggregate payments.
- For state fiscal years beginning April 1, 2009, and thereafter, additional medical assistance payments for inpatient hospital services may be made to public general hospitals, other than those operated by the State of New York or the State University of New York, that are located in a city with a population over one million. Additional medical assistance payments for medical inpatient hospital services of up to \$120 million may be made during each state fiscal year beginning April 1, 2009 and for state fiscal years thereafter based on the relative share of each such non-state operated public general hospital's medical assistance and uninsured losses after all other medical assistance payments including disproportionate share payments. For the state fiscal year beginning April 1, 2009 and for state fiscal years thereafter, initial payments will be based on reported 2000 reconciled data and be further reconciled to actual reported date for 2009 and to actual reported data for each respective succeeding year. Payments to eligible public general hospitals may be added to rates of payments or made as aggregate payments.
- Continues, effective for periods April 1, 2009, and thereafter, the 3.33% reduction to the average reimbursable operating costs per discharge of a general hospital, excluding the costs of graduate medical education, to encourage improved productivity and efficiency.
- Continues, effective April 1, 2009, and thereafter, an \$89 million reduction per year in inpatient rates of payment for general hospital services to encourage improved productivity and efficiency.
- Continues, effective April 1, 2009, and thereafter, to allow an annual increase in the statewide average case mix of one percent per year in inpatient rates of payment. The increase in the statewide average case mix in the period January 1, 2000 through December 31, 2000, from the statewide average case mix for the period January 1, 1996 through December 31, 1996, shall not exceed 4% plus an additional 1% per year thereafter. This increase continues to be based on a comparison of data only for patients that are eligible for medical assistance including those patients enrolled in health maintenance organizations.
- Effective April 1, 2009, and thereafter, continues the provision that rates of payment for inpatient hospital services shall not reflect trend factor projections or adjustments for the period April 1, 1996 through March 31, 1997.
- Continues through June 30, 2009, an increase to rates of payment for hospital inpatient services by an amount not to exceed \$60 million in the aggregate. This amount will be allocated among those voluntary non-profit general hospitals, which continue to provide inpatient services as of April 1, 2007, and that have Medicaid discharge percentages equal to or greater than 35%. This percentage shall be computed based on inpatient discharge data reported in each hospital's 2004 cost report submitted on or before January 1, 2007. The rate adjustments shall be calculated by allocating the available funding proportionately based on each eligible hospital's total 2004 Medicaid discharges to the total 2004 Medicaid discharges of all eligible hospitals. The rate adjustments calculated in accordance with this provision will be subject to reconciliation to ensure that each hospital receives in the aggregate its proportionate share of the full allocation. The adjustments may be added to rates of payment or made in aggregate payments to eligible hospitals.
- Extends current provisions to services on and after April 1, 2009. The reimbursable operating cost component for general hospital inpatient rates will be established with the 2006 final trend factor equal to the final CPI less 0.25%.
- Continues, effective April 1, 2009, and thereafter, holding the operating component of rates of payment for patients assigned to one of the twenty most common non-Medicare diagnosis-related groups (DRGs) to the lower of the facility specific blended operating cost component or the group average operating cost price for all hospitals assigned to the same peer group.
- Continues, effective April 1, 2009, and thereafter, certain cost containment initiatives that were enacted in Chapter 81 of the Laws of 1995 and extended by subsequent legislation. The extended provisions are as follows: (1) hospital short stay adjustment factor remains at 100%; (2) hospital long stay adjustment factor remains at 50%; (3) hospital capital costs shall exclude 44% of major moveable equipment costs; (4) elimination of reimbursement of staff housing operating and capital costs; (5) capital costs will be allocated between Medicare and non-Medicare payers based on the proportion of total days for these payers; (6) budgeted capital inpatient costs of a general hospital applicable to the rate year shall be decreased to reflect the percentage amount by which the budgeted costs for capital related inpatient costs of the hospital for the base year two years prior to the rate year exceeded actual costs; (7) reimbursement of based year inpatient administrative and general costs; and (8) elimination of NYPHRM rate enhancements for new technology and universal precautions.
- For periods on and after January 1, 2009, the \$27M available in the existing Supplemental Indigent Care Hospital Pool will be increased by an additional \$283 million and will be distributed to hospitals designated as teaching hospitals. For purposes of the distribution of this funding, each eligible teaching hospital's relative uncompensated care need amount shall be determined as follows:
 - Inpatient units of service for all uninsured patients from the calendar year two years prior to the distribution year, excluding referred ambulatory, will be multiplied by the applicable Medicaid inpatient rates in effect for such prior year, excluding prospective rate adjustments and rate add-ons; however, for distributions on and after January 1, 2010, the units of service will be multiplied by the inpatient rate in effect as of July 1 of such prior year, excluding prospective rate adjustments and rate add-ons.
 - Outpatient units of service for all uninsured patients from the

calendar year two years prior to the distribution year, including emergency department and ambulatory surgery, will be multiplied by the applicable Medicaid outpatient rates based on the APG methodology in effect for the distribution year; however, for those services for which APG rates are not available, the applicable Medicaid outpatient rate will be the rate in effect for the calendar year two years prior to the distribution year.

- For periods on and after January 1, 2010, uncompensated care need for each facility will be reduced by the sum of all payment amounts collected from such patients, further adjusted by application of a nominal need scale.

Long Term Care Services

- For the period April 1, 2009 through March 31, 2011, a quality of care incentive pool will be established for eligible residential health care facilities (RHCs) in order to increase Medicaid rates of payment for such eligible facilities. Aggregate payments will be up to \$50 million for the period April 1, 2009 through March 31, 2010, and up to \$125 million for the period April 1, 2010 through March 31, 2011. Such payments will be determined by applying criteria, including, but not limited to, the quality components of the minimum data set required under federal law, staffing and survey information, and other facility data. Facilities that fall within one or more of the following categories during a review period will be excluded from award eligibility:
 - any RHC that is currently designated by the federal Centers for Medicare and Medicaid Services as a “special focus facility”;
 - any RHC for which the Department has issued a finding of immediate jeopardy during the most recently completed federal fiscal year;
 - any RHC that has received a citation for substandard quality of care in the areas of quality of life, quality of care, resident behavior, and/or facility practices during the most recently completed federal fiscal year;
 - any RHC that is part of a continuing care retirement community;
 - any RHC that operates as a transitional care unit; and
 - any other exclusion deemed appropriate by the Commissioner.

In the event the total amount of funding allocated for a particular fiscal year is not distributed, funds shall be reserved and accumulated from year to year so that remaining funds at the end of a particular fiscal year will be available for distribution during the following fiscal year.

- The current authority to adjust Medicaid rates of payment for non-public residential health care facilities (RHCs) to include an adjustment for recruitment and retention of non-supervisory health care workers or any worker with direct patient care responsibility has been extended through March 1, 2009. Aggregate payments for the period April 1, 2008 through March 1, 2009 is \$59.4 million.
- For state fiscal year beginning April 1, 2009, and thereafter, continues additional payments to non-state operated public residential health care facilities, including public residential health care facilities located in Nassau, Westchester, and Erie counties, but excluding public residential health care facilities operated by a town or city within a county, in aggregate amounts of up to \$300 million. The amount allocated to each eligible public RHC will be in accordance with the previously approved methodology. Payments to eligible RHCs may be added to rates of payment or made as aggregate payments.
- Continues, effective April 1, 2009, and thereafter, the provision that rates of payment for RHCs shall not reflect trend factor projections or adjustments for the period April 1, 1996 through March 31, 1997.
- Extends current provisions to services on and after April 1, 2009, the reimbursable operating cost component for RHCs rates will be established with the final 2006 trend factor equal to the final CPI less 0.25%.

- Continues, effective April 1, 2009, and thereafter, long-term care Medicare maximization initiatives.
- Effective for periods on and after March 1, 2009, the operating cost component of payment rates for inpatient services provided by residential health care facilities will be computed on a regional basis, and will reflect allowable operating costs as reported in each facility’s 2005 cost reports, filed with the Department as of December 1, 2008, adjusted for inflation calculated in accordance with current statutory provisions. The regions of the State are defined as follows:
 - New York City: Bronx, New York, Kings, Queens and Richmond Counties;
 - Long Island: Nassau and Suffolk Counties;
 - Northern Metropolitan: Columbia, Delaware, Dutchess, Orange, Putnam, Rockland, Sullivan, Ulster and Westchester Counties;
 - Northeast: Albany, Clinton, Essex, Fulton, Greene, Montgomery, Rensselaer, Saratoga, Schenectady, Schoharie, Warren and Washington Counties;
 - Utica/Watertown: Franklin, Hamilton, Herkimer, Lewis, Oswego, Otsego, St. Lawrence, Jefferson, Chenango, Madison and Oneida Counties;
 - Central: Broome, Cayuga, Chemung, Cortland, Onondaga, Schuyler, Steuben, Tioga and Tompkins Counties;
 - Rochester: Monroe, Ontario, Livingston, Seneca, Wayne and Yates Counties; and
 - Western: Allegany, Cattaraugus, Chautauqua, Erie, Genesee, Niagara, Orleans and Wyoming Counties.

Effective for periods on and after January 1, 2009, the capital component of payment rates will fully reflect the cost of local property taxes, an payments in lieu of local property taxes, as reported in each facility’s cost report submitted for the year two years prior to the rate year.

The direct component of the operating component of payment rates will be subject to a case mix adjustment through application of the Minimum Data Set (MDS) classification used by the federal government for Medicare payments to skilled nursing facilities to reflect patient services intensity and as may be further adjusted by the Commissioner. Such adjustments will be made semi-annually in each calendar year, and both the adjustments and patient classifications in each facility will be subject to audit review in accordance with regulations promulgated by the Commissioner of Health.

Effective on and after March 1, 2009, rates of payment for inpatient services provided by residential health care facilities will, except for the establishment of regional prices, be calculated utilizing only the number of patients properly assessed and reported in each patient classification group and eligible for Medicaid.

Effective March 1, 2009, the operating component of payment rates, for the following categories of facilities will reflect the rates in effect for such facilities on December 31, 2006, as adjusted for inflation in accordance with current statutory provisions:

- AIDS facilities or discrete AIDS units;
- discrete units for residents receiving care in a long-term inpatient rehabilitation program for traumatic brain injury;
- discrete units providing specialized program for residents requiring behavioral interventions;
- discrete units for long term ventilator dependent residents; and
- facilities or discrete units that provide extensive nursing, medical, psychological and counseling support services for children.

Such rates will remain in effect until the Department, in consultation with representatives of the nursing home industry, develops a regional pricing or alternative methodology for determining such rates.

Effective no later than the 2012 rate period, the operating component of the rates will be based on allowable costs from an annual cost report period which is not earlier than three years prior to the initial rate year. Thereafter, the operating component base year will be updated to be current no less frequently than every six years, provided,

however, that current shall mean that the operating components of the initial rate year shall utilize updated base year costs for periods no earlier than three years prior to the initial rate year, adjusted for inflation.

The operating component of the rates will be adjusted to reflect a per diem add-on for the following patient categories:

- each patient whose body mass index is greater than 35;
 - each patient who qualifies under the RUG-III impaired cognition and behavioral problems categories, or has been diagnosed with Alzheimer's disease or dementia, and is classified in the reduced physical functions A, B, or C, or in behavioral problems A or B categories, and has an activities of daily living index score of less than ten; and
 - each patient who qualifies for extended care as a result of traumatic brain injury as defined by applicable regulations.
- For periods March 1, 2009 through March 31, 2013, additional transition adjustments may be made to payment rates for residential health care facilities (RHCfs) operations and finances in accordance with the following:
 - RHCfs eligible for distributions will be those non-public facilities and state operated public residential health care facilities, which have an average annual Medicaid utilization percentage of 50% or greater, for the period two years prior to the rate year, and which experience a reduction in their Medicaid revenue of a percentage as a result of the application of regional pricing.
 - Transition funds distributed will be allocated based on each eligible facility's relative need and will be available for the following periods in the following amounts: March 1, 2009 through March 31, 2010, up to \$75 million; April 1, 2010 through March 31, 2011, up to \$75 million; April 1, 2011 through March 31, 2012, up to \$50 million; and April 1, 2012 through March 31, 2013, up to \$25 million. Payments made will not be subject to retroactive adjustment or reconciliation and may be added to payment rates or made as lump sum payments.
 - As a condition for eligibility for receiving such funds, each RHCf will adopt a resolution of the Board of Directors or submit a report by the owner acceptable to the Commissioner setting forth its current financial condition and a plan for reforming and improving such financial condition, including ongoing board or owner oversight, and will after two years, issue a report, adopted by such board or issue a further acceptable report by the owner setting forth progress achieved regarding such improvement, provided, however, if such further report is not submitted or fails to set forth adequate progress, such facility may be deemed ineligible for further distributions which may be redistributed to other eligible facilities. Copies of all such resolutions and reports will be provided to the Commissioner.
 - Effective March 1, 2009, the Department will only review administrative rate appeals for the correction of computational errors or omissions of data in determining the operating rate based upon the information provided to the Department prior to the computation of the rate, capital cost reimbursement, or such reasons as the Commissioner determines are appropriate. Any revisions made to a facility's annual cost report for operating rate adjustment purposes later than the due date will not be considered.
 - Capital cost reimbursement for proprietary residential health care facilities which would be entitled to residual reimbursement as provided under applicable regulation, may have the capital cost component of its rate recalculated by the Department to take into account any capital improvements and/or renovations made to the facility's existing infrastructure for the purpose of converting beds to alternative long-term care uses or protecting the health and safety of patients, based on approval of the Commissioner and all applicable certificate of need requirements. The adequacy of current capital cost reimbursement for voluntary residential health care facilities will be evaluated by the Department.

- Effective for rate periods on and after April 1, 2009, rate of payment for eligible RHCfs, excluding public facilities, will reflect an adjustment for financially disadvantaged assistance. Eligibility for such adjustment will continue to be determined based on RHCfs operating margin over the most recent three-year period for which data is available. Disqualification from such adjustment continues to include any facility with a positive operating margin, a negative operating margin that is within the quartile of the smallest margins, a positive margin in the most recent year of the three year period, or an average Medicaid utilization percentage of 50% or less during the most recent year of the three-year period. However, disqualification will not be applied solely on the basis of a positive margin in the most recent year of such three-year period. Additionally, disqualification will include any facility with a negative operating margin within the quartile with the second smallest margins; and any facility with an average Medicaid utilization percentage of less than 70% during the most recent year of the three-year period.

Determination of the operating loss for eligibility continues to be based on the average of the three-year period and will be calculated by subtracting total operating expenses for the three-year period from total operating revenues for the that period, provided, however, on and after April 1, 2009, such average loss will be reduced by an amount equal to the amount of financially distressed funds received by each facility.

For hospital-based RHCfs, for which the average loss cannot be calculated on the basis of submitted costs reports, the sponsoring hospital's overall average loss for the three-year period will be apportioned to the RHCf based on the proportion of the RHCf's total revenues for the period to the total revenues reported by the sponsoring hospital, and such apportioned average annual operating loss will be further reduced by an amount equal to the amount received by such facility.

- For periods prior to April 1, 2009, each facility's qualifying average operating loss continues to be multiplied by the applicable percentage, based on its location in a county with a population of 200,000 persons or more, or a county with a population of less than 200,000 persons, and on a quartile in which each facility's negative operating margin falls. The financially distressed assistance distributions will not be reduced by a facility's estimated benefit of the 2001 update to the regional input price adjustment factors. However, the amount of each facility's distribution will be limited to no more than \$1 million for the period April 1, 2009 through December 31, 2009 and for each annual rate period thereafter.

The total amount of funds to be allocated and distributed as medical assistance for financially disadvantaged RHCf rate adjustments to eligible facilities will be \$40 million on an annualized basis on and after January 1, 2009.

For periods on and after April 1, 2009, RHCfs which are eligible for financially disadvantaged rate adjustments will, as a condition for receipt of such rate adjustments, submit to the Commissioner a written restructuring plan that is in accordance with the following:

- The plan will be submitted to the Commissioner within 60 days of the facility's receipt of the rate adjustments for a rate period subsequent to March 31, 2008, provided, however, facilities which are allocated \$400,000 or less on an annualized basis shall be required to submit such plans within 120 days, and further provided that these periods may be extended by the Commissioner by no more than 30 days, for good cause shown;
- The plan will provide a detailed description of the steps the facility will take to improve operational efficiency and align its expenditures with its revenues, and will include a projected schedule of quantifiable benchmarks to be achieved in the implementation of the plan;
- The plan will require periodic reports to the Commissioner, in accordance with a schedule acceptable to the Commissioner, setting forth the progress the facility has made in implementing its plan; and
- The plan will include the facility's retention of a qualified chief

restructuring officer to assist in the implementation of the plan, provided, however, that this requirement be waived by the Commissioner, for good cause shown, upon written application by the facility.

If a RHCf fails to submit an acceptable restructuring plan in accordance with these provisions, the facility will, from that time forward, be precluded from receipt of all further financially disadvantaged rate adjustments and will be deemed ineligible from any future re-application for such adjustments. Further, if the Commissioner determines that a facility has failed to make substantial progress in implementing its plan or in achieving the benchmarks set forth in such plan, then the Commissioner may, upon 30 days notice to that facility, disqualify the facility from further participation in the rate adjustments, and the Commissioner may require the facility to replay some or all of the previous rate adjustments.

- Effective March 1, 2009, rates of payment for inpatient services provided by RHCfs, in determining the operating component of a facility's rate for care provided for an AIDS patient in a RHCf designated as an AIDS facility or discrete AIDS unit, the operating component will not reflect an occupancy factor increase.

Non-Institutional Services

- Effective March 1, 2009, distributions will be made to public general hospitals located in a city with a population over one million persons, other than those hospitals operated by the State or the State University system, for those hospitals which experienced free patient visits in excess of 20% of the total free and self pay visits, and uninsured losses in excess of 75% of the total inpatient and outpatient losses as reported in the 1999 ICR. Such distributions will be based on each eligible hospital's proportionate share of Medicaid outpatient visits to the total of all Medicaid outpatient visits for all eligible hospitals. The proportionate distributions may be added to the rates or made in aggregate payments.
- Effective on and after March 1, 2009, the operating component of payment rates, for adult day health care services provided by RHCfs, that have not achieved an occupancy rate of 90% or greater for a calendar year prior to January 1, 2009, or for programs that achieved an occupancy percentage of 90% or greater prior to the 2004 calendar year but in such year had an approved capacity that was not the same as in the 2004 calendar year, will be calculated using 2009 reported allowable costs divided by visits imputed at actual or 90%, whichever is greater.
- Effective March 1, 2009, and thereafter, continues the provision that rates of payment for RHCfs providing adult day health care services to patients diagnosed with AIDS will reflect trend factors to project for the effects of inflation except that such trend factors will not be applied to services for which rates of payment are established by the Commissioner of Mental Hygiene.
- To improve health outcomes and efficiency through patient care continuity and coordination of health services, the Commissioner is authorized to certify certain clinicians and clinics as health care homes. Providers will be eligible for enhanced payments for services provided to: recipients eligible for Medicaid fee-for-service, persons enrolled in Medicaid HMOs or Family Health Plus; and enrollees eligible for Child Health Plus and in approved organizations.
 - On or before October 1, 2009, under the Statewide Health Care Home Program, standards of certification for health care homes for Medicaid fee-for-service and Medicaid managed care, Family Health Plus and Child Health Plus programs will be developed and implemented considering existing standards developed by national accrediting and professional organizations; and consulting with national and local organizations working on medical home models, physicians, hospitals, clinics, health plans and consumers and their representatives.
 - To maintain certification, health care homes must: renew their certification at a frequency determined by the Commissioner; and provide data to the Department and to health plans to permit the Commissioner, or his contractor or designee, to evaluate the impact of health care homes on quality, outcomes, and cost.
 - Enhanced rates of payment may be made to clinics and clinicians that are certified as health care homes. Such enhancements may be tiered based on the level of standard achieved by the clinician or clinic and will be made to health care homes that meet specific process or outcome standards.
 - On or before December 31, 2012, the Commissioner will report to the Governor and the Legislature on the impact of the Statewide Health Care Home Program on quality, cost, and outcomes for enrollees in Medicaid fee-for-service, Medicaid managed care, Family Health Plus and Child Health Plus.
- To promote improved quality of, and access to health care services, and improved clinical outcomes to residents in the upper northeastern region of New York, through patient care continuity and coordination of services, under the Adirondack Health Care Home Multipayor Program, the Commissioner is authorized to certify certain clinicians and clinics in the upper northeastern region of New York as health care homes. Providers will be eligible for enhanced payments for services provided to: recipients eligible for Medicaid fee-for-service; persons enrolled in Medicaid HMOs or Family Health Plus; enrollees eligible for Child Health Plus and in approved organizations; enrollees and subscribers of commercial managed care plans organized and operating in accordance with Article 43 of the Insurance Law or other commercial insurers; and employees of employer-sponsored self-insured plans.
 - Under the active supervision of the Commissioner, the policy will be to encourage cooperative, collaborative and integrative arrangements between health care services payors and providers who might otherwise be competitors. To the extent such arrangements might be anti-competitive under federal anti-trust laws, the intent is to supplant competition to the extent necessary and to provide state action immunity under the state and federal antitrust laws with respect to planning; implementation and operation of the Adirondack Health Care Home Multipayor Program; and health care services payors and providers.
 - The Commissioner or his designee may engage in appropriate state supervision necessary to promote state action immunity under the state and federal antitrust laws, and may inspect or request additional documentation to verify the program is implemented in accordance with its intent and purpose.
 - The Commissioner is authorized to participate in, actively supervise, facilitate, and approve a primary care health care home collaborative with health care services providers, which may include hospitals, freestanding clinics, private practices, and health care services payors including employers, health plans, and insurers, to establish: the boundaries of the program and the providers eligible to participate; practice standards for health care home professional organizations including the joint principles of the American College of Physicians (ACP), the American Academy of Family Physicians (AAFP), the American Academy of Pediatrics (AAP), the American Osteopathic Association (AOA), and as further defined by Patient-Centered Medical Home, as represented in certification programs developed by the National Committee for Quality Assurance (NCQA); methodologies by which payors will provide enhanced rates of payment to certified health care homes; and methodologies to pay additional amounts for health care homes that meet specific process or outcome standards established by the Adirondack Health Care Home Collaborative.
 - Patient and health care services provider participation in the program will be on a voluntary basis. Clinics and clinicians participating in the program are not eligible for additional enhancements or bonuses under the Statewide Health Care Home program for services provided to participants in Medicaid fee-for-service, Medicaid managed care, Family Health Plus or Child Health Plus.

Enhanced rates of payment may be made to clinics and clinicians that are certified as health care homes under this program. Additional payment amounts will be made to health care homes that meet specific process or outcome standards specified by the Commissioner, in

consultation with the Adirondack Health Care Home Collaborative. Effective for periods on and after March 1, 2009, rates of payment for diagnostic and treatment centers, certified home health agencies and personal care providers providing adult day health care services to patients diagnosed with AIDS as defined by applicable regulations, the Commissioner will apply trend factors using existing methodology, except that such trend factors will not be applied to services for which rates of payment are established by the Commissioner of Mental Hygiene.

- Effective January 1, 2010, payments for services provided by certified home health agencies will be based on episodic payments. Such payments will be established, using a statewide base price for each 60 day episode of care and adjusted by a provider regional wage index factor and an individual patient case mix index. Such episodic payments may be further adjusted for low utilization cases and to reflect a percentage of the cost for high utilization cases that exceed outlier thresholds of such payments. Base year episodic payments will be further adjusted to the applicable rate year by inflation factors in accordance with current statutory provisions.

Initial base year episodic payments will be based on Medicaid paid claims, for services provided by all certified home health agencies in the 2007 base year. Subsequent base year episodic payments may be based on Medicaid paid claims for services provided in a base year subsequent to 2007 as determined by the Commissioner. In determining case mix, each patient will be classified using a system based on measures including, but not limited to, clinical and functional measures, as reported on the federal Outcome and Assessment Information Set (OASIS). Agencies will be required to collect and submit any data required and regulations may be proposed to implement these provisions.

- For the period April 1, 2009 through March 31, 2011, a quality of care incentive pool will be established for payments to eligible Certified Home Health Agencies (CHHAs) that meet quality measures. Aggregate payments will be up to \$20 million for the period April 1, 2009 through March 31, 2010, and up to \$20 million for the period April 1, 2010 through March 31, 2011. Such payments will be made as adjustments to medical assistance rates of payment for services provided by eligible CHHAs meeting such quality measures. To be eligible for such rate adjustments, a CHHA must have, provided services to Medicaid recipients, during a 15-month period prior to the payment, as reported on the agency's cost reports. An agency that has changed ownership during that same period, however, will not be eligible. An eligible CHHA must submit such reports and data as required by the Commissioner and must not have received a condition level deficiency of non-compliance during the most recently completed recertification survey. Eligibility exclusions for such rate adjustments will be based on criteria that the Commissioner deems appropriate. Regulations will be proposed to implement these provisions.
- Medicaid payments under the Ambulatory Patient Group (APG) methodology for general hospital outpatient services, and freestanding clinic services, including freestanding ambulatory surgery centers, shall be in accordance with the following:
 - General Hospital Outpatient Services: for the period December 1, 2008 through June 30, 2009, 75% of the operating component of such payment rates will reflect the 2007 average Medicaid payment per claim, for each hospital, for services provided by that hospital in the 2007 calendar year excluding payments for services covered by the facility's licensure, if any, under the Mental Hygiene Law, and 25% of the operating component will reflect the utilization of the Ambulatory Patient Groups (APG) reimbursement methodology.
 - For the period July 1, 2009 through June 30, 2010, 50% of the operating component of such payment rates will reflect the 2007 average Medicaid payment per claim and 50% of the operating component will reflect the utilization of the APG reimbursement methodology.
 - For the period July 1, 2010 through June 30, 2011, 25% of the

operating component of such payment rates will reflect the 2007 average Medicaid payment per claim and 75% of the operating component will reflect the utilization of the APG reimbursement methodology.

- For periods on and after July 1, 2011, 100% of such payment will reflect the utilization of the APG reimbursement methodology.
- Freestanding clinics including freestanding ambulatory surgery centers: for the period March 1, 2009 through June 30, 2009, 75% of the operating cost component of payment rates will reflect the average 2007 calendar year Medicaid payment per claim, for services provided by that facility excluding any payments for services covered by the facility's licensure, if any, under the Mental Health Law, and 25% of the operating component will reflect the utilization of the APG reimbursement methodology.
- For the period July 1, 2009 through June 30, 2010, 50% of the operating cost component of payment rates will reflect the average 2007 Medicaid payment per claim and 50% of will reflect the utilization of the APG reimbursement methodology.
- For the period July 1, 2010 through June 30, 2011, 25% of the operating cost component of payment rates will reflect the average 2007 Medicaid payment per claim, and 75% of such rates of payments will, for the operating cost component, will reflect the utilization of the APG reimbursement methodology.
- For periods on and after July 1, 2011, 100% of such payment rates will reflect the utilization of the APG reimbursement methodology.
- If the Commissioner determines that the use of the APG methodology is not, or is not yet appropriate or practical for specified services, the Commissioner may use existing payment methodologies for such services, or may establish alternative payment methodologies for such services or may promulgate regulations, and may promulgate emergency regulations, establishing alternative payment methodologies for such services.
- The APG payment methodology may incorporate payment for services provided by facilities pursuant to licensure under the Mental Hygiene Law, provided such APG payment methodology may be phased into effect in accordance with a schedule or schedules as jointly determined by the Commissioner of Mental Health, the Commissioner of Alcoholism and Substance Abuse Services, and the Commissioner of Mental Retardation and Developmental Disabilities.
- Rates of payment for general hospital outpatient services, general hospital emergency services and ambulatory surgical services provided by a general hospital will result in an aggregate increase of \$56 million for the periods December 1, 2008 through March 31, 2009; \$178 million on an annualized basis for the period April 1, 2009 through June 31, 2009; and \$270 million annually for periods thereafter, provided that for periods on and after April 1, 2009, such amounts may be adjusted to reflect projected decreases in fee-for-service Medicaid utilization and changes in case-mix with regard to such services may be adjusted from the 2007 calendar year to the applicable rate year. Funds made available as a result of any decreases may be used by the Commissioner to increase capitation rates paid to Medicaid managed care plans and Family Health Plus plans to cover increased payments to health care providers for ambulatory care services and to increase such other ambulatory care payment rates necessary to facilitate access to quality ambulatory care services.
- Rates of payment for diagnostic and treatment center services will result in an aggregate increase of \$12.5 million on an annualized basis for the period March 1, 2009 through June 30, 2009, and \$50 million annually for periods thereafter.
 - The following additional services provided by general hospital outpatient departments and freestanding clinics will be reimbursed with rates of payment based entirely on the APG methodology, provided that the Commissioner may utilize existing payment methodologies or may propose regulations establishing alternative payment methodologies for one or more of the services that are specified:

- Effective for dates of service on and after March 1, 2009, smoking cessation counseling services provided to pregnant women on any day of her pregnancy, during a medical visit provided by a general hospital outpatient department or a freestanding clinic.
- On or after January 1, 2010, smoking cessation counseling for post-partum women through the end of the month in which the one hundredth day following the end of the pregnancy occurs, during a medical visit.
- On and after January 1, 2010, cardiac rehabilitation services when ordered by the attending physician and provided in a hospital-based or free-standing clinic in an area set aside for cardiac rehabilitation.
- On and after January 1, 2010, smoking cessation counseling services to children and adolescents 10 to nineteen years of age.
- Effective for dates of services on and after March 1, 2009, payments to general hospital outpatient departments and freestanding clinics will be based on fees established by the Department for: (1) wheelchair evaluations, (2) eyeglass dispensing, (3) individual psychotherapy services provided by licensed social workers to people under the age of 19, and to people requiring such services as a result of or related to pregnancy or giving birth, and (4) individual psychotherapy services provided by licensed social workers at freestanding clinics that provided, billed for, and received payment for these services between January 1, 2007 through December 31, 2007.
- For periods on and after October 1, 2009, the Commissioners of Mental Health and Health, subject to the approval of the Director of the Budget, are jointly authorized to implement and enhance funding of the APG reimbursement methodology, for determining rates of payment for outpatient clinic services rendered by providers pursuant to their licensure under Article 31 of the Mental Hygiene Law. Regulations will be proposed to reflect utilization of the APG reimbursement methodology.
- For periods on and after October 1, 2009, the Commissioners of Health and Mental Retardation and Developmental Disabilities, subject to the approval of the Director of the Budget, are jointly authorized to implement the APG reimbursement methodology for clinic services rendered by providers pursuant to their licensure under Article 16 of the Mental Hygiene Law. Regulations will be proposed by the Commissioner of Mental Retardation and Developmental Disabilities, subject to the approval of the Commissioner of Health and Director of the Budget, to reflect utilization of the APG reimbursement methodology.
- For periods on and after October 1, 2009, the Commissioners of Health and Alcoholism and Substance Abuse Services, subject to the approval of the Director of the Budget, are jointly authorized to implement and enhance funding for determining rates of payment for outpatient clinic services rendered pursuant to providers' operating certificates under Article 32 of the Mental Hygiene Law. Regulations will be proposed by the Commissioner of Alcoholism and Substance Abuse Services, subject to the approval of the Commissioner of Health and the Director of the Budget, to reflect the utilization of the APG reimbursement methodology.
- Effective for dates of service on and after July 1, 2009, APG relative weights, APG base-rates, and other associated aspects of the APG payment system will be reweighted and updated.
- Continues, effective 4/1/2009, and thereafter, the provision that payments for hospital-based and freestanding ambulatory surgery center services will be at the rates in effect as of March 31, 2003.
- Continues, effective April 1, 2009, and thereafter, certain cost containment initiatives currently in effect for Medicaid rates of payment. These are as follows: diagnostic and treatment center rate freeze, including products of ambulatory care; diagnostic and treatment center and certified home health agency administrative and general cost reimbursement limits, home health care Medicare maximization initiatives; hospital outpatient and emergency department reimbursement reductions attributable to

exclusion of 44% of major moveable equipment capital costs and elimination of staff housing costs; and adult day health care reimbursement caps.

- Extends current provisions to services on and after April 1, 2009, the reimbursable operating cost component for general hospital outpatient rates and adult day health care services provided by RHCs will be established with the 2006 final trend factor equal to the final CPI less 0.25%.
- Effective for services rendered on and after March 1, 2009, rates of payment for home health services provided by certified home health agencies will be adjusted to reflect a uniform percentage reduction of 3.5%. Rates of payment for home health services including AIDS home care services, and personal care services, including those personal care services provided in social services districts, who rates of payments for such services are issued by social service districts pursuant to a rate-setting exemption issued by the Commissioner of Health will be adjusted to reflect a uniform percentage reduction of 1.5%. These uniform percentage reductions will be applied after applicable adjustments to the trend factors affecting such rates.
- The current authority to adjust Medicaid rates of payment for Certified Home Health Agencies (CHHAs), long term home health care programs, AIDS home care programs, hospice programs, and managed long term care plans for purposes of supporting recruitment and retention of non-supervisory health care workers or any worker with direct patient care responsibility has been extended for the period April 1, 2009 through March 31, 2011. Aggregate payment for the period April 1, 2009 through March 31, 2010 will not exceed \$90 million, provided, however that up to \$27 million will be reserved and distributed to CHHAs for the period April 1, 2009 through December 31, 2009. Additionally, the remaining funds will be distributed to eligible providers that are not CHHAs.

For the period January 1, 2010, and thereafter, CHHAs will not be eligible for distributions.

For the period April 1, 2010 through March 31, 2011, aggregate payment for eligible providers will not exceed \$63 million.

- Additional payments of \$3,694,000 for the period December 1, 2008 through December 31, 2008, will be made to qualifying diagnostic and treatment centers to reflect additional costs associated with the operation of electronic health records systems that meet such standards as established by the Commissioner of Health. This represents a \$1.218 million reduction in the amount noticed December 31, 2008. Such additional payments will not be subject to subsequent adjustment or reconciliation and can be made as aggregate payments to eligible providers.

Prescription Drugs

- Effective April 1, 2009, specialized HIV pharmacy reimbursement rates will be discontinued. As of that date, a pharmacy previously designated as a specialized HIV pharmacy will receive the same reimbursement as all other pharmacies.
- Effective September 1, 2009, for certain multiple source brand name outpatient drugs that have a lower net pharmacy reimbursement cost to Medicaid than the generic equivalent, the pharmacy dispensing fee for such drugs will be \$4.50. Enrollee co-payments for such brand name drugs will be \$1.00. Reimbursement, dispensing fees, and enrollee co-payments for generic equivalents of such drugs will remain unchanged; however, the prescriber must obtain prior authorization.
- Effective October 1, 2009, financial incentives will be paid to medical practitioners, clinics, and pharmacies for the purpose of encouraging the electronic transmission of prescriptions for drugs prescribed and dispensed in accordance with State and federal requirements. Such payments will be in the following amounts: for medical practitioners and clinics, 80 cents per dispensed electronic prescription; for dispensing pharmacies, 20 cents per dispensed electronic prescription.

The estimated annual net aggregate increase in gross Medicaid expenditures attributable to this proposed initiative for state fiscal year 2009/2010 is \$1.4 billion.

Copies of the proposed state plan amendments will be on file in each local (county) social services district and available for public review.

For the New York City district, copies will be available at the following places:

New York County
250 Church Street
New York, New York 10018

Queens County, Queens Center
3220 Northern Boulevard
Long Island City, New York 11101

Kings County, Fulton Center
114 Willoughby Street
Brooklyn, New York 11201

Bronx County, Tremont Center
1916 Monterey Avenue
Bronx, New York 10457

Richmond County, Richmond Center
95 Central Avenue, St. George
Staten Island, New York 10301

The public is invited to review and comment on this proposed state plan amendment.

For further information and to review and comment, please contact:

Mr. Philip N. Mossman
New York State Department of Health
Bureau of HCRA Operations & Financial Analysis
Corning Tower Building, Rm. 984
Empire State Plaza
Albany, New York 12237
(518) 474-1673
(518) 473-8825 (FAX)
PNM01@health.state.ny.us

PUBLIC NOTICE

Department of Housing and Community Renewal
Consolidated Annual Performance Report
Available for Public Comment

In accordance with the provisions of the National Affordable Housing Act, the State of New York is making a draft of its Consolidated Annual Performance Report (CAPER) for Program Year 2008 available for public comment. The CAPER analyzes New York State's progress in implementing its HUD-approved Annual Action Plan for 2008.

The public is invited to review the draft New York State CAPER and to offer comments on the document. The draft 2008 CAPER, as published for public comment, will be available during the public comment period on the New York State Division of Housing and Community Renewal (DHCR) website at www.nysdhcr.gov. In addition, copies can be requested by e-mail at DHCRConPln@nysdhcr.gov or by telephoning 1-866-ASK-DHCR (1-866-275-3427).

The public comment period will begin on Friday, February 27, 2009 and end on Friday, March 13, 2009. Written comments must be postmarked no later than March 13, 2009. E-mail comments must be sent by that date. Comments should be addressed to Brian McCarthy, NYS DHCR, Hampton Plaza, 38-40 State Street, Albany, NY 12207 or e-mailed to: DHCRConPln@nysdhcr.gov

PUBLIC NOTICE

Nassau County Deferred Compensation Plan Board

Pursuant to Part 9003.2 of Title 9 of the New York State Codes, Rules and Regulations, the Nassau County Deferred Compensation Plan Board hereby gives notice of the following:

The Nassau County Deferred Compensation Plan Board (the "Plan" and the "Board" respectively) is requesting proposals from firms authorized to do business in New York State to provide Deferred Compensation Services, including serving as the Plan's administrative service agency, custodial trustee and financial organization. Details of the proposal can be found in the Request for Proposals posted at the Nassau County website at www.nassaucountyny.gov and also can be obtained by contacting the individuals named below. Pre-proposal questions must be submitted to the individuals named below by March 11, 2009 and proposals must be submitted by March 31, 2009.

For further information, contact: Nassau County Deferred Compensation Plan Board, c/o Segal Advisors, Inc., Attn: Mr. Frank Picarelli, One Park Avenue, New York, NY 10016-5895, e-mail: fpicarelli@segaladvisors.com

With a copy to: Nassau County Deferred Compensation Plan Board, Attn: Mr. Steven D. Conkling, 240 Old Country Road, Mineola, NY 11501, e-mail: sconkling@nassaucountyny.gov

PUBLIC NOTICE

Department of State

The New York State Real Estate Board will hold a public hearing on general real estate issues on Wednesday, March 18, 2009 at 10:30 a.m. at Department of State, Division of Licensing Services, Alfred E. Smith State Office Building, 80 South Swan Street, 10th Floor Conference Room, Albany, NY and 123 William Street, 19th Floor Conference Room, New York, NY. The Board will hold an open board meeting immediately following the public hearing at the same locations (via video-conference).

Should you wish to participate in the public hearing or attend the board meeting, please contact Debra Ryan-Campana at debra.ryan-campana@dos.state.ny.us or 518-473-6155. If you plan to attend in Albany, please consult our web site (<http://www.dos.state.ny.us/lcns/contact.htm>) for instructions on pre-registering in order to gain access to the building. Please always consult the Department of State website (www.dos.state.ny.us/about/calendar.htm) on the day before the meeting to be sure the meeting has not been rescheduled.

SALE OF

FOREST PRODUCTS

Allegheny Reforestation Area No. 7
Contract No. X007333

Pursuant to Section 9-0505 of the Environmental Conservation Law, the Department of Environmental Conservation hereby gives Public Notice for the following:

Sealed bids for 82.8 MBF more or less of hardwood timber located on Allegheny Reforestation Area No. 7, Vandermark State Forest, Stands 48 & 66, will be accepted at the Department of Environmental Conservation, Contract Unit, 625 Broadway, 10th Fl., Albany, NY 12233-5027 until 11:00 a.m., Thursday, March 12, 2009.

For further information, contact: David Zlomek, Senior Forester, Department of Environmental Conservation, Division of Lands and Forests, Region 9, 5425 County Rte. 48, Belmont, NY 14813-9758, (585) 268-5392

SALE OF

FOREST PRODUCTS

Cattaraugus Reforestation Area No. 7
Contract No. X006901

Pursuant to Section 9-0505 of the Environmental Conservation Law, the Department of Environmental Conservation hereby gives Public Notice of the following:

Sealed bids for 401.2 MBF more or less of sawtimber and 400 std. cords more or less of cordwood located on Cattaraugus Reforestation Area No. 7, Stands 5 & 6, will be accepted at the Department of Environmental Conservation, Contract Unit, 625 Broadway, 10th Fl., Albany, NY 12233-5027 until 11:00 a.m., Thursday, March 12, 2009.

For further information, contact: Victor Anderson, Sr. Forester, Department of Environmental Conservation, Division of Lands and Forests, Region 9, 215 S. Work St., Falconer, NY 14733, (716) 665-6111

SALE OF
FOREST PRODUCTS

Otsego Reforestation Area No. 10
Contract No. X007367

Pursuant to Section 9-0505 of the Environmental Conservation Law, the Department of Environmental Conservation hereby gives Public Notice for the following:

Sealed bids for 262.1 MBF, more or less, of red pine sawtimber; 3.1 MBF, more or less of miscellaneous hardwood and softwood sawtimber; 8 cords, more or less, of miscellaneous hardwood firewood located on Otsego Reforestation Area No. 10, Stand A-14, will be accepted at the Department of Environmental Conservation, Bureau of Procurement & Expenditure Services, 625 Broadway, 10th Fl., Albany, NY 12233-5027 until 11:00 a.m., Thursday, March 12, 2009.

For further information, contact: Paul Wenner, Senior Forester, Department of Environmental Conservation, Division of Lands and Forests, Region 4, 65561 State Hwy. 10, Suite 1, Stamford, NY 12167-9503, (607) 652-7365