

RULE MAKING ACTIVITIES

Each rule making is identified by an I.D. No., which consists of 13 characters. For example, the I.D. No. AAM-01-96-00001-E indicates the following:

- AAM -the abbreviation to identify the adopting agency
01 -the *State Register* issue number
96 -the year
00001 -the Department of State number, assigned upon receipt of notice.
- E -Emergency Rule Making—permanent action not intended (This character could also be: A for Adoption; P for Proposed Rule Making; RP for Revised Rule Making; EP for a combined Emergency and Proposed Rule Making; EA for an Emergency Rule Making that is permanent and does not expire 90 days after filing.)

Italics contained in text denote new material. Brackets indicate material to be deleted.

Department of Agriculture and Markets

PROPOSED RULE MAKING NO HEARING(S) SCHEDULED

Animal Health Requirements for Animals Entering Fairs

I.D. No. AAM-02-09-00005-P

PURSUANT TO THE PROVISIONS OF THE State Administrative Procedure Act, NOTICE is hereby given of the following proposed rule:

Proposed Action: This is a consensus rule making to amend Part 351 of Title 1 NYCRR.

Statutory authority: Agriculture and Markets Law, sections 18(6), 31-b and 72(3)

Subject: Animal health requirements for animals entering fairs.

Purpose: To clarify regulatory requirements, make technical changes to existing rules and better protect the health of animals at fairs.

Text of proposed rule: Subdivision (q) of section 351.1 is repealed and a new subdivision (q) is added to read as follows:

(q) *New World camelidae means any member of the camelidae family native to South America, including alpacas (*Vicugna pacos*), llamas (*Lama glama*), guanacos (*Lama guanicoe*) and vicunas (*Vicugna vicugna*).*

Subdivision (c) of section 351.3 is amended to read as follows:

(c) All animals presented for admission to a fair that originate from a location other than this State shall meet all State importation regulations appropriate to the species in addition to the requirements of this Part. State importation requirements can be obtained by contacting the department at [One Winners Circle] 10B Airline Drive, Albany, NY 12235, (518) 457-3502, www.agmkt.state.ny.us

Section 351.5 is amended to read as follows:

(a) To qualify for admission to a fair all camels, deer, elephants, llamas, non-human primates, ruminants and swine must:

(1) be accompanied by an original intrastate or interstate certificate of veterinary inspection which shall be presented to the commissioner at any time upon request; and

(2) be permanently and uniquely identified by an official *approved means or device including an official eartag, [tattoo] registration tattoo*, electronic identification or a sketch or photograph signed *and dated* by the accredited veterinarian who has inspected the individual animal.

Section 351.7 is repealed and a new section 351.7 is added to read as follows:

Section 351.7 Deer

In addition to the requirements listed in sections 351.4 and 351.5 of this Part, all deer presented for admission to a fair must be accompanied by a permit as required by Part 60, Part 62 and Part 68 of the NYCRR. Permit information can be obtained by contacting the department at 10B Airline Drive, Albany, NY 12235, (518)457-3502, www.agmkt.state.ny.us

Section 351.9 is amended to read as follows:

In addition to the requirements listed in sections 351.3 and 351.4 of this Part, all horses *six months of age or older* presented for admission to a fair must be accompanied by an original certificate or statement showing that the horse has tested negative to a USDA approved test for equine infectious anemia (swamp fever) during the calendar year in which the fair is held or during the preceding calendar year.

[(a) Foals less than six months of age accompanied by a test negative dam do not have to be tested.]

[(b)] (a) The required certificate shall include a complete identification of the horse, the date of the test, and the name and address of the laboratory that conducted the test.

[(c)] (b) The certificate must be signed by an accredited veterinarian and the director of the laboratory where the test was conducted.

Section 351.10 is repealed and a new section 351.10 is added to read as follows:

Section 351.10 New World camelidae.

In addition to the requirements listed in sections 351.4 and 351.5 of this Part, all New World camelidae presented for admission to a fair must be accompanied by an original intrastate or interstate certificate of veterinary inspection that contains proof that the New World camelidae have tested negative for being persistently infected with bovine viral diarrhea.

Subdivision (a) of section 351.12 is amended to read as follows:

(a) shall not originate from any state where the commissioner has determined that highly pathogenic avian influenza is present. A list of such states is maintained at the offices of the department's Division of Animal Industry, [One Winners Circle,] 10B Airline Drive, Albany, NY 12235; and

Section 351.13 is amended by adding a new subdivision (c) to read as follows:

(c) *All sheep and goats must be individually identified by U.S.D.A. approved scrapie program identification as required under section 62.5 of this Title.*

Text of proposed rule and any required statements and analyses may be obtained from: John P. Huntley, DVM, Director, Division of Animal Industry, NYS Department of Agriculture and Markets, 10B Airline Drive, Albany, New York 12235, (518) 457-3502.

Data, views or arguments may be submitted to: Same as above.

Public comment will be received until: 45 days after publication of this notice.

This action was not under consideration at the time this agency's regulatory agenda was submitted.

Consensus Rule Making Determination

The Department has considered the proposed amendments to Part 351 and has determined that this rule making is a consensus rule making within the meaning of section 101(11) of the State Administrative Procedure Act (SAPA), in that no person is likely to object to its adoption because it

merely repeals regulatory provisions which are no longer applicable to any person (SAPA section 101(11)(a)) and/or makes technical changes or is otherwise non-controversial (SAPA section 101(11)(c)).

This proposal consists of seven amendments to Part 351.

1) Section 351.1(q).

Section 351.1(q) defines "llama" as "any member of the genus *Lama* including llamas, alpacas, vicunas, and guanacos." The proposed amendment would repeal section 351.1(q) and add a new section 351.1(q), which would define "New World camelidae" as "any member of the camelidae family native to South America, including alpacas (*Vicugna pacos*), llamas (*Lama glama*), guanacos (*Lama guanicoe*) and vicunas (*Vicugna vicugna*)."

This amendment is a consensus rule within the meaning of SAPA section 101(11)(c). The current definition of "llama" and the proposed definition of "New World camelidae" consists of the same animals. The change in nomenclature is designed to make the definition consistent with prevailing biological classification practices for animals. Since this is a technical change that is non-controversial, the Department has determined that no one is likely to object to its adoption.

2) Section 351.3(c).

The proposed amendment to section 351.3(c) would update the Department's street address and add the Department's e-mail address.

This amendment is a consensus rule within the meaning of SAPA section 101(11)(c), since it is merely a technical change. Accordingly, the Department has determined that no one is likely to object to its adoption.

3) Section 351.7.

Section 351.7 requires that all deer presented for admission to a fair be accompanied by an original intrastate or interstate certificate of veterinary inspection that contains proof that the deer to be admitted originated from either a herd classified as accredited, under 9 CFR section 77.35, or qualified, under 9 CFR section 77.36. The proposed amendment would repeal these references to the federal regulations and replace them with a requirement that deer presented for admission to a fair be accompanied by a permit as required by Parts 60, 62 and 68 of 1 NYCRR.

This amendment is a consensus rule within the meaning of SAPA section 101(11)(c). Department regulations governing health requirements for sheep, goats, llamas and deer (Part 62 of 1 NYCRR) have since been amended to incorporate by reference, Part 77 of 9 CFR which includes sections 77.35 and 77.36. In addition, Parts 60, 62 and 68 of 1 NYCRR require permits for the movement of deer in the State, including fairs within the State. Accordingly, since this amendment is a technical change that clarifies existing regulatory requirements and as such is non-controversial, the Department has determined that no one is likely to object to its adoption.

4) Section 351.9.

Section 351.9 requires that all horses presented for admission to a fair be accompanied by an original certificate or statement showing that the horse has tested negative to a United States Department of Agriculture (USDA) approved test for equine infectious anemia during the calendar year in which the fair is held or during the preceding calendar year. Section 351.9 also requires that the certificate include the identity of the horse, date of the test, name and address of the laboratory conducting the test and the signature of the laboratory director or accredited veterinarian. Finally, section 351.9 exempts from this requirement a foal less than six months of age accompanied by its mother which has tested negative. The proposed amendment would exempt from this test all horses under six months of age.

This amendment is a consensus rule within the meaning of SAPA section 101(11)(c). Department regulations governing the movement and transfer of horses and other equidae (Part 64 of 1 NYCRR) only require proof of testing for equine infectious anemia on horses six months or more of age. These regulations apply to the movement and transfer of horses in the State, including fairs within the State. Accordingly, since this amendment is a technical change that clarifies existing regulatory requirements and as such is non-controversial, the Department has determined that no one is likely to object to its adoption.

5) Section 351.10.

Section 351.10 requires that all llamas presented for admission to a fair be accompanied by an original intrastate or interstate certificate of veterinary inspection showing that llamas over one year of age tested negative on a thoracic tuberculosis skin test or that the llamas' herd of origin has tested negative for tuberculosis within the previous five years. The proposed amendment would repeal the tuberculosis testing requirement and replace it with a requirement that the llamas be accompanied with proof of having tested negative for being persistently infected with bovine viral diarrhea (BVD).

The amendment repealing the tuberculosis testing requirement for llamas is a consensus rule within the meaning of SAPA section 101(11)(a). Department regulations governing health requirements for sheep, goats, llamas and deer (Part 62 of 1 NYCRR) have since been amended to repeal

tuberculosis testing requirements for goats and llamas. Department regulations in Part 62 no longer require tuberculosis testing for llamas in the State, including llamas presented for admission at fairs. Accordingly, since this amendment merely repeals regulatory provisions which are no longer applicable to any person, the Department has determined that no one is likely to object to its adoption.

The amendment adding the requirement that llamas entering a fair be accompanied with proof that the animals have tested negative for being persistently infected with BVD is a consensus rule within the meaning of SAPA section 101(11)(c).

BVD is a disease which is caused by a pestivirus from the family Flaviviridae. The disease afflicts animals in one of two ways. Acutely infected animals are often unvaccinated against the disease and upon exposure, manifest symptoms, including mucosal erosions and diarrhea. BVD reduces productivity and increases mortality in these animals. Persistently infected animals are exposed to BVD during mid-gestation, which results in the fetus incorporating the virus into its biological chemistry. Consequently, the fetus never recognizes the BVD virus as a foreign invader and upon birth, becomes a carrier of the disease, shedding the virus in such great numbers that vaccinated as well as unvaccinated animals are often at risk for contracting BVD. Although occasionally exhibiting decreased weight gain, increased disease susceptibility and reduced fertility, persistently infected animals often exhibit no clinical signs of BVD. For this reason, a test is the only way to determine whether an animal is persistently infected with BVD and thus a threat to vaccinated as well as unvaccinated animals.

Section 351.6 currently requires that cattle entering a fair be accompanied with proof that the animals have tested negative for being persistently infected with BVD. This amendment would extend this protection to llamas, thereby helping to ensure the health of animals attending fairs. 406 llamas and alpacas were exhibited at fairs in 2008. Since the Alpaca Owners and Breeders Association (AOBA) now requires this BVD test for all sanctioned alpaca shows, it is anticipated that many alpacas have already been tested, thereby reducing the total number of animals which would need to be tested. The amendment would require untested animals to be tested only once at a cost of \$36.00 per animal. Since the testing can be done in pools of two animals (if under 61 days of age) or pools of five animals (if 61 days of age or older), the cost of the test, per animal, could be reduced to \$18.00 and \$7.20, respectively.

In light of the foregoing, the Department concludes that the proposed amendment is a necessary and beneficial animal disease control measure which would benefit all regulated parties at minimal cost. For this reason, the Department has determined that this rule making is a consensus rule making, in that no person is likely to object to the rule as written, since it is non-controversial.

6) Section 351.12.

The proposed amendment to section 351.12 would update the Department's street address.

This amendment is a consensus rule within the meaning of SAPA section 101(11)(c), since it is merely a technical change. Accordingly, the Department has determined that no one is likely to object to its adoption.

7) Section 351.13.

Section 351.13 requires that all sheep and goats presented for admission to a fair be accompanied by an original intrastate or interstate certificate of veterinary inspection showing that the herd of origin was inspected on or after May 1st of the current year and no evidence of contagious, infectious or communicable disease was found. The proposed amendment would add a requirement that all sheep and goats be individually identified by USDA-approved scrapie program identification as required under section 62.5 of 1 NYCRR.

This amendment is a consensus rule within the meaning of SAPA section 101(11)(c). Department regulations governing health requirements for sheep, goats, llamas and deer (Part 62 of 1 NYCRR) have since been amended to incorporate by reference, federal regulations at Part 79 of 9 CFR which set forth animal identification requirements under the USDA's scrapie program. These regulations apply to all sheep and goats in the State, including those presented for admission to a fair. Accordingly, since this amendment is a technical change that clarifies existing regulatory requirements and as such is non-controversial, the Department has determined that no one is likely to object to its adoption.

Job Impact Statement

The proposed amendments to Part 351 would clarify regulatory requirements, make technical changes to existing regulations and better protect the health of New World camelidae exhibited at fairs by requiring proof that all such animals have a negative test for being persistently infected with bovine viral diarrhea.

The proposed amendments would have no detrimental impact on jobs and employment opportunities in New York State but rather, could better ensure the retention of jobs in New York State. By clarifying regulatory requirements and making technical changes to existing regulations, the

proposal would better enable regulated parties to comply with those requirements. By requiring all New World camelidae entering fairs to have a negative test for being persistently infected with BVD, the proposal would help further protect these animals in the State against this disease, thereby helping protect regulated parties against potential financial losses. This would help protect jobs in New York State for farm workers engaged in such activities as trucking; building and maintaining fencing and shelter; brokering; locating sources and markets; and moving and watering as needed.

Office of Children and Family Services

EMERGENCY RULE MAKING

Educational Stability of Foster Children, Transition Planning and Relative Involvement in Foster Care Cases

I.D. No. CFS-02-09-00002-E

Filing No. 1334

Filing Date: 2008-12-26

Effective Date: 2008-12-31

PURSUANT TO THE PROVISIONS OF THE State Administrative Procedure Act, NOTICE is hereby given of the following action:

Action taken: Amendment of sections 421.24(c), 428.3(b), 428.5(c), 430.11(c) and 430.12(c); and addition of sections 428.3(b)(2)(v), 430.11(c)(2)(ix), (4), 430.12(c)(4) and (j) to Title 18 NYCRR.

Statutory authority: Social Services Law, sections 20(3)(d) and 34(3)(f)

Finding of necessity for emergency rule: Preservation of public health, public safety and general welfare.

Specific reasons underlying the finding of necessity: The regulations must be filed on an emergency basis to prevent the loss of federal funding that supports the health, safety and welfare of the children in foster care, children receiving adoption assistance and families receiving child welfare services.

Subject: Educational stability of foster children, transition planning and relative involvement in foster care cases.

Purpose: To implement the federal Fostering Connections to Success and Increasing Adoptions Act of 2008 (P.L. 110-351).

Text of emergency rule: Paragraph (19) of subdivision (c) of section 421.24 is amended to read as follows:

(19) The social services official on an *annual* [a biennial] basis in a *written notification* must remind the adoptive parents of their obligation to support the adopted child and to notify the social services official if the adoptive parents are no longer providing any support or are no longer legally responsible for the support of the child. *Where the adopted child is school age under the laws of the state in which the child resides, such notification must include a requirement that the adoptive parents must certify that the adopted child is a full-time elementary or secondary student or has completed secondary education. For the purposes of this paragraph, an elementary or secondary school student means an adopted child who is: (i) enrolled or in the process of enrolling in a school which provides elementary or secondary education, as determined under the laws where the school is located; (ii) instructed in elementary or secondary education at home in accordance with the laws in which the home is located; (iii) in an independent study elementary or secondary education program in accordance with the laws in which the adopted child's education program is located; or (iv) incapable of attending school on a full-time basis due to the medical condition of the adopted child, which incapacity is supported by annual information submitted by the adoptive parents as part of this certification.*

Subparagraphs (iii) and (iv) of paragraph (2) of subdivision (b) of section 428.3 are amended and a new subparagraph (v) is added to read as follows:

(iii) educational and/or vocational training reports or evaluations indicating the educational goals and needs of each foster child, including school reports and Committee on Special Education evaluations and/or recommendations; [and]

(iv) if the child has been placed in foster care outside of the state, a report prepared every six months by a caseworker employed by either the

authorized agency with case management and/or case planning responsibility for the child, the state in which the placement home or facility is located, or a private agency under contract with either the authorized agency or other state, documenting the caseworker's visit(s) with the child at his or her placement home or facility within the six-month period; and

(v) *the child's transition plan prepared in accordance with the standards set forth in section 430.12(j) of this Part.*

Paragraph (6) of subdivision (c) of section 428.5 is amended to read as follows:

(6) description of contacts with educational/vocational personnel on behalf of the child, *including, but not limited to, contacts made with school personnel in accordance with sections 430.11(c)(1)(i) and 430.12(c)(4) of this Part;*

Subparagraph (viii) of paragraph (10) of subdivision (c) of section 428.5 is amended to read as follows:

(iii) any information acquired about an absent or non-respondent parent that is in addition to information recorded pursuant to section 428.4(c)(1) of this Part, [and] the results of an investigation into the location of any relatives, including grandparents of a child subject to article 10 of the Family Court Act or section 384-a of the Social Services Law, *and the efforts to identify and provide notification to grandparents and other adult relatives in accordance with the requirements of section 430.11(c)(4) of this Part;*

Subparagraph (i) of paragraph (1) of subdivision (c) of section 430.11 is amended to read as follows:

(1)(i) Standard. Whenever possible, a child shall be placed in a foster care setting which permits the child to retain contact with the persons, groups and institutions with which the child was involved while living with his or her parents, or to which the child will be discharged. It shall be deemed inappropriate to place a child in a setting which conforms with this standard only if the child's service needs can only be met in another available setting at the same or lesser level of care. *The placement of the child into foster care must take into account the appropriateness of the child's existing educational setting and the proximity of such setting to the child's placement location. When is it in the best interests of the foster child to continue to be enrolled in the same school in which the child was enrolled when placed into foster care, the agency with case management responsibility for the foster child must coordinate with applicable local school authorities to ensure that the child remains in such school. When it is not in the best interests of the foster child to continue to be enrolled in the same school in which the child was enrolled when placed into foster care, the agency with case management responsibility must coordinate with applicable local school authorities where the foster child is placed in order that the foster child is provided with immediate and appropriate enrollment in a new school; and the agency with case management responsibility must coordinate with applicable local school authorities where the foster child previously attended in order that all of the applicable school records of the child are provided to the new school.*

Subparagraph (viii) of paragraph (2) of subdivision (c) of section 430.11 is amended, subparagraph (ix) is renumbered as subparagraph (x) and a new subparagraph (ix) is added to read as follows:

(viii) if the child has been placed in a foster care placement a substantial distance from the home of the parents of the child or in a state different from the state in which the parent's home is located, the uniform case record must contain documentation why such placement is in the best interests of the child; [and]

(ix) *show in the uniform case record that efforts were made to keep the child in his or her current school, or where distance was a factor or the educational setting was inappropriate, that efforts were made to seek immediate enrollment in a new school and to arrange for timely transfer of school records; and*

(x) if the child has been placed in foster care outside of the state in which the home of the parents of the child is located, the uniform case record must contain a report prepared every six months by a caseworker employed by the authorized agency with case management and/or case planning responsibility over the child, the state in which the home is or facility is located, or a private agency under contract with either the authorized agency or other state documenting the caseworker's visit to the child's placement within the six-month period.

Paragraph (4) of subdivision (c) of section 430.11 is added to read as follows:

(4) *Within 30 days after the removal of a child from the custody of the child's parent or parents, or earlier where directed by the court, the social services district must exercise due diligence in identifying all of the child's grandparents and other adult relatives, including adult relatives suggested by the child's parent or parents and, with the exception of grandparents and/or other identified relatives with a history of family or domestic violence. The social services district must provide the child's grandparents and other identified relatives with notification that the child has been or is being removed from the child's parents and which explains*

the options under which the grandparents or other relatives may provide care of the child, either through foster care or direct legal custody or guardianship, and any options that may be lost by the failure to respond to such notification in a timely manner. The identification and notification efforts made in accordance with the paragraph must be recorded in the child's uniform case record as required by section 428.5(c)(10)(viii) of this Part.

Paragraph (4) of subdivision (c) of section 430.12 is amended and re-numbered paragraph (5) and a new paragraph (4) is added to read as follows:

(4) Education. (i) Standard. The social services district with care and custody or guardianship and custody of a foster child who has attained the minimum age for compulsory education under the Education Law is responsible for assuring that the foster child is a full-time elementary or secondary school student or has completed secondary education. For the purpose of this paragraph, an elementary or secondary school student means a child who is: (i) enrolled or in the process of enrolling in a school which provides elementary or secondary education, as determined under the laws where the school is located; (ii) instructed in elementary or secondary education at home in accordance with the laws in which the home is located; (iii) in an independent study elementary or secondary education program in accordance with the laws in child's education program is located, which is administered by the local school or school district; or (iv) incapable of attending school on a full-time basis due to the medical condition of the child, which incapability is supported by regularly updated information in the child's uniform case record.

(ii) Documentation. The progress notes for each school age child in foster care must reflect either the education program in which the foster child is presently enrolled; or the date the foster child completed his or her compulsory education; or where the child is not capable of attending school on a full-time basis, what the medical condition is and why such condition prevents full-time attendance. The social services district must update the progress notes on an annual basis to reflect why such medical condition continues to prevent the foster child's full-time attendance in an education program.

(5) [(4)] Discharge planning. (i) Standard. For any child age 18 or under who is discharged from foster care, the district [shall] must consider the need to provide preventive services to the child and his or her family subsequent to [his] the child's discharge.

(ii) Documentation. The uniform case record form to be completed upon discharge of the child [shall] must show either the recommended type of preventive services and the district's attempts to provide or arrange for these services, or the reasons why these services are deemed unnecessary.

Subdivision (j) of section 430.12 is added to read as follows:

(j) Transition plan. Whenever a child will remain in foster care on or after the child's eighteenth birthday, the agency with case management responsibility must develop with such child during the 90 day period preceding the child's eighteenth birthday or during the 90 days preceding the child's scheduled discharge date where the child is consenting to remain in foster care after the child's eighteenth birthday, a transition plan that is personalized at the direction of the child. Such plan must include specific options on housing, health insurance, education, local opportunities for mentors and continuing support services, and work force supports and employment services. The transition plan must be as detailed as the foster child may elect.

This notice is intended to serve only as a notice of emergency adoption. This agency intends to adopt this emergency rule as a permanent rule and will publish a notice of proposed rule making in the *State Register* at some future date. The emergency rule will expire March 25, 2009.

Text of rule and any required statements and analyses may be obtained from: Public Information Office, Office of Children and Family Services, 52 Washington St., Rensselaer, NY 12144, (518) 473-7793

Regulatory Impact Statement

1. Statutory Authority

Section 20(3)(d) of the Social Services Law (SSL) authorizes the Office of Children and Family Services (OCFS) to establish rules and regulations to carry out its duties pursuant to the provisions of the SSL.

Section 34(3) (f) of the SSL requires the Commissioner of OCFS to promulgate regulations for the administration of public assistance and care within the state.

2. Legislative Objectives

The regulations implement standards required by the federal Fostering Connections to Success and Increasing Adoptions Act of 2008 (P.L. 110-351) that went into effect on October 7, 2008.

3. Needs and Benefits

The regulations will reduce disruption experienced by a child when

removed from the child's home and placed into foster care and will enhance continuity in the child's environment.

Regarding the relationship of the child with his or her relatives, the regulations require that within 30 days of the removal of a foster child from his or her home, the social services district must exercise due diligence in identifying and notifying relatives of the child, including all grandparents and other relatives identified by the child's parents, that the child was removed, the options available to relatives to become the child's foster parent or to otherwise care for the child and any options that may be lost by the failure of the relative to respond to such notification in a timely manner. The regulations take into consideration the safety of the child by excluding the need to notify any relative who has a history of family or domestic violence.

The regulations address the need to minimize disruption by requiring the social services district to assess the proximity of the foster care placement to the school the child attended before placement into foster care and the appropriateness of the child remaining in that school upon entry into foster care. Where it is not in the best interests of the child to attend such school, the regulations require the social services district to work with the appropriate local school officials to see that the child is immediately enrolled in a new school.

The regulations also support the preparation of the foster child to transition out of foster care. One of the fundamental needs of any child is his or her education. The regulations clarify that each foster child of school age must either be enrolled in an appropriate educational setting, unless the child is incapable of attending school, or has completed his or her secondary education. The regulations impose a similar requirement in regard to a child who is in receipt of an adoption subsidy and is of school age.

The regulations support the transition of older foster children out of foster care by requiring the authorized agency with case management responsibility to develop a transition plan for a foster child who is aging out of foster care. This plan must be developed to meet the needs of the particular foster child, with such child's input. The transition plan must be developed within 90 days preceding discharge of the child from foster care. Such plan must address such basic post discharge issues as housing, health insurance, education, supports services and employment.

4. Costs

The regulatory amendments are required by the federal Fostering Connections to Success and Increasing Adoption Act of 2008. There is no fiscal impact associated with implementing the regulations because current OCFS regulations require social services districts to carry out similar functions as those prescribed in these regulations. With the exception of the regulatory amendment associated with the transition plan, the regulatory changes are federally mandated under Title IV-E of the Social Security Act. Currently, New York must demonstrate that it has implemented these requirements in order to have a compliant Title IV-E State Plan. This is a condition for continuing to receive federal funds for foster care, adoption assistance and the administration of these programs.

The regulatory change regarding the transition plan for children who are aging out of foster care is a federal mandate under Title IV-B, Subpart 1 of the Social Security Act. In order to have a compliant Title IV-B State Plan and to continue to receive federal Child Welfare Services funding, New York State must demonstrate that it has implemented such standard.

There is no fiscal impact associated with the regulatory amendment to 18 NYCRR 421.19(c)(19). Currently, the New York City Administration for Children's Services notifies adoptive parents to verify that they are continuing to support their adoptive children and continue to be legally responsible for the support of their adoptive children. Acceptable documentation includes proof of school attendance. Documentation provided by the adoptive parent can be maintained in the social services district in the adoption subsidy case file. The regulatory amendments do not require any modification to CONNECTIONS. The requirements associated with documenting information in the child's uniform case record progress notes can be supported by CONNECTIONS.

5. Local Government Mandates

The regulations require social services districts to carry out functions similar to those they already have been obligated by State statute and OCFS regulations to perform. Current OCFS regulation 18 NYCRR 430.11(c) requires the social services district placing a child into foster care, whenever possible, to place the child in a foster care setting that permits the child to retain contact with the persons, groups and institutions with which the child was involved while living with his or her parents. OCFS regulation 18 NYCRR 430.10(b) currently requires the social services district that is contemplating the placement of a child into foster care to attempt, prior to placement, to locate adequate alternative living ar-

rangements with a relative or family friend which would enable the child to avoid placement into foster care. Section 1017 of the Family Court Act and section 384-a of the SSL currently provide that when a child is to be removed from his or her home, the social services district must identify and discuss with such relative, including grandparents, available options to function as the child's foster parent or to assume direct legal custody of the child. The social services district must also notify the relative that the child may be adopted by foster parents if attempts at reunification with the birth parent are not required or are unsuccessful.

Social services districts are obligated pursuant to section 409-e of the SSL and OCFS regulations 18 NYCRR Part 428 and 430.12 to develop for each foster child a family assessment and service plan that addresses the needs of the child, including those related to education and the preparation of the child for discharge from foster care. These standards also presently require that foster children over the age of 10 be invited to participate in such planning.

6. Paperwork

The regulations require the recording of the actions taken by the social services district or voluntary authorized agency with case management responsibility in meeting the standards referenced above. Such documentation will be recorded in New York State's statewide automated child welfare information system, CONNECTIONS.

7. Duplication

The regulations do not duplicate other state or federal requirements. The regulations build on related existing requirements.

8. Alternative Approaches

Given the mandates imposed by the federal Foster Connections to Success and Increasing Adoptions Act of 2008 (P.L. 110-351) and the adverse financial consequences for non-compliance, there is no viable alternative to implementing the regulations.

9. Federal Standards

Each of the regulatory amendments reflects requirements imposed by the federal Foster Connections to Success and Increasing Adoptions Act of 2008. The regulatory changes relating to relatives and education are federally mandated under Title IV-E of the Social Security Act. New York State must demonstrate that it has implemented such standards in order to have a compliant Title IV-E State Plan which is a condition for New York to continue to receive federal funding for foster care and adoption assistance. The regulatory change relating to the transition plan for aging out foster children is federally mandated under Title IV-B, Subpart 1 of the Social Security Act. New York must demonstrate that it has implemented such standard in order to have a compliant Title IV-B State Plan which is a condition for New York to continue to receive federal child welfare services funding.

10. Compliance Schedule

Compliance with the regulations would take effect upon adoption.

Regulatory Flexibility Analysis

1. Effect on Small Businesses and Local Governments

Social service districts, the St. Regis Mohawk Tribe and voluntary authorized agencies that have contracts with social service districts to provide foster care, will be affected by the regulations. There are 58 social service districts and approximately 160 voluntary authorized agencies.

2. Compliance Requirements

The regulations implement standards required by the federal Fostering Connections to Success and Increasing Adoptions Act of 2008 (P.L. 110-351) that went into effect on October 7, 2008. Implementation of the regulations is necessary for the State of New York to maintain compliant Title IV-B and Title IV-E State Plans which are required for New York to continue to receive federal funding under Title IV-B and Title IV-E of the Social Security Act for foster care, adoption assistance, child welfare services and the administration of those programs.

The regulations require that within 30 days of the removal of a foster child from his or her home, the social services district must exercise due diligence in identifying and notifying relatives of the child, including all grandparents and other relatives identified by the child's parents, that the child was removed, the options available to the relatives to become the child's foster parent or to otherwise care for the child and any option that may be lost by the failure of the relatives to respond to such notification in a timely manner. Notification must be made earlier than 30 days of removal if directed by the court. Notification is not required in regard to relatives who have a history of family or domestic violence.

The regulations require the authorized agency with case management responsibility to develop a transition plan for a foster child who is aging out of foster care. Such plan must be personalized to the particular foster child and developed with the involvement of such child. The plan must be

developed during the 90 day period preceding the child from foster care. The transition plan must address housing, health insurance, education, local opportunities or mentors and continuing support services, and work force supports and employment services.

The regulations set forth standards social services districts must satisfy in relation to the educational stability of children when they are removed from their homes and placed into foster care. The regulations address the need to assess the proximity of foster care placements to the school the child attended at the time of removal and the appropriateness of the child remaining in that same school after entering foster care. Where the foster child can not remain in the same school, the agency with case management responsibility must coordinate with local school officials in order that the foster child will be provided with immediate and appropriate enrollment in a new school.

The regulations require that foster children of school age must either be enrolled in an appropriate educational setting, unless incapable of attending school or have completed secondary education. The regulations impose a similar requirement post discharge from foster care for a child who is school age and is in receipt of an adoption subsidy.

3. Professional Services

It is anticipated that the requirements imposed by the regulations will be implemented by existing case work staff.

4. Compliance Costs

The regulatory amendments are required by the federal Fostering Connections to Success and Increasing Adoptions Act of 2008. There is no fiscal impact associated with implementing the regulations because current OCFS regulations require social services districts to carry out similar functions as those prescribed in these regulations. With the exception of the regulatory amendment associated with the transition plan, the regulatory changes are federally mandated under Title IV-E of the Social Security Act. Currently, New York must demonstrate that it has implemented these requirements in order to have a compliant Title IV-E State Plan. This is a condition for continuing to receive federal funds for foster care, adoption assistance and the administration of these programs.

The regulatory change regarding the transition plan for children who are aging out of foster care is a federal mandate under Title IV-B, Subpart 1 of the Social Security Act. In order to have a compliant Title IV-B State Plan and to continue to receive federal Child Welfare Services funding, New York State must demonstrate that it has implemented such standard.

There is no fiscal impact with the regulatory amendment to 18 NYCRR 421.24(c)(19). Currently, the New York City Administration for Children's Services notifies adoptive parents to verify that they are continuing to support their adopted children and continue to be legally responsible for the support of their adoptive children. Acceptable documentation includes proof of school attendance. Documentation provided by the adoptive parent can be maintained by the social services district in the adoption subsidy case file. The regulatory amendments do not require any modification to CONNECTIONS. The requirements associated with documenting information in the child's uniform case record progress notes can be supported by CONNECTIONS.

5. Economic and Technological Feasibility

The regulations require the recording of the actions taken to comply with the regulatory standards noted above. Such information will be recorded in New York State's statewide automated child welfare information system, CONNECTIONS.

6. Minimizing Adverse Impact

The standards set forth in the regulations reflect mandates imposed on the states by the federal Fostering Connections to Success and Increasing Adoptions Act of 2008. Implementation is necessary for New York to continue to be eligible to receive federal funding for foster care, adoption assistance child welfare services and the administration thereof, as required by Title IV-B and title IV-E of the Social Security Act. The regulations do not go beyond the scope of the federal mandates.

7. Small Business and Local Government Participation

By letter dated, December 5, 2008, OCFS informed the commissioner of each of the local department of social services in the State of New York of the amendments to OCFS regulations that are necessitated by the federal Fostering Connections to Success and Increasing Adoptions Act of 2008. The letter included a brief summary of the new regulatory requirements. In addition, it informed local commissioners of the requirements enacted by the federal legislation that are already in effect in New York and that will not require any further regulatory amendments. OCFS advised the local commissioners that OCFS will provide any clarification received from the federal Department of Health and Human Services on these requirements. A copy of the OCFS regulations was provided along with a contact person if the local commissioners or their staff had any questions.

Rural Area Flexibility Analysis

1. Types and estimated number of rural areas

Social services districts, the St. Regis Mohawk Tribe and voluntary authorized agencies that have contracts with social services districts to provide foster care will be affected by the regulations. There are 44 social services districts and the St. Regis Mohawk Tribe that are in rural areas. Currently, there are also approximately 100 voluntary authorized agencies in rural areas of New York State.

2. Reporting, recordkeeping and other compliance requirements; and professional services

The regulations implement standards required by the federal Fostering Connections to Success and Increasing Adoptions Act of 2008 (P.L. 110-351) that went into effect on October 7, 2008. Implementation of the regulations is necessary for the State of New York to maintain compliant Title IV-B and Title IV-E State Plans which are required for New York to continue to receive federal funding under Title IV-B and Title IV-E of the Social Security Act for foster care, adoption assistance, child welfare services and the administration of those programs.

The regulations require that within 30 days of the removal of a foster child from his or her home, the social services district must exercise due diligence in identifying and notifying relatives of the child, including all grandparents and other relatives identified by the child's parents, that the child was removed, the option available to the relative to become the child's foster parent or to otherwise care for the child and any options that may be lost by the failure of the relative to respond to such notification in a timely manner. Notification must be made earlier than 30 days of removal if directed by the court. Notification is not required in regard to relatives with a history of family or domestic violence.

The regulations require the authorized agency with case management responsibility to develop a transition plan for a foster child who is aging out of foster care. Such plan must be personalized to the particular foster child and developed with the involvement of such child. The plan must be developed during the 90 day period preceding discharge of the child from foster care. The transition plan must address housing, health insurance, education, local opportunities for mentors and continuing support services and work force supports and employment services.

The regulations set forth standards social services districts must satisfy in relation to the educational stability of children when they are removed from their homes and placed into foster care. The regulations address the need to assess the proximity of foster care placements to the school the child attended at the time of removal and the appropriateness of the child remaining in that school after entering foster care. Where the foster child can not remain in the same school, the agency with case management responsibility must coordinate with local school officials in order that the foster child be provided with immediate and appropriate enrollment in a new school.

The regulations require that foster children of school age must either be enrolled in an appropriate educational setting, unless incapable of attending school, or have completed secondary education. The proposed regulations would impose a similar requirement post discharge from foster care in regard to a school age child who is in receipt of an adoption subsidy.

3. Costs

Each of the regulatory amendments is required by the federal Fostering Connections to Success and Increasing Adoptions Act of 2008. There is no fiscal impact associated with implementing the regulations because current OCFS regulations require social services districts to carry out similar functions as those prescribed in these amendments. With the exception of the regulatory amendment associated with the transition plan, the regulatory changes are federally mandated under Title IV-E of the Social Security Act. Currently, New York must demonstrate that it has implemented these requirements in order to have a compliant Title IV-E State Plan. This is a condition for continuing to receive federal funds for foster care, adoption assistance and the administration of these programs.

The regulatory change regarding the transition plan for children who are aging out of foster care is a federal mandate under Title IV-B, Subpart 1 of the Social Security Act. In order to have a compliant Title IV-B State Plan, and to continue to receive federal Child Welfare Services funding, New York State must demonstrate that it has implemented such standard.

There is no fiscal impact associated with the regulatory amendment to 18 NYCRR 421.24(c)(19). Currently, the New York City Administration for Children's Services notifies adoptive parents to verify that they are continuing to support their adoptive children and continue to be legally responsible for the support of their adoptive children. Acceptable documentation includes proof of school attendance. Documentation provided by the adoptive parent can be maintained by the social services

district in the adoption subsidy case file. The regulatory amendments do not require any modification to CONNECTIONS. The requirements associated with documenting information in the child's uniform case record progress notes can be supported in CONNECTIONS.

4. Minimizing adverse impact

The regulations require the recording of the actions taken to comply with the regulatory standards noted above. Such information will be recorded in New York State's statewide automated child welfare information system, CONNECTIONS.

5. Rural area participation

By letter dated, December 5, 2008, OCFS informed the commissioner of each local department of social services in the State of New York of the amendments to OCFS regulations necessitated by the federal Fostering Connections to Success and Increasing Adoptions Act of 2008. The letter included a brief summary of the new regulatory requirements. In addition, it informed local commissioners of the requirements enacted by the federal legislation that are already in effect in New York and that will not require any further regulatory amendments. OCFS advised the local commissioners that OCFS will provide any clarification received from the federal Department of Health and Human Services on these requirements. A copy of the regulations was provided along with a contact person if the local commissioners or their staff had any questions.

Job Impact Statement

A full job impact statement has not been prepared for the regulations. The amendments will not result in the loss or creation of any jobs.

Education Department

NOTICE OF EXPIRATION

The following notice has expired and cannot be reconsidered unless the Education Department publishes a new notice of proposed rule making in the *NYS Register*.

Identifying Badges for Health Care Professionals

I.D. No.	Proposed	Expiration Date
EDU-52-07-00008-P	December 26, 2007	December 25, 2008

Department of Health

**EMERGENCY
RULE MAKING****DRGs, SIWs, Trimpoints and the Mean LOS**

I.D. No. HLT-42-08-00011-E

Filing No. 1357

Filing Date: 2008-12-29

Effective Date: 2008-12-29

PURSUANT TO THE PROVISIONS OF THE State Administrative Procedure Act, NOTICE is hereby given of the following action:

Action taken: Amendment of sections 86-1.55, 86-1.62 and 86-1.63 of Title 10 NYCRR.

Statutory authority: Public Health Law, sections 2803(2), 2807(3), 2807-c(3) and (4)

Finding of necessity for emergency rule: Preservation of public health.

Specific reasons underlying the finding of necessity: 86-1.55 Development of Outlier Rates of Payment

The Department of Health and Human Services (HHS), Office of Inspector General, has issued to the New York State Department of Health a final audit report (A-02-04-01022, June 2006) on the State's hospital outlier payment methodology. This report addressed vulnerabilities in the methodology that may result in excessive payments to certain hospitals. HHS noted that NYS does not use the most accurate cost-to-charge data in determining the outlier payments, and that if it had done so there could be savings for the Medicaid program. After reviewing the report and HHS's recommendations, the Department of Health concurs with the findings

and has agreed to update the outlier payment methodology to reflect a calculation based on cost-to-charge data from the year of the patient discharge. However, revised regulations need to be adopted in order to implement the HHS recommendations because current regulation does not provide for the use of updated data.

86-1.62 Service Intensity Weights and Group Average Arithmetic Lengths of Stay

86-1.63 Non-Medicare Trim Points

The Department finds that the immediate adoption of this amendment is necessary to make current regulations consistent with changes made to the diagnosis related group (DRG) classification system used by the Medicare prospective payment system (PPS). This is required by Section 2807-c(3) of the Public Health Law, which states, "The Commissioner shall establish as a basis for case classification for case based rates of payment the same system of diagnosis-related groups for classification of hospital discharges as established for purposes of reimbursement of inpatient hospital service pursuant to Title XVIII of the Federal Social Security Act (Medicare) in effect on the first day of July in the year preceding the rate period." Additionally, such amendments modify existing DRGs and add new DRGs to reflect medically appropriate patterns of health resource use. The current service intensity weights (SIWs) and trimpoints are also updated to be consistent with the proposed DRG modifications.

In addition, the SIWs and group average inlier length of stays (LOS) were updated to reflect 2004 costs and statistics reported to the Department for a representative sample of hospitals. The current SIWs and LOS are based on twelve year old data and need to be updated for hospital payment to reflect prevailing patterns of health use and services. This update ensures a reflection of more current clinical practices, advances in technology, changes in patient resource consumption, and changes in hospital length of stay patterns.

The SIWs and non-Medicare trimpoints are an integral part of the hospital Medicaid and like payor inpatient rates. The amendments provide payors of inpatient hospital services with the new values used to determine the correct case based payment for each DRG for each hospital so hospital claims can be submitted and paid in a timely manner. Additionally, the Legislature sought to have the DRGs used in the hospital reimbursement methodology be consistent with those used in Medicare reimbursement and reflect medically appropriate, efficient and economic patterns of health use and services. Such requirements warrant adoption of these amendments as soon as practicable.

Subject: DRGs, SIWs, Trimpoints and the Mean LOS.

Purpose: Updates the calculation of outlier payments based on HHS audit findings and recommendations.

Substance of emergency rule: 86-1.55 - Development of Outlier Rates of Payment

The proposed amendment of section 86-1.55 of Title 10 (Health) NYCRR is intended to update the calculation of cost outlier payments to reflect a cost to charge ratio which is based on data for the year in which the discharge occurred. Currently the payments are calculated based on the most recent information available, generally two year old cost to charge data.

This amendment is the result of a final audit report by the Department of Health and Human Services on Medicaid hospital outlier payments.

86-1.62 - Service Intensity Weights and Group Average Arithmetic Inlier Lengths of Stay

The proposed amendments of section 86-1.62 of Title 10 (Health) NYCRR are intended to change the diagnosis related group (DRG) classification system for inpatient hospital services and the corresponding service intensity weight (SIWs) and group average arithmetic inlier length of stay (LOS) for each DRG.

The DRG classification system used in the hospital case payment system is updated to incorporate those changes made by Medicare for use in the prospective payment system, and additional changes to identify medically appropriate patterns of health resource use for services that are efficiently and economically provided. The SIWs were revised accordingly to reflect the costs of the redistributed cases.

In addition, the SIWs and group average inlier length of stays were updated to reflect 2004 costs and statistics reported to the Department for a representative sample of hospitals. This update ensures a reflection of more current clinical practices, advances in technology, changes in patient resource consumption, and changes in hospital length of stay patterns. The revised service intensity weights based on 2004 data are being phased-in over a three year period. The weights effective for the period January 1, 2008 through December 31, 2008 will be based on 75% of the service intensity weights in effect as of December 31, 2007 that are based on 1992 data, and 25% of the service intensity weights based on 2004 data. The

service intensity weights effective for the period January 1, 2009 through December 31, 2009, will be based on 33% of the service intensity weights in effect as of December 31, 2007 that are based on 1992 data, and 67% of the service intensity weights based on 2004 data. Effective January 1, 2010 and thereafter, the service intensity weights will be based on 2004 data. Effective July 1, 2008, the service intensity weights and group average arithmetic lengths of stay are being revised to incorporate several methodological changes.

86-1.63 - Non-Medicare Trimpoints

The proposed amendments of section 86-1.63 of Title 10 (Health) NYCRR are intended to change the non-Medicare trimpoints used to determine the outlier days in the hospital case based payment system to be based on 2004 data. In addition, the trimpoints are being revised effective July 1, 2008 to reflect the methodological changes referenced above.

General Summary for 86-1.62 and 1.63

The changes in the DRG classification system and service intensity weights described above (Section 86-1.62 of Title 10 (Health) NYCRR) cause a modification of the non-Medicare trimpoints to reflect the redistribution of cases from the existing DRGs to the new DRGs. These new trimpoint values are provided in Section 86-1.63.

The changes to the DRG classification system will enable providers to place patients in the most appropriate DRG and, therefore, they will receive adequate reimbursement for services provided. In the aggregate, these changes will have a budget-neutral impact on the reimbursement system.

The Department is statutorily required to update the grouper to be consistent with changes made to the DRG classification system used by the Medicare prospective payment system (PPS) and to modify existing and add new DRGs to more accurately reflect patterns of health resource use.

This notice is intended to serve only as a notice of emergency adoption. This agency intends to adopt the provisions of this emergency rule as a permanent rule, having previously submitted to the Department of State a notice of proposed rule making, I.D. No. HLT-42-08-00011-P, Issue of October 15, 2008. The emergency rule will expire February 26, 2009.

Text of rule and any required statements and analyses may be obtained from: Katherine Ceroalo, DOH, Bureau of House Counsel, Regulatory Affairs Unit, Room 2438, ESP, Tower Building, Albany, NY 12237, (518) 473-7488, email: regsqna@health.state.ny.us

Regulatory Impact Statement

Statutory Authority:

The authority for the subject regulations is contained in sections 2803(2), and 2807(3) and 2807(4) of the Public Health Law (PHL), which require the State Hospital Review and Planning Council (SHRPC), subject to the approval of the Commissioner, to adopt and amend rules and regulations for hospital reimbursement rates that are reasonable and adequate to meet the costs that must be incurred by efficiently and economically operated facilities. PHL section 2807-c (3) authorizes the SHRPC to adopt rules subject to the Commissioner's approval, to adjust the diagnosis related groups (DRGs) or establish additional DRGs to reflect subsequent revisions applicable to reimbursement for discharges of Medicare beneficiaries or to identify medically appropriate patterns of health resource use efficiently and economically provided and to subsequently amend the service intensity weights (SIWs) and trimpoints for each DRG. Sections 34, 34-a and 34-b, of Part C of Chapter 58 of the Laws of 2007 authorizes the SHRPC and the Commissioner to update the cost and statistical base used to determine the SIWs and trimpoints to calendar year 2004 data and to provide for a phase-in of the new weights. PHL section 2807-c (4) authorizes the SHRPC to adopt rules, subject to the Commissioner's approval, for exceptions to case based payments for cost outliers.

Legislative Objectives:

The Legislature sought to have the DRGs used in the hospital reimbursement methodology be consistent with those used in Medicare reimbursement and reflect medically appropriate, efficient and economic patterns of health resource use and services.

Needs and Benefits:

The proposed amendment to section 86-1.55 of Title 10 (Health) NYCRR is intended to revise the methodology for calculating hospital cost outlier payments. The proposed methodology is based on more current and appropriate cost to charge ratios for determining the outlier expense, which is consistent with the method used in Medicare reimbursement. The proposal will provide for an update to the ratio from the initial payments based on two year old data, to data from the year in which the discharge occurred. This will cause the outlier payments to more accurately reflect reasonable costs incurred by each hospital, and address the problem of excessive over payments.

The proposed amendments to sections 86-1.62 and 86-1.63 of Title 10 (Health) NYCRR are intended to make current regulations consistent with changes made to the diagnosis related group (DRG) classification system used by the Medicare prospective payment system (PPS) and to modify existing and add new DRGs to reflect medically appropriate patterns of health resource use. The current service intensity weights (SIWs) and trimpoints are also updated to be consistent with the proposed DRG modifications. Additionally, the SIWs and trimpoints are updated from the current 1992 cost and statistic base to 2004 data reported to the Department and being phased-in over a three year period.

The SIWs and non-Medicare trimpoints are an integral part of the hospital Medicaid and like payor inpatient rates. The Department makes changes to the grouper used to assign inpatient cases to the appropriate DRG. As part of this process, the Department may make modifications, revisions and create new DRGs that reflect the current resources consumed by inpatients. After the grouper is modified, the SIWs and trimpoints must be recalculated consistent with the newly created and updated list of DRGs, and to incorporate the 2004 cost and statistical basis, thus creating new values for the SIWs and trimpoints in sections 86-1.62 and 86-1.63. Lastly, the amendments provide payors of inpatient hospital services with the new values used to determine the correct case base payment for each DRG so hospital claims can be submitted and paid in a timely manner.

COSTS:

Costs to State Government:

The proposed amendment to 86-1.55, development of outlier payments, is estimated to produce savings to the State.

The amendments to 86-1.62 and 86-1.63 revising the DRGs, SIWs and trimpoints has been legislated as budget neutral; therefore there is no additional costs to the State as a result of these regulation changes.

Costs of Local Government:

No increase or decrease in costs to local governments is anticipated as a result of these amendments.

Costs to Private Regulated Parties:

In the aggregate, there will be no increases or decreases in hospital revenues as a result of these amendments. Changes to the DRG classification system will cause a realignment of cases among the DRGs. Those cases that require more intensive provision of care will realize an increase in the SIW (and reimbursement) for that DRG. The removal of such cases from the DRG to which they were previously assigned will decrease the SIW (and reimbursement) for that DRG. Therefore, revenues will shift among individual hospitals depending upon the diagnosis of and procedures performed on the patients they treat. The extent of the shift in revenues cannot be determined because it will depend upon future patient services.

Costs to the Department of Health:

There will be no additional costs to the Department of Health as a result of these amendments.

Local Government Mandates:

This regulation affects the costs to counties and New York City for services provided to Medicaid beneficiaries as described above. It imposes no program, service, duty or other responsibility upon any county, city, town, village, school district, fire district or other special district.

Paperwork:

There is no additional paperwork required of providers as a result of these amendments.

Duplication:

These regulations do not duplicate existing State and Federal regulations.

Alternatives:

The change to the outlier payment methodology is based on an audit by the Department of Health and Human Services. The Department concurs with the findings of the audit and HHS's recommended methodology change.

Based upon suggestions/recommendations received from hospital industry representatives, the Department has included adjustments that provide more appropriate recognition of the costs related to current clinical practices, new medical technologies, changes in patient resource consumption, and changes in hospital length of stay patterns. Two alternatives were considered for the means of adjusting the revised SIWs to ensure budget neutrality. The first alternative was to apply a neutrality adjustment in the calculation of the SIWs. However, since the SIWs are formulated on non-medicare costs and the budget neutrality provision in statute applies to Medicaid expenditures, this approach was rejected. Instead, budget neutrality for Medicaid expenditures will be achieved by applying an adjustment to the Medicaid hospital inpatient rates.

Federal Standards:

The proposed rule does not exceed any minimum standards of the federal government for the same or similar subject areas.

Compliance Schedule:

The proposed rule establishes rates of payment as of July 1, 2008; there is no period of time necessary for regulated parties to achieve compliance.

Contact Person: Ms. Katherine Ceroalo
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Bureau of House Counsel, Regulatory Affairs Unit
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Empire State Plaza
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(518) 473-7488
(518) 473-2019 (FAX)
REGSQNA@health.state.ny.us

Comments submitted to Department personnel other than this contact person may not be included in any assessment of public comment issued for this regulation.

Regulatory Flexibility Analysis

Effect on Small Business and Local Governments:

For the purpose of this regulatory flexibility analysis, small businesses were considered to be general hospitals with 100 or fewer full time equivalents. Based on recent financial and statistical data extracted from the Institutional Cost Report, seven hospitals were identified as employing fewer than 100 employees.

Compliance Requirements:

No new reporting, recordkeeping or other compliance requirements are being imposed as a result of these rules.

Professional Services:

No new or additional professional services are required in order to comply with the proposed amendments.

Economic and Technological Feasibility:

Small businesses will be able to comply with the economic and technological aspects of this rule. The proposed amendments are intended to make current regulations consistent with changes made to the outlier payments; the DRG classification system used by the Medicare prospective payment system (PPS), and add new DRGs to reflect medically appropriate patterns of health resource use. The current SIWs and trimpoints are also updated to be consistent with the proposed DRG modifications, and the new cost and statistical base.

Compliance Costs:

No initial capital costs will be imposed as a result of this rule, nor will there be an annual cost of compliance. As a result of the amendment to 86-1.55, there maybe a decrease to specific hospitals' revenues. In the aggregate, as a result of the amendments to 86-1.62 and 86-1.63 there will be no anticipated increases or decreases in hospitals' Medicaid revenues. However, revenues will shift among individual hospitals depending upon the diagnoses of and procedures performed on the patients they treat and the extent to which they would be classified into the modified diagnosis related groups.

Minimizing Adverse Impact:

The proposed amendments will be applied to all general hospitals. The Department of Health considered approaches specified in section 202-b (1) of the State Administrative Procedure Act in drafting the proposed amendments and rejected them as inappropriate given the reimbursement system mandated in statute.

Small Business and Local Government Participation:

Local governments and small businesses were given notice of these proposals by its inclusion in the agenda of the Fiscal Policy Committee of the State Hospital Review and Planning Council for its May 22, 2008 meeting. That agenda is mailed to general hospitals qualifying as small businesses, providers, members of the Fiscal Policy Committee, the New York State Legislature and representatives of the hospital associations, among others. The associations are member organizations that represent the interests and concerns of hospitals across New York State, including small businesses and local governments. This outreach resulted in the Department of Health receiving comments and suggestions related to additional changes that industry representatives recommended be implemented. Based on this feedback, the Department did make additional changes to the service intensity weights to incorporate several of these comments and suggestions.

Rural Area Flexibility Analysis

Effect on Rural Areas:

Rural areas are defined as counties with a population less than 200,000

and, for counties with a population greater than 200,000, includes towns with population densities of 150 persons or less per square mile. The following 44 counties have a population less than 200,000:

Allegany	Hamilton	Schenectady
Cattaraugus	Herkimer	Schoharie
Cayuga	Jefferson	Schuyler
Chautauqua	Lewis	Seneca
Chemung	Livingston	Steuben
Chenango	Madison	Sullivan
Clinton	Montgomery	Tioga
Columbia	Ontario	Tompkins
Cortland	Orleans	Ulster
Delaware	Oswego	Warren
Essex	Otsego	Washington
Franklin	Putnam	Wayne
Fulton	Rensselaer	Wyoming
Genesee	St. Lawrence	Yates
Greene	Saratoga	

The following 9 counties have certain townships with population densities of 150 persons or less per square mile:

Albany	Erie	Oneida
Broome	Monroe	Onondaga
Dutchess	Niagara	Orange

Compliance Requirements:

No new reporting, record keeping, or other compliance requirements are being imposed as a result of this proposal.

Professional Services:

No new additional professional services are required in order for providers in rural areas to comply with the proposed amendments.

Compliance Costs:

No initial capital costs will be imposed as a result of this rule, nor will there be an annual cost of compliance. As a result of the amendment to 86-1.55, there may be a decrease to specific hospitals' revenues. In the aggregate, as a result of the amendments to 86-1.62 and 86-1.63 there will be no increases or decreases in hospitals' revenues. Revenues will shift among individual hospitals depending upon the diagnoses of and approved procedures performed on the patients they treat.

Minimizing Adverse Impact:

The proposed amendments will be applied to all general hospitals. The Department of Health considered the approaches specified in section 202-bb (2) of the State Administrative Procedure Act in drafting the proposed amendments and rejected them as inappropriate given the reimbursement system mandated in statute.

Opportunity for Rural Area Participation:

Rural areas were given notice of this proposal by its inclusion in the agenda of the Fiscal Policy Committee of the State Hospital Review and Planning Council for its May 22, 2008 meeting. That agenda is mailed to members of the Fiscal Policy Committee, the New York State Legislature and representatives of the hospital associations, among others. The associations are member organizations, which represent the needs and concerns of providers across New York State, including rural areas. The amendment was described at meetings of the Fiscal Policy Committee prior to the filing of the notice of proposed rulemaking.

This outreach resulted in the Department of Health receiving comments and suggestions related to additional changes that industry representatives recommended be implemented. Based on this feedback, the Department did make additional changes to the service intensity weights to incorporate several of these comments and suggestions.

Job Impact Statement

A Job Impact Statement is not required pursuant to Section 201-a(2)(a) of the State Administrative Procedure Act. It is apparent, from the nature and purpose of the proposed rules, that they will not have a substantial adverse impact on jobs or employment opportunities. The proposed regulations revise the calculation of cost outlier payments and update the diagnosis related group (DRG) classification system for inpatient hospital services as well as the corresponding service intensity weights and length of stay

standards. The cost outlier payments are exceptions to the case payment rates for high cost or long stay cases and have been in effect since 1988 in New York State. The DRG classification system, which also has been in effect since 1988, is utilized to reimburse hospitals for inpatient services rendered to Medicaid beneficiaries. The proposed regulations have no implications for job opportunities.

Insurance Department

EMERGENCY RULE MAKING

Flexible Rating for Nonbusiness Automobile Insurance Policies

I.D. No. INS-02-09-00001-E

Filing No. 1333

Filing Date: 2008-12-24

Effective Date: 2008-12-24

PURSUANT TO THE PROVISIONS OF THE State Administrative Procedure Act, NOTICE is hereby given of the following action:

Action taken: Repeal of Part 163 and addition of new Part 163 (Regulation 153) to Title 11 NYCRR.

Statutory authority: Insurance Law, sections 201, 301, 2350 and article 23

Finding of necessity for emergency rule: Preservation of general welfare.

Specific reasons underlying the finding of necessity: Chapter 136 of the Laws of 2008, which takes effect on January 1, 2009, enacts a new Section 2350 of the Insurance Law, which replaces the prior approval system, in effect since 2001 for nonbusiness motor vehicle insurance rates, with a flexible rating (flex-rating) system. Section 2350 requires the superintendent to promulgate rules and regulations implementing the new flexible rating system. Since insurers will be authorized to use the new flexible rating system as of the effective date of the new law, January 1, 2009, it is essential that this regulation be promulgated on an emergency basis in order to have procedures in place that implement the provisions of the law. It also is essential that insurers be made aware of the rules and standards governing the notice requirements as soon as possible.

For the reasons cited above, this regulation is being promulgated on an emergency basis for the preservation of the general welfare.

Subject: Flexible Rating for Nonbusiness Automobile Insurance Policies

Purpose: This rule re-establishes flexible rating for nonbusiness automobile insurance policies required by section 2350 of the Ins. Law.

Text of emergency rule: A new Part 163 is added to read as follows:

§ 163.0 Preamble.

On June 30, 2008, the Governor signed Chapter 136 of the Laws of 2008 into law to enhance competition in the nonbusiness motor vehicle market, by adding a new Insurance Law section 2350. Chapter 136 replaces the prior approval system, in effect since 2001 for nonbusiness motor vehicle insurance rates, with a flexible rating (flex-rating) system. The new system, which takes effect on January 1, 2009, is a blend of prior approval and competitive rating. The system allows periodic overall average rate changes up to five percent on a file and use basis, and requires the superintendent's prior approval of overall average rate increases above five percent in any twelve-month period. The new section 2350 requires the superintendent to promulgate rules and regulations implementing the new flex-rating system.

§ 163.1 Definitions.

For the purpose of this Part, the following definitions shall apply:

(a) *Base rate means the dollar charge for a given coverage for one car year prior to the application of rating factors.*

(b) *Car year means insuring a motor vehicle for one year.*

(c) *Coverage means the following motor vehicle insurance coverages:*
 (1) *no-fault (personal injury protection), residual bodily injury liability, property damage liability, statutory uninsured motorists, supplementary uninsured/underinsured motorists, comprehensive, and collision; and*

(2) *any other motor vehicle coverage.*

(d) *Current average rate for a given coverage means the weighted average of an insurer's latest filed base rates modified by the applicable rating factors for each motor vehicle for the given coverage with the weights proportional to the latest available number of car years associated with each rating factor, or any materially equivalent calculation.*

(e) Current overall average rate means:

(1) the weighted average of the current average rate for:

(i) all coverages listed in paragraph (1) of subdivision (a) of this section; and

(ii) any other motor vehicle coverages not listed in paragraph (1) of subdivision (a) of this section, if the insurer proposes a change in the rate for that coverage, with the weights proportional to the latest available number of car years for the respective coverages; or

(2) any materially equivalent calculation.

(f) Effective date means the date a revised set of base rates or rating factors shall apply to all existing nonbusiness automobile insurance policies as such policies are renewed. If a filing only applies to new business, then the effective date means the date that an insurer may first write new business.

(g) File and use means the process by which an insurer files with the superintendent a proposed overall average rate change that is within the flex-band, and then uses the proposed overall average rate change without having to obtain the superintendent's prior approval.

(h) Flexibility band or flex-band means the range of overall average rate increase or decrease (up to +5%) within which an insurer may change its motor vehicle insurance rates without having to obtain the superintendent's prior approval.

(i) Motor vehicle has the meaning set forth in section 5102(f) of the Insurance Law.

(j) Nonbusiness automobile insurance policy means a contract of insurance covering losses or liabilities arising out of the ownership, operation or use of a motor vehicle that is predominately used for nonbusiness purposes, when a natural person is the named insured.

(k) Proposed average rate for a given coverage means the weighted average of an insurer's proposed base rates modified by the applicable rating factors for each motor vehicle for the given coverage with the weights proportional to the latest available number of car years associated with each rating factor, or any materially equivalent calculation.

(l) Proposed overall average rate means:

(1) the weighted average of the proposed average rate for:

(i) each coverage listed in paragraph (1) of subdivision (a) of this section regardless of whether the insurer is filing a change for that coverage; and

(ii) any other motor vehicle coverages not listed in paragraph (1) of subdivision (a) of this section if the insurer proposes a change in the rate for that coverage, with the weights proportional to the latest available number of car years for the respective coverages; or

(2) any materially equivalent calculation.

(m) Proposed overall average rate change means the percentage difference between the proposed overall average rate and the current overall average rate. For example, if the proposed overall average rate is \$1,200 and the current overall average rate is \$1,000, then the proposed overall average rate change is 20% $((1,200/1,000)-1) \times 100$.

(n) Rating factors means the various elements that are applied or added to the base rates to obtain the actual nonbusiness automobile insurance policy premiums. These include classification factors based on the age, sex, and marital status of the insured, territorial rating factors, merit rating factors based on the driving record of the insured, increased limit factors, motor vehicle symbol and model year rating factors, and multi-tier rating factors.

§ 163.2 Rules and standards governing proposed file and use overall average rate changes for nonbusiness automobile insurance policies.

(a) An insurer may implement a proposed overall average rate increase on a file and use basis provided that the change is within the five percent flex-band. If the proposed overall average rate increase exceeds the five percent flex-band, then the insurer shall obtain the superintendent's prior approval before implementing the change.

(b) During any twelve-month period, an insurer may implement no more than two overall average rate increases on a file and use basis provided that the cumulative effect of the increases shall be within the five percent flex-band. If a proposed overall average rate increase combined with a prior rate increase implemented within a twelve-month period of the proposed effective date of the request exceeds the five percent flex-band, then the insurer shall obtain the superintendent's prior approval before implementing the change. For example, if an insurer implements on a file and use basis a +2.9% overall average rate increase effective February 1, 2009 and a +2% overall average rate increase effective August 1, 2009, then the insurer may not implement another file and use overall average rate increase before February 1, 2010. However, at such time, the insurer may implement an overall average rate increase up to a maximum of +2.9%.

(c) An insurer may reduce its overall average rate on a file and use basis up to a maximum of five percent at any one time from the overall average rate currently in effect.

(d) Notwithstanding any provision of this Part, an insurer shall not

implement an overall average rate increase on a file and use basis subsequent to an overall average rate increase greater than the five percent flex-band that the superintendent has already prior approved in the twelve-month period immediately preceding the effective date of the proposed increase.

§ 163.3 Rules and standards governing changes in rating factors.

(a) An insurer may adjust its rating factors as part of a file and use change. The insurer shall incorporate the rate impact of these adjustments in the overall average rate change. These changes shall be consistent with the rate change limitations for individual insureds contained in section 163.4 of this Part.

(b) An insurer may adjust its rating factors in separate and distinct filings independent of an overall average rate change. If these filings have no overall average rate impact, then the insurer may implement them on a file and use basis and the insurer shall not be precluded from implementing a file and use change for an overall average rate increase within the time periods specified in section 163.2(b) of this Part. For example, the introduction of a physical damage coverage's model year rating factor for a new model year that is consistent with an existing model year rating rule is not subject to prior approval. These filings shall be consistent with the rate change limitations for individual insureds contained in section 163.4 of this Part.

§ 163.4 Rules and standards governing nonbusiness automobile insurance policy premium change limitations for individual insureds as a consequence of file and use filings.

(a) In any twelve-month period, the total premium on any nonbusiness automobile insurance policy shall not change by more than 30% as a consequence of file and use filings. An insurer shall meet this requirement by adjusting the base rates or rating factors in the file and use filing. An insurer shall not cap an individual insured's premium as a final step. If a filing produces an annual total premium change on an insurance policy that exceeds the 30% maximum, then the filing shall be subject to the superintendent's prior approval.

(b) Changes in the premium of a nonbusiness automobile insurance policy as a consequence of changes in an insured's rating characteristics or changes in the coverages or the amounts of coverage being purchased shall not be considered within the calculation of the individual insured premium limitation contained in subdivision (a) of this section. For example, if an insured has an accident during the prior year and incurs a 25% surcharge or an uptier, then this 25% surcharge/uptier shall not be considered within the individual premium limitations. The application of a different classification factor as a consequence of a change in the age of an insured shall not be considered within the premium limitation.

§ 163.5 Support for filings submitted on a file and use basis.

An insurer shall include support for all proposed changes specified in each filing submitted on a file and use basis. The support shall include the specific reasons for the proposed changes, and any other material information required by section 2304 of the Insurance Law (e.g., the underlying data upon which the change is based). Filings submitted on a file and use basis shall be subject to the superintendent's review in accordance with Article 23 of the Insurance Law.

§ 163.6 Support for filings subject to prior approval.

(a) An insurer shall include support for all proposed changes specified in each filing subject to the superintendent's prior approval. The support shall include the specific reasons for the proposed changes, and any other material information as required by section 2304 of the Insurance Law.

(b) Any filings that contain new or revised territorial definitions and/or rating classifications including, but not limited to, discounts, surcharges, merit rating plans, and multi-tier programs remain subject to the superintendent's prior approval pursuant to Article 23 of the Insurance Law.

(c) If any one element of a filing is subject to prior approval, then the entire filing shall be subject to prior approval.

§ 163.7 Notification to insureds of rate changes.

(a) An insurer shall mail or deliver to every named insured affected by a rate increase due to a flex-band rate filing, at least 30 but not more than 60 days in advance of the end of the policy period, a notice of its intention to change the insured's rate. The notice shall set forth the specific reason or reasons for the rate change.

(b) An insurer shall not implement a rate increase due to a flex-band rate filing unless the insurer has mailed or delivered to the named insured affected by the rate increase the notice required by subdivision (a) of this section.

(c) An insurer shall submit a flex-band rate filing to the superintendent in a timely manner. An insurer shall not submit a flex-band filing to the superintendent after insureds have received notification pursuant to subdivision (a) of this section.

This notice is intended to serve only as an emergency adoption, to be valid for 90 days or less. This rule expires March 23, 2009.

Text of rule and any required statements and analyses may be obtained from: Andrew Mais, NYS Insurance Department, 25 Beaver Street, New York, NY 10004, (212) 480-2285, email: amais@ins.state.ny.us

Regulatory Impact Statement

1. Statutory authority: Sections 201, 301, and Article 23 of the Insurance Law (most specifically, section 2350).

These sections establish the superintendent's authority to promulgate regulations establishing standards for flexible rating systems providing nonbusiness automobile insurance policies. Sections 201 and 301 of the Insurance Law authorize the superintendent to effectuate any power accorded to him by the Insurance Law, and prescribe regulations interpreting the Insurance Law.

Article 23 promotes the public welfare by regulating insurance rates to the end that they not be excessive, inadequate or unfairly discriminatory, to promote price competition and competitive behavior among insurers.

Chapter 136 of the Laws of 2008 adds a new section 2350 to the Insurance Law, which reintroduces flexible rating for nonbusiness automobile insurance rates.

2. Legislative objectives: The stated purpose of Article 23 of the Insurance Law is to ensure the availability and reliability of insurance, and to promote public welfare, by regulating insurance rates to assure that they are not excessive, inadequate or unfairly discriminatory and are responsive to competitive market conditions. Chapter 136 of the Laws of 2008 reestablished flexible rating for nonbusiness automobile insurance. It should strengthen the high level of competition that already exists in this market. The nonbusiness automobile market can benefit from the additional competitive impetus of a flexible rating system.

3. Needs and benefits: Flexible rating, which is a hybrid system borrowing elements from open competition and prior approval, has been applicable to commercial risk, professional liability and public entity insurance since 1986. In those markets, flexible rating has proved successful in restoring stability, promoting fair competition, and providing a firm foundation for long-term thinking and strategic planning, not only on the part of the insurance industry, but for the benefit of businesses and consumers that must rely upon, and budget for, insurance protection.

The above benefits are pertinent to the application of flex rating for the nonbusiness automobile market. Competition and market forces have always been strong determinants of rates for nonbusiness automobile coverages, and flex rating should strengthen the high level of competition that already exists in this market.

Chapter 113 of the Laws of 1995 first introduced flex rating to nonbusiness automobile insurance effective July 1, 1995 until it expired on August 2, 2001 and was replaced by prior approval requirements. However, section 13 of Chapter 136 of the Laws of 2008 adds a new section 2350 to the Insurance Law, which reintroduces flexible rating for nonbusiness automobile insurance rates. It permits insurers to place nonbusiness automobile insurance rates in effect without the superintendent's prior approval, provided that the overall average rate level does not result in an increase above five percent from the insurer's prior rate level in effect during the preceding 12 months. Section 2350 also limits the overall average rate level decreases without prior approval up to five percent from the insurer's current rate level in effect. The prior regulation, which implemented the former flex rating system, is hereby being repealed pursuant to this new Part 163 of Title 11 of the Official Compilation of Codes, Rules and Regulations of the State of New York (Regulation No. 153). In accordance with section 2350(c), Insurance Department Regulation No. 153 (11 NYCRR 163) is being promulgated to provide guidance to insurers in implementing the new law's requirements.

4. Costs: This rule imposes no compliance costs on state or local governments. There are no additional costs incurred by the Insurance Department. For regulated parties, the costs of submitting a flexible rate filing should be no different than the costs of submitting a rate filing under the prior law. Since insurers will be able to implement flexible rate changes without having to wait for the Insurance Department's formal approval, they will be able to respond more quickly to competitive forces in the marketplace. However, there is an additional requirement to provide notice to all policyholders affected by a rate increase due to a flexible rate filing. Compliance with this notice requirement of premium increases pursuant to the flexible rating regulation will have a minimal cost, since the notice language may be included along with the renewal policy information sent to insureds. In any event, the notice requirement is imposed by the statute, not the regulation.

5. Local government mandates: This amendment does not impose any program, service, duty or responsibility upon a city, town or village, or school or fire district.

6. Paperwork: There is no additional paperwork required under the private passenger automobile flexible rating system. While the paperwork associated with the submission and monitoring of a flexible rate filing is essentially the same as that associated with private passenger automobile insurance rate filings under the prior law, there is an additional requirement imposed by the statute to provide notice to all policyholders affected by a rate increase due to a flexible rate filing. This notice language may be included along with the renewal policy information sent to insureds.

7. Duplication: This rule will not duplicate any existing state or federal rule.

8. Alternatives: The Department performed outreach with three property/casualty insurer trade organizations (individually "insurer trade organization") and two property/casualty insurance agents and brokers trade organizations (individually "agents and brokers trade organization") and received comments from four out of the five organizations.

a. The legislative intent was for any rate change that results in an overall rate increase above 5% during a 12-month period to require prior approval. The alternative approach would be not to consider any rate increase that exceeds the 5% overall flex band limit that has been prior approved during the same 12-month period. While this approach would require newer data to support any flex rate filing made subsequent to a prior approved rate filing, it still seems to be clearly against the legislative intent to keep significant automobile rate increases occurring within a 12-month period to be subject to prior approval. For example, if an insurer received approval for a rate increase of 7% effective February 1, 2009, the insurer may not implement an additional increase to be effective before February 1, 2010 on a flexible rating basis.

b. The Department considered reducing the limitation from the prior regulation standard of a 30% maximum individual premium change as a consequence of file and use filings to 25%, with the understanding that such maximum policyholder change bears some relationship to the overall flex band (which has decreased from 7% in the prior flex rating statute to 5% in the new statute). However, in consideration of comments received, the Department agreed that the maximum individual premium change is not truly relevant to the overall average rate change resulting from a flexible rate filing made by an insurer. It is quite common for rate filings with little or no overall rate effect to still produce significant individual policyholder impacts.

c. An insurer trade organization objected to the provision of Section 163.4, which precludes an insurer from capping an individual insured's premium to comply with the maximum individual premium change provision. This organization asserted that "capping" is a method that is considered acceptable in other states to achieve that result as opposed to making adjustments to base rates and factors for an entire class of policyholders. However, it has long been the Department's view that the capping of individual policy premiums is unfairly discriminatory to new policyholders with the same characteristics as current policyholders whose rates have been capped and therefore contrary to Article 23.

d. An insurer trade organization inquired as to whether the cumulative effect of two flexible rate increases would be measured, by simple addition or by multiplication. Pursuant to Section 163.2 of this regulation, the cumulative effect of two flexible rate increases will be multiplicative, consistent with the rate methodology used in deriving rate effects. In response to this comment, an example has been included in the regulation by way of clarification.

e. Two insurer trade organizations commented that the regulation fails to specify the instances under which the superintendent may order an insurer to make a change in its rates filed under file and use basis. However, section 2320 of the Insurance Law provides procedures that must be followed by the superintendent and insurers in addressing issues related to rate filings that are not subject to prior approval. Thus, no change to the proposal was made in response to this comment.

f. An insurer trade organization and an agents and brokers trade organization suggested that the Department clarify that the maximum permitted increase for an individual insured's premium should be applied to the full coverage or total premium of a nonbusiness automobile insurance policy. Consequently, the Department modified section 163.4(a) of the regulation to clarify that the provision applies to an insured's total policy premium and not to a specific coverage.

g. Two insurer trade organizations and an agents and brokers trade organization requested a definition of the term "predominantly" with regard to the definition of "nonbusiness automobile insurance policy" and a revision to the definition of the term "effective date" with regard to new business and renewals. However, the term "predominantly" is not unique to the flexible rating statute, and is used elsewhere in the Insurance Law, such as section 3425. In addition, the term "predominantly" has been previously clarified through opinions of the Department's Office of General Counsel. Thus, the Department made no changes to the regulation in response to this comment. The Department considered the request for revision of the definition of the term "effective date" but determined that the current definition, contained in section 163.1 of the regulation, was appropriate.

h. An agents and brokers trade organization inquired if an insurer may increase the premium on a six month policy at each policy renewal. However, article 23 of the Insurance Law requires an insurer to use the rates in effect upon renewal of each policy, regardless of the rate filing system used to make the rate filing (i.e., regardless of whether the filing was made as file and use or in accordance with prior approval). Thus, the

Department made no changes to the regulation in response to this comment.

i. An insurer trade organization commented on the fact that the regulation would allow an insurer to file multiple file and use rate reductions while being limited to only two file and use increases within any 12-month period. The flexible rating statute provides for a maximum of two file and use overall average rate increases within any 12-month period, up to an overall maximum increase of 5%. The statute does not, however, provide any restrictions on the number of file and use overall average rate decreases, provided that the overall average rate decrease does not exceed the 5% flex-band from the rate currently in effect. All rate filings must include support for the proposed changes as required by Article 23 of the Insurance Law, as the Department will monitor the cumulative effect of the decreases to ensure that the rates are not inadequate or otherwise in violation of the Insurance Law.

9. Federal standards: There are no minimum standards of the federal government for the same or similar subject areas.

10. Compliance schedule: Insurers should be able to comply with the requirements of this rule as soon as they are effective.

Regulatory Flexibility Analysis

1. Small businesses:

The Insurance Department finds that this rule will not impose any adverse economic impact on small businesses and will not impose any reporting, recordkeeping or other compliance requirements on small businesses. The basis for this finding is that this rule is directed at property/casualty insurance companies licensed to do business in New York State, none of which falls within the definition of "small business" as found in section 102(8) of the State Administrative Procedure Act. The Insurance Department has monitored Annual Statements and Reports on Examination of authorized property/casualty insurers subject to this rule, and believes that none of the insurers falls within the definition of "small business", because there are none that are both independently owned and have fewer than one hundred employees.

2. Local governments:

The rule does not impose any impacts, including any adverse impacts, or reporting, recordkeeping, or other compliance requirements on any local governments. The basis for this finding is that this rule is directed at property/casualty insurance companies, none of which are local governments.

Rural Area Flexibility Analysis

1. Types and estimated numbers of rural areas: This regulation applies to all property/casualty insurance companies licensed to write insurance in New York State (specifically, those writing automobile insurance). Property/casualty insurance companies do business throughout New York State, including rural areas as defined under State Administrative Procedure Act Section 102(10).

2. Reporting, recordkeeping and other compliance requirements, and professional services: This regulation is not expected to impose any reporting, recordkeeping or other compliance requirements on public or private entities in rural areas. This regulation re-establishes flexible rating for nonbusiness automobile insurance policies, as required by section 2350 of the Insurance law. While the paperwork associated with the submission and monitoring of a flexible rate filing is essentially the same as that associated with private passenger automobile insurance rate filings under the prior law, there is an additional requirement imposed by the statute to provide notice to all policyholders affected by a rate increase due to a flexible rate filing. This notice language may be included together with the renewal policy information that is sent to insureds.

3. Costs: The costs to regulated parties of submitting a flexible rate filing should be no different than the costs for submitting a rate filing under the prior law. Since insurers will be able to implement flexible rate changes without having to wait for the Insurance Department's formal approval, they will be able to respond more quickly to competitive forces in the marketplace. However, there is an additional requirement to provide notice to all policyholders affected by a rate increase due to a flexible rate filing. Compliance with this notice requirement of premium increases pursuant to the flexible rating regulation will have a minimal cost, since the notice language may be included along with the renewal policy information sent to insureds. In any event, the notice requirement is imposed by the statute, not the regulation.

4. Minimizing adverse impact: The regulation does not impose any impact unique to rural areas.

5. Rural area participation: This regulation is required by statute.

Job Impact Statement

The Insurance Department finds that this rule will have no adverse impact on jobs and employment opportunities. It merely implements section 2350 of the Insurance Law, which directs the superintendent to establish standards for flexible rating systems providing nonbusiness automobile insurance policies. The number of insurance company personnel necessary to

submit a flexible rating filing should be no different than submitting a rate filing under the prior law.

Office of Medicaid Inspector General

PROPOSED RULE MAKING NO HEARING(S) SCHEDULED

Compliance Programs for Medical Assistance Providers

I.D. No. MED-02-09-00004-P

PURSUANT TO THE PROVISIONS OF THE State Administrative Procedure Act, NOTICE is hereby given of the following proposed rule:

Proposed action: Addition of Part 521 to Title 18 NYCRR.

Statutory authority: Social Services Law, section 363-d; Public Health Law, section 32

Subject: Compliance programs for medical assistance providers.

Purpose: To set forth regulations governing compliance programs for medical assistance providers.

Text of proposed rule: A new Part 521, entitled "Provider Compliance Programs," is added to Title 18 of the Codes, Rules and Regulations of the State of New York to read as follows:

PART 521

PROVIDER COMPLIANCE PROGRAMS

§ 521.1 General requirements and scope.

To be eligible to receive medical assistance payments for care, services, or supplies, or to be eligible to submit claims for care, services, or supplies for or on behalf of another person, the following persons shall adopt and implement effective compliance plans:

(a) persons subject to the provisions of articles twenty-eight or thirty-six of the public health law;

(b) persons subject to the provisions of articles sixteen or thirty-one of the mental hygiene law; or

(c) other persons, providers or affiliates who provide care, services or supplies under the medical assistance program or persons who submit claims for care, services, or supplies for or on behalf of another person for which the medical assistance program is or should be reasonably expected by a provider to be a substantial portion of their business operations.

§ 521.2 Definitions.

For purposes of this Part, the definitions contained in Parts 504 and 515 of this Title shall apply. In addition, the following terms, as used in this Part, shall have the following meanings:

(a) "Required provider" means a provider meeting any of the criteria listed in subpart 521.1 of this Part.

(b) "Substantial portion" of business operations means any of the following:

(1) a person, provider or an affiliate of the provider claims or orders, or has claimed or has ordered, or should be reasonably expected to claim or order at least five hundred thousand dollars (\$500,000) in a consecutive twelve-month period from the medical assistance program;

(2) a person, provider or an affiliate of the provider receives or has received, or should be reasonably expected to receive at least \$500,000 in any consecutive twelve-month period directly or indirectly from the medical assistance program; or

(3) a person, provider or an affiliate of the provider who submits or has submitted claims for care, services, or supplies to the medical assistance program on behalf of another person or persons in the aggregate of at least five hundred thousand dollars (\$500,000) in a consecutive twelve-month period.

§ 521.3 Compliance Program Provider Duties.

(a) Every required provider shall adopt and implement an effective compliance program. The compliance program may be a component of more comprehensive compliance activities by the required provider so long as the requirements of this Part are met. Required providers' compliance programs shall be applicable to:

(1) billings;

(2) payments;

(3) medical necessity and quality of care;
 (4) governance;
 (5) mandatory reporting;
 (6) credentialing; and
 (7) other risk areas that are or should with due diligence be identified by the provider.

(b) Upon applying for enrollment in the medical assistance program, and during the month of December each year thereafter, a required provider shall certify to the department, using a form provided by the Office of the Medicaid Inspector General on its website, that a compliance program meeting the requirements of this Part is in place. The Office of the Medicaid Inspector General will make available on its website compliance program guidelines for certain types of required providers.

(c) A required provider's compliance program shall include the following elements:

(1) written policies and procedures that describe compliance expectations as embodied in a code of conduct or code of ethics, implement the operation of the compliance program, provide guidance to employees and others on dealing with potential compliance issues, identify how to communicate compliance issues to appropriate compliance personnel and describe how potential compliance problems are investigated and resolved;

(2) designate an employee vested with responsibility for the day-to-day operation of the compliance program; such employee's duties may solely relate to compliance or may be combined with other duties so long as compliance responsibilities are satisfactorily carried out; such employee shall report directly to the entity's chief executive or other senior administrator designated by the chief executive and shall periodically report directly to the governing body on the activities of the compliance program;

(3) training and education of all affected employees and persons associated with the provider, including executives and governing body members, on compliance issues, expectations and the compliance program operation; such training shall occur periodically and shall be made a part of the orientation for a new employee, appointee or associate, executive and governing body member;

(4) communication lines to the responsible compliance position, as described in paragraph (2) of this subdivision, that are accessible to all employees, persons associated with the provider, executives and governing body members, to allow compliance issues to be reported; such communication lines shall include a method for anonymous and confidential good faith reporting of potential compliance issues as they are identified;

(5) disciplinary policies to encourage good faith participation in the compliance program by all affected individuals, including policies that articulate expectations for reporting compliance issues and assist in their resolution and outline sanctions for:

(i) failing to report suspected problems;

(ii) participating in non-compliant behavior; or

(iii) encouraging, directing, facilitating or permitting either actively or passively non-compliant behavior; such disciplinary policies shall be fairly and firmly enforced;

(6) a system for routine identification of compliance risk areas specific to the provider type, for self-evaluation of such risk areas, including but not limited to internal audits and as appropriate external audits, and for evaluation of potential or actual non-compliance as a result of such self-evaluations and audits, credentialing of providers and persons associated with providers, mandatory reporting, governance, and quality of care of medical assistance program beneficiaries;

(7) a system for responding to compliance issues as they are raised; for investigating potential compliance problems; responding to compliance problems as identified in the course of self-evaluations and audits; correcting such problems promptly and thoroughly and implementing procedures, policies and systems as necessary to reduce the potential for recurrence; identifying and reporting compliance issues to the department or the office of Medicaid inspector general; and refunding overpayments;

(8) a policy of non-intimidation and non-retaliation for good faith participation in the compliance program, including but not limited to reporting potential issues, investigating issues, self-evaluations, audits and remedial actions, and reporting to appropriate officials as provided in sections seven hundred forty and seven hundred forty-one of the labor law.

521.4 Determination of Adequacy of Compliance Program.

(a) The commissioner of health and the Medicaid inspector general shall have the authority to determine at any time if a provider has a compliance program that is effective and appropriate to its characteristics and satisfactorily meets the requirements of this Part.

(b) A provider whose compliance program that is accepted by the

federal department of health and human services office of inspector general and remains in compliance with the standards promulgated by such office shall be deemed in compliance with the provisions of this Part, so long as such plans adequately address medical assistance program risk areas and compliance issues.

(c) In the event that the commissioner of health or the Medicaid inspector general finds that the required provider does not have a satisfactory program, the provider may be subject to any sanctions or penalties permitted by federal or state laws and regulations, including revocation of the provider's agreement to participate in the medical assistance program.

Text of proposed rule and any required statements and analyses may be obtained from: Erin C. Morigerato, Senior Counsel, Office of Medicaid Inspector General, Riverview Center, 150 Broadway, Albany, NY 12204, (518) 408-0508, e-mail: ecm03@omig.state.ny.us

Data, views or arguments may be submitted to: Same as above.

Public comment will be received until: 45 days after publication of this notice.

Regulatory Impact Statement

1. Statutory authority:

An independent Office of the Medicaid Inspector General (OMIG) within the Department of Health was created by Chapter 442 of the Laws of 2006 (Chapter 442). OMIG is responsible for coordinating and implementing state-wide initiatives aimed at combating fraud and abuse within the medical assistance program.

Public Health Law (PHL) section 32, which was added by Chapter 442 of the laws of 2006, sets forth the functions, duties and responsibilities of the Medicaid Inspector General. Section 32 specifically authorizes the Medicaid Inspector General to "implement and amend, as needed, rules and regulations relating to the prevention, detection, investigation and referral of fraud and abuse within the medical assistance program and the recovery of improperly expended medical assistance program funds." PHL § 32 (20).

Social Services Law section 363-d, which was also added by Chapter 442, requires that certain medical assistance providers adopt and implement a compliance program, and that the Medicaid Inspector General, in consultation with the Department of Health, promulgate regulations establishing which providers are subject to the compliance program requirement.

2. Legislative objectives:

The overall purpose of Chapter 442 is to implement reform measures that will enhance the integrity of New York's Medicaid program. These measures are aimed at avoiding or recovering improper Medicaid claims and combating fraud and abuse within the Medicaid program. One component of this effort is the requirement that certain medical assistance providers develop and implement a compliance program.

3. Needs and benefits:

The Legislature has determined that medical assistance providers should be required to develop and implement compliance programs in order to reduce fraud and abuse in the Medicaid program. Social Services Law (SSL) section 363-d (4) directs the Medicaid Inspector General to adopt regulations, in consultation with the Department of Health, that establish and specify the types of providers that will be subject to the compliance program requirements. The proposed regulations will apply to any businesses that fall under one or more of three general categories:

1. providers that are subject to the provisions of Articles 28 or 36 of the public health law;

2. providers that are subject to the provisions of Articles 16 or 31 of the mental hygiene law; and

3. persons, providers and affiliates of such persons who submit Medicaid claims totaling \$500,000.00 or greater in a twelve month period.

The first two categories of providers are already required by Social Services Law (SSL) section 363-d to put compliance programs into effect. The proposed regulations are consistent with those statutory requirements. The third category of providers was identified generally by the SSL section 363-d as providers for which Medicaid claims made up a "substantial portion" of the provider's business operations. The proposed regulations define "substantial portion" and establish a \$500,000.00 threshold for this third category. The \$500,000.000 threshold was established because not only has it been previously included in other DOH regulations¹ but it also encompasses ten percent of providers and ninety-five percent of the Medicaid billings based on a 2006 and 2007 summary².

This rulemaking is necessary in order for the Medicaid Inspector General to comply with the statutory directive in SSL section 363-d (4). This rulemaking will also ensure that the regulated community is given appropriate notice as to which providers must produce and implement a compliance program.

This rulemaking is part of an overall effort by New York State to enhance the integrity of its Medicaid program. The compliance program

requirement will help to ensure: that Medicaid funds are used properly and that payments are made only for legitimate claims; that providers systematically identify, report, and return overpayments; that medical care, services, and supplies provided meet required standards of care; that individuals can report unacceptable practices, such as fraud, directly and safely; and that providers establish accountability in governance structures. As was noted by the Legislature in the bill memorandum in support of the new SSL 363-d, this rulemaking is part of an initiative that will "achieve substantial savings for taxpayers and preserve quality health care for the state's Medicaid recipients."

Providers that are subject to the proposed regulations may also realize benefits associated with implementation of a compliance program. An effective compliance program will help a provider to ensure that appropriate quality of care is offered to Medicaid recipients by appropriately credentialed staff, that billings and payments are accurate, that sufficient internal controls exist to prevent inappropriate billings and payments and that sanctions are avoided, such as penalties and exclusions, that are imposed as a result of unacceptable practices. Cost benefits to providers are further discussed below.

4. Costs:

The requirement that certain medical assistance providers prepare and adopt compliance programs is established by statute in SSL section 363-d (2). Therefore, any costs that may be incurred by these providers would be a direct result of that statute and not this rulemaking. However, SSL section 363-d also directs OMIG to adopt regulations that establish which providers are subject to the compliance program requirements. In particular, OMIG's regulations must address providers for which the medical assistance program constitutes "a substantial portion" of the provider's business. This rulemaking clarifies the types of providers that are subject to the compliance program requirement and must therefore incur costs, if any, associated with such a program.

Costs to regulated parties:

The costs incurred by regulated parties in order to comply with the proposed rulemaking will vary depending upon any existing control measures the provider has in place at the time the regulation takes effect. For those providers who already have an operating compliance program, potentially little or no costs may be incurred in order to establish a compliance program that satisfies the proposed regulations. However, for those providers who do not have a program in place that meets the requirements set forth in this proposed rulemaking, some costs will be incurred in order to establish a compliance program. The extent of those costs will depend on the level of effort that is necessary for the provider to establish a compliance program that satisfies each of the eight mandatory elements. Those elements are listed and described in both the proposed regulations and SSL section 363-d.

In assessing the costs incurred by a provider when it establishes a compliance program pursuant to SSL § 363-d and the proposed regulations, due consideration should be given to the cost savings that may result from the implementation of an effective compliance program. In preparing this proposed rulemaking, OMIG staff looked for existing literature and studies on the issue of costs associated with compliance programs. Only one report was identified: *Impact of a Compliance Program for Billing on Internal Medicine Faculty's Documentation Practices and Productivity*, ACADEMIC SCIENCE (March 2001). The results of this study, which focused on the implementation of a compliance program by the Saint Louis University Medical Group (UMG), suggest that compliance programs may provide certain financial benefits to the provider. For example, in the study of UMG, the gross collection rate for all services increased, staff productivity increased, unbillable services decreased, and the financial risks associated with an adverse audit decreased. These cost savings may result in a net cost savings to providers who establish compliance programs. For those providers that do not find net cost savings, the expected cost savings should diminish, if not completely offset, any costs incurred by providers in the development and implementation of a compliance program.

Costs to OMIG, the State and local governments

The proposed rulemaking will not result in any new costs to OMIG or state government in general. OMIG staff may seek to review provider compliance plans, but no new costs would be involved because staff already investigate and audit Medicaid providers for compliance with the requirements of the Medicaid program which compliance programs are intended to address, improve, and enhance. Reviewing compliance plans would become a component of that process.

The proposed rulemaking will not impose costs on local governments in general, but local government entities that fall within the definition of a "required provider" as set forth in the proposed regulations, including school districts, will be required to implement a compliance program. The cost analysis would be the same as the discussion above for "regulated parties." The cost savings discussed above for regulated parties would apply to local government providers as well.

5. Local government mandates:

The proposed rulemaking does not impose any program, service, duty or responsibility on local government entities in general. However, there are a small number of local government entities which will be required under this proposal to have compliance program in place because they fall within the proposed definition of "required provider."

6. Paperwork:

Medical assistance providers who are subject to the proposed regulations will be required to complete paperwork associated with the development and implementation of compliance programs. No additional paperwork will be required for those providers who already have an established compliance program that satisfies the elements contained in the proposed regulations. At a minimum, each required provider will need to have in place certain written policies and procedures and will need to retain documentation that verifies. SSL § 363-d(2)(a).

7. Duplication:

There are no other legal requirements at the state or federal level that duplicate the requirements of the proposed regulations and SSL section 363-d for Medicaid. However, some providers establish compliance programs in connection with their participation in the federal Medicare program, as an effective business practice, or to comply with federal tax and other state and federal statutory and regulatory requirements. Both SSL 363-d and the proposed regulations include a provision recognizing a provider whose compliance program is accepted by the Federal Office of Inspector General for the Department of Health and Human Services. Such a program may satisfy the requirements of the proposed regulations if it adequately addresses "medical assistance risk areas and compliance issues."

8. Alternatives:

The Medicaid Inspector General is required by section 363-d (4) to promulgate these regulations. There are no reasonable alternatives to this rulemaking.

9. Federal standards:

There are no mandatory federal standards or requirements for compliance programs for medical assistance providers. However, the federal government has issued guidance for many types of providers interested in voluntary compliance programs.

10. Compliance schedule:

SSL section 363-d and its compliance program requirements took effect on January 1, 2007. Certain provider types were addressed specifically: providers subject to the provisions of Public Health Law Article 28, Public Health Law Article 36, Mental Hygiene Law Article 16, and Mental Hygiene Law Article 31. These providers are required to have a compliance program, and those programs should have been implemented during the time that has passed since the law took effect. To the extent that any such providers have not fully implemented a compliance program to date, they should be able to do so by the time the proposed regulations take effect, if this proposed rulemaking is adopted.

For those providers that are subject to the proposed regulations but are not specifically mentioned in SSL section 363-d, compliance could reasonably be achieved within sixty days from the date the regulations take effect. In no event should a provider require more than 90 days from the date the regulations take effect in order to implement a provider compliance program. Pursuant to SSL 363-d, providers that do not have a compliance program in place within 90 days from the date the regulations take effect may be subject to sanctions or penalties.

¹ 18 NYCRR 504.11(a)(3) requires Medicaid providers who bill more than \$500,000.00 a year to furnish financial security.

² Summary of Providers by total yearly billings for 2006 and 2007 calendar years.

Regulatory Flexibility Analysis

1. Effect of the rule:

The proposed regulations require that certain Medicaid providers, including some small businesses, implement and maintain a compliance program. The proposed regulations will apply to any businesses that fall under one or more of three general categories:

1. providers that are subject to the provisions of Articles 28 or 36 of the public health law;
2. providers that are subject to the provisions of Articles 16 or 31 of the mental hygiene law; and
3. persons, providers and affiliates of such persons who submit Medicaid claims totaling \$500,000.00 or greater in a twelve month period.

The State Administrative Procedure Act (SAPA) defines "small business" as "any business which is resident in this state, independently owned and operated, and employs one hundred or less individuals." SAPA § 102(8). Small businesses covered by any one of the above three categories will be required to comply with the proposed regulations concerning compliance programs.

The first two categories of providers are already required by Social Services Law (SSL) section 363-d to put compliance programs into effect. The proposed regulations are consistent with those statutory requirements. The third category of providers was identified generally by the SSL section 363-d as providers for which Medicaid claims made up a "substantial portion" of the provider's business operations. The proposed regulations define "substantial portion" and establish a \$500,000.00 threshold for this third category. The \$500,000.000 threshold is a reasonable threshold because not only has it been previously included in other DOH regulations¹ but it also encompasses ten percent of providers and ninety-five percent of the Medicaid billings based on a 2006 and 2007 summary². The definition includes three scenarios in which a provider's participation in the medical assistance program would constitute a substantial portion of the provider's business. Small businesses falling under this definition will be required to have a compliance program. The types of small business providers that may be subject to these regulations include, but are not limited to, pharmacies, physicians, dentists, durable medical equipment (DME) businesses, service bureaus, and transportation providers.

A small percentage of local government providers, including some school districts, fall under one or more of the categories of providers that are required to establish compliance programs. These entities will be required to comply with the proposed regulations.

2. Compliance requirements:

Any small business or local government that is subject to the proposed regulations will be required to develop and implement a compliance program in accordance with the eight specific elements listed in the proposed regulations. For example, each required provider will need to have in place: "written policies and procedures that describe compliance expectations as embodied in a code of conduct or code of ethics, implement the operation of the compliance program, provide guidance to employees and others on dealing with potential compliance issues, identify how to communicate compliance issues to appropriate compliance personnel and describe how potential compliance problems are investigated and resolved." SSL § 363-d(2)(a). Depending on what policies, procedures and controls a provider has already instituted, additional action may be necessary for a provider to meet each of the remaining seven elements of a Medicaid provider compliance program.

No affirmative acts will likely be required for a provider if that provider already has an effective compliance program that satisfies the elements contained in the proposed regulations.

3. Professional services:

Providers may require the services of certain professionals, including medical professionals, auditors, attorneys, and compliance professionals in order to establish and maintain effective compliance programs.

4. Compliance costs:

The requirement that certain medical assistance providers prepare and adopt compliance programs was imposed by statute in SSL section 363-d (2). Therefore, the costs incurred by these providers are a direct result of that statute and not this rulemaking. However, SSL section 363-d also directs OMIG to adopt regulations that establish which providers are subject to the compliance program requirements. In particular, OMIG's regulations must address providers for which the medical assistance program constitutes "a substantial portion" of the provider's business. This rulemaking clarifies the types of providers that are subject to the compliance program requirement and must therefore incur costs, if any, associated with such a program.

The costs incurred by regulated parties in order to comply with the proposed rulemaking will vary depending upon any existing control measures the provider has in place at the time the regulation takes effect. For those providers who already have an operating compliance program, potentially little or no costs may be incurred in order to establish a compliance program that satisfies the proposed regulations. However, for those providers who do not have a program in place that meets the requirements set forth in this proposed rulemaking, some costs will be incurred in order to establish a compliance program. The extent of those costs will depend on the level of effort that is necessary for the provider establish a compliance program that satisfies each of the eight mandatory elements. Those elements are listed and described in both the proposed regulations and SSL section 363-d.

The costs will also vary depending upon the size and other specific attributes of the provider. SSL section 363-d states that a provider's compliance plan should reflect the provider's size, complexity, resources, and culture. Thus, a large, complex provider may incur more costs in implementing an effective compliance plan than a smaller provider might incur.

The proposed rulemaking will not impose costs on local governments in general, but local government entities that fall within the definition of a "required provider" as set forth in the proposed regulations, including school districts, will be required to implement a compliance program. There are approximately 66 local school districts who fall within the definition of "required providers" statewide. The cost analysis would be the same as for other providers covered by this regulation.

In assessing the costs that may be incurred by a provider when it establishes a compliance program, pursuant to SSL section 363-d and the proposed regulations, OMIG also considered the cost savings that could result from the implementation of an effective compliance program. OMIG staff reviewed existing literature and studies for information concerning the issue of costs associated with compliance programs. During that research, only one report was identified: *Impact of a Compliance Program for Billing on Internal Medicine Faculty's Documentation Practices and Productivity*, ACADEMIC SCIENCE (March 2001). The results of this study, which focused on the implementation of a compliance program by the Saint Louis University Medical Group (UMG), suggest that compliance programs may provide certain financial benefits to the provider. For example, in the study of UMG, the gross collection rate for all services increased, staff productivity increased, unbillable services decreased, and the financial risks associated with an adverse audit decreased. These cost savings should diminish, if not completely offset, any costs incurred by providers in the development and implementation of a compliance program.

5. Economic and technological feasibility:

Although there may be some costs involved for some providers in complying with the proposed regulations, OMIG anticipates those costs will be lessened or offset entirely by the cost savings that Medicaid providers will realize once the program is implemented.

There are no technologically challenging aspects to the requirements of the proposed rulemaking that do not already exist as requirements in current statutes, such as HIPAA, as a compliance program would establish measures to ensure compliance with laws relevant to the Medicaid program.

For these reasons, OMIG concludes that the proposed regulations will be economically and technically feasible for any affected small businesses and local governments.

6. Minimizing adverse impact:

SSL section 363-d states in part: "The legislature. . . recognizes the wide variety of provider types in the medical assistance program and the need for compliance programs that reflect a provider's size, complexity, resources, and culture. For a compliance program to be effective, it must be designed to be compatible with the provider's characteristics."

While each required provider will need to develop a compliance program that adequately addresses each of the eight elements listed in the proposed regulations and SSL section 363-d, OMIG will give due consideration and attention to the concerns noted by the Legislature and review compliance programs for appropriateness consistent with the provider's characteristics.

A small percentage of local government providers, including some school districts, fall under one or more of the categories of providers that are required to establish compliance programs. These entities will be required to comply with the proposed regulations. Although some local government entities expressed concern with the requirement to have a compliance program, there are no reasonable alternatives to this rulemaking, as the statutorily required providers include certain Medicaid providers that are part of local governments. Additional providers that are included in the regulation but which were not mandated by statute have a sufficiently high billing threshold that failing to require a compliance program would not be a responsible fiscal management expectation. Local government did not suggest any alternatives to having these entities be included in a mandatory compliance program in order to effectuate compliance. The requirement that certain medical assistance providers prepare and adopt compliance programs is established by statute in SSL section 363-d (2).

The benefits associated with implementation of a compliance program far outweigh any adverse economic impact. An effective compliance program will assist a provider in preventing inappropriate payments and avoiding costs, such as reimbursements, penalties, and other adverse consequences that might otherwise be incurred due to violations. The compliance program requirement will also help to ensure: that Medicaid funds are used properly and that payments are made only for legitimate claims; that providers systematically identify, report, and return overpayments; that medical care, services, and supplies provided meet required standards of care; that individuals can report unacceptable practices, such as fraud, directly and safely; and that providers establish accountability in governance structures. As was noted by the Legislature in the bill memorandum in support of the new SSL 363-d, this rulemaking is part of an initiative that will "achieve substantial savings for taxpayers and preserve quality health care for the state's Medicaid recipients."

The federal government has developed and issued model compliance programs for many types of providers such as hospitals, nursing facilities, managed care programs, pharmaceutical manufacturers and the ambulance industry³. The OMIG is in the process of creating compliance guidance for various types of providers which will be posted on the OMIG's website when completed. The DOH may also issue advisory opinions on appropri-

ate standards of compliance once this regulation has been promulgated. Local government entities as well as all affected providers required to comply with this regulation can utilize those guidelines and advisory opinions when developing an effective compliance program pursuant to this regulation.

Although there are no mandatory federal standards or requirements for compliance programs for medical assistance providers, the federal government has issued guidance for many types of providers interested in voluntary compliance programs. The DOH also issues advisory opinions on appropriate standards of compliance. Local government entities required to comply with this regulation can utilize those guidelines and advisory opinions when developing an effective compliance program pursuant to this regulation.

7. Small business and local government participation:

OMIG has posted information on its website concerning "Mandatory Provider Compliance Programs," including a synopsis of SSL section 363-d. The website also indicates that OMIG will be proposing regulations on this issue in the near future.

A copy of this Notice of Proposed Rulemaking will be posted on OMIG's website and also published in the Medicaid Update. These notices will invite comments on the proposal during the public comment period for this rulemaking. The notices will also include instructions for those interested in submitting comments.

OMIG also invited comments from various small business groups and representatives from local governments at an advisory meeting for this regulation held on April 23, 2008. During the advisory meeting, the New York State Association of Counties expressed opposition to this regulation but was advised by OMIG that adoption of a satisfactory compliance program is statutorily required by Social Services Law (SSL) section 363-d and that this regulation is a direct result of that statute.

¹ 18 NYCRR 504.11(a)(3) requires Medicaid providers who bill more than \$500,000.00 a year to furnish financial security.

² Summary of Providers by total yearly billings for 2006 and 2007 calendar years.

³ For a complete list of voluntary Federal compliance guidance and resource materials see www.oig.hhs.gov/fraud/complianceguidance.html

Rural Area Flexibility Analysis

1. Types and estimated numbers of rural areas:

This rulemaking implements Social Services Law (SSL) section 363-d and applies to certain Medicaid providers. Both SSL section 363-d and the proposed regulations apply uniformly throughout the State, including all rural areas of the State.

2. Reporting, recordkeeping and other compliance requirements; and professional services:

Any public or private entities in rural areas that are subject to the proposed regulations will be required to develop and implement a compliance program in accordance with the eight specific elements listed in the proposed regulations. For example, each required provider will need to have in place: "written policies and procedures that describe compliance expectations as embodied in a code of conduct or code of ethics, implement the operation of the compliance program, provide guidance to employees and others on dealing with potential compliance issues, identify how to communicate compliance issues to appropriate compliance personnel and describe how potential compliance problems are investigated and resolved." SSL § 363-d(2)(a). Depending on what control measures a provider has already instituted, additional action may be necessary for a provider to meet the remaining seven elements of a Medicaid provider compliance program.

No affirmative acts will likely be required for a provider if that provider already has an established compliance program that satisfies the elements contained in the proposed regulations.

Professional services are not likely to be required to comply with the reporting, record keeping, and other requirements of this rule.

3. Costs:

This rulemaking clarifies the types of providers, including those in rural areas, that are subject to the compliance program requirement and must incur costs, if any, associated with such a program. Therefore, the costs incurred by these providers, including those in rural areas, are a direct result of that statute and not this rulemaking. SSL section 363-d directs OMIG to adopt regulations that establish which providers are subject to the compliance program requirements. In particular, OMIG's regulations must address providers for which the medical assistance program constitutes "a substantial portion" of the provider's business.

The costs incurred by regulated parties in order to comply with the proposed rulemaking will vary depending upon any existing control measures the provider has in place at the time the regulation takes effect. For those providers who already have an operating compliance program,

such as those who have a program as a result of their participation in Medicare, there may be little or no costs incurred in order to satisfy the proposed regulations. However, there will be some costs for those providers who do not have a program in place that meets the requirements set forth in this proposed rulemaking. The extent of those costs will depend on the level of effort that is necessary for the provider to establish a compliance program that satisfies each of the eight mandatory elements. Those elements are listed and described in both the proposed regulations and SSL section 363-d.

The costs will also vary depending upon the size and other specific attributes of the provider. SSL section 363-d states that a provider's compliance plan should reflect the provider's size, complexity, resources, and culture. Thus, a large, complex provider may incur more costs in implementing an appropriate compliance plan than a smaller provider might incur.

The proposed rulemaking will not impose costs on local governments in general, but local government entities in rural areas that fall within the definition of a "required provider" as set forth in the proposed regulations, including school districts, will be required to implement a compliance program. The cost analysis would be the same as the discussion above for "regulated parties." The cost savings discussed above for regulated parties would apply to local government providers as well.

In assessing the costs that may be incurred by a provider when it establishes a compliance program, pursuant to SSL section 363-d and the proposed regulations, OMIG also considered the cost savings that could result from the implementation of an effective compliance program. OMIG staff reviewed existing literature and studies for information concerning the issue of costs associated with compliance programs. During that research, only one report was identified: Impact of a Compliance Program for Billing on Internal Medicine Faculty's Documentation Practices and Productivity, ACADEMIC SCIENCE (March 2001). The results of this study, which focused on the implementation of a compliance program by the Saint Louis University Medical Group (UMG), suggest that compliance programs may provide certain financial benefits to the provider. For example, in the study of UMG, the gross collection rate for all services increased, staff productivity increased, unbillable services decreased, and the financial risks associated with an adverse audit decreased. These cost savings should diminish, if not completely offset, any costs incurred by providers in the development and implementation of a compliance program.

4. Minimizing adverse impact:

SSL section 363-d states in part: "The legislature . . . recognizes the wide variety of provider types in the medical assistance program and the need for compliance programs that reflect a provider's size, complexity, resources, and culture. For a compliance program to be effective, it must be designed to be compatible with the provider's characteristics."

While each required provider will need to develop a compliance program that adequately addresses each of the eight elements listed in the proposed regulations and SSL section 363-d, OMIG will give due consideration and attention to the concerns noted by the Legislature and review compliance programs for appropriateness consistent with the provider's characteristics.

5. Rural area participation:

OMIG has posted information on its website concerning "Mandatory Provider Compliance Programs," including a synopsis of SSL section 363-d. The website also indicates that OMIG would be proposing regulations on this issue in the near future.

A copy of this Notice of Proposed Rulemaking will be posted on OMIG's website and also published in the Medicaid Update. These notices will invite comments on the proposal during the public comment period for this rulemaking. The notices will also include instructions for anyone interested in submitting comments, including public and private entities in rural areas.

Job Impact Statement

The Office of the Medicaid Inspector General (OMIG) has determined that this rule will not have a substantial adverse impact on jobs or employment opportunities. Therefore, a job impact statement is not required.

The Legislature has determined that medical assistance providers should be required to develop and implement compliance programs in order to reduce errors and fraud in Medicaid billing. Social Services Law (SSL) section 363-d (4) directs the Medicaid Inspector General to adopt regulations, in consultation with the Department of Health, that establish and specify the types of providers which will be subject to the compliance program requirements. This rulemaking is necessary in order for the Medicaid Inspector General to comply with the statutory directive in SSL section 363-d (4). This rulemaking will also ensure that the regulated community is given appropriate notice as to which providers must produce and implement a compliance program.

This rulemaking is part of an overall effort by New York State to enhance the integrity of its Medicaid program. The compliance program

requirement will help to ensure that Medicaid funds are used properly and that payments are made only for legitimate claims. As was noted by the Legislature in the bill memorandum in support of the new SSL 363-d, this rulemaking is part of an initiative that will “achieve substantial savings for taxpayers and preserve quality health care for the state’s Medicaid recipients.”

Although this rulemaking will require providers that are subject to the proposed regulation to develop guidelines for employee training and education and designate an employee with the responsibility of overseeing the compliance program, those providers may also realize benefits associated with implementation of a compliance program. An effective compliance program will assist a provider in preventing inappropriate payments and avoiding costs; reimbursements, penalties, and other adverse consequences that might otherwise be incurred due to violations.

The costs incurred by regulated parties in order to comply with the proposed rulemaking will vary depending upon any existing control measures the provider has in place at the time the regulation takes effect. For those providers who already have an operating compliance program, such as those who have a program as a result of their participation in Medicare, potentially little or no costs may be incurred in order to certify that a program is in place that satisfies the proposed regulations. However, for those providers who do not have a program in place that meets the requirements set forth in this proposed rulemaking, some costs will be incurred in order to achieve compliance. The extent of those costs will depend on the level of effort that is necessary for the provider to establish a compliance program that satisfies each of the eight mandatory elements. Those elements are listed and described in both the proposed regulations and SSL section 363-d.

The requirement that certain medical assistance providers prepare and adopt compliance programs is established by statute in SSL section 363-d (2). Therefore, any adverse impact on jobs or employment opportunities that may be incurred by these providers would be a direct result of that statute and not this rulemaking. However, SSL section 363-d also directs OMIG to adopt regulations that establish which providers are subject to the compliance program requirements. In particular, OMIG’s regulations must address providers for which the medical assistance program constitutes “a substantial portion” of the provider’s business. This rulemaking clarifies the types of providers that are subject to the compliance program requirement and must therefore incur costs, if any, associated with such a program.

In assessing the adverse impact on jobs or employment opportunities incurred by a provider when it establishes a compliance program pursuant to SSL § 363-d and the proposed regulations, due consideration should be given to the cost savings that may result from the implementation of an effective compliance program. In preparing this proposed rulemaking, OMIG staff looked for existing literature and studies on the issue of costs associated with compliance programs. Only one report was identified: *Impact of a Compliance Program for Billing on Internal Medicine Faculty’s Documentation Practices and Productivity*, ACADEMIC SCIENCE (March 2001). The results of this study, which focused on the implementation of a compliance program by the Saint Louis University Medical Group (UMG), suggest that compliance programs may provide certain financial benefits to the provider. For example, in the study of UMG, the gross collection rate for all services increased, staff productivity increased, unbillable services decreased, and the financial risks associated with an adverse audit decreased. These cost savings should diminish, if not completely offset, any costs incurred by providers or adverse impacts on jobs or employment opportunities in the development and implementation of a compliance program.

It is anticipated that the total impact on jobs and employment opportunities associated with establishing a provider compliance program will be relatively modest, particularly for providers who already have a full or partial program in place. For those providers who do not yet have an established program, the cost savings associated with such a program will help to offset the expense of implementing the program.

Therefore, the statutorily required compliance program for certain Medicaid providers, as implemented by this rulemaking, should not have a substantial adverse impact on jobs and employment opportunities.

Office of Mental Health

EMERGENCY RULE MAKING

Comprehensive Outpatient Programs

I.D. No. OMH-02-09-00003-E

Filing No. 1356

Filing Date: 2008-12-29

Effective Date: 2008-12-29

PURSUANT TO THE PROVISIONS OF THE State Administrative Procedure Act, NOTICE is hereby given of the following action:

Action taken: Amendment of Part 592 of Title 14 NYCRR.

Statutory authority: Mental Hygiene Law, sections 7.09, 31.04, 43.02; Social Services Law, sections 364 and 364-a

Finding of necessity for emergency rule: Preservation of general welfare.

Specific reasons underlying the finding of necessity: The amendments are the result of the enacted State Budget and the Financial Management Plan.

Subject: Comprehensive Outpatient Programs.

Purpose: To adjust the Medicaid reimbursement associated with certain outpatient treatment programs regulated by OMH.

Text of emergency rule: 1. Subdivisions (c), (d), and (k) are amended and a new subdivision (l) is added to section 592.8 of Title 14 NYCRR as follows:

(c) The supplemental rate, for providers with at least one Level I comprehensive outpatient program, shall be calculated as follows:

(1) For outpatient mental health programs *other than clinics* which are designated Level I providers pursuant to this Part, grants received for the local fiscal year ended in 2001 for upstate and Long Island based providers, and for the local fiscal year ended in 2001 for New York City based providers, *as well as grants received for subsequent fiscal years which have been identified for inclusion by the Office of Mental Health* shall be added, if applicable, to the annualized eligible deficit approved in the calculation of the previous supplemental rate. *Effective January 1, 2009, the amount of the grant funding utilized in calculation of the rate supplement shall be reduced as follows:*

(i) *if the rate supplement effective immediately prior to January 1, 2009 is less than \$100 per visit, no reduction to the grant funding used in the rate calculation will be made;*

(ii) *if the rate supplement immediately prior to January 1, 2009 is greater than or equal to \$100 but less than \$250, a reduction of 3 percent shall be made to the grant funding used in the rate calculation, provided, however, that the resultant rate calculated effective January 1, 2009 in accordance with paragraph (3) of this subdivision shall not result in a rate lower than the highest rate for the providers described in subparagraph (i) of this paragraph;*

(iii) *if the rate supplement immediately prior to January 1, 2009 is greater than or equal to \$250 but less than \$300, a reduction of 5 percent shall be made to the grant funding used in the rate calculation, provided, however, that the resultant rate calculated effective January 1, 2009 in accordance with paragraph (3) of this subdivision shall not result in a rate lower than the highest rate for the providers described in subparagraph (ii) of this paragraph;*

(iv) *if the rate supplement immediately prior to January 1, 2009 is greater than or equal to \$300, a reduction shall be made to the grant funding used in the rate calculation that is the greater of 10 percent of the grant funding or an amount necessary to reduce the rate supplement to \$300, provided, however, that the resultant rate calculated effective January 1, 2009 in accordance with paragraph (3) of this subdivision shall not result in a rate lower than the highest rate for the providers described in subparagraph (iii) of this paragraph;*

(2) *For clinic treatment programs which are designated Level I programs pursuant to this Part, grants received for the local fiscal year ended in 2001 for upstate and Long Island based providers, and for the local fiscal year ended in 2001 for New York City based providers, as well as grants received for subsequent fiscal years which have been identified for inclusion by the Office of Mental Health shall be added, if applicable, to the annualized eligible deficit approved in the calculation of the previous supplemental rate. Effective January 1, 2009, the amount of the grant funding utilized in calculation of the rate supplement shall be reduced as follows:*

(i) if the rate supplement effective immediately prior to January 1, 2009 is less than \$100 per visit, no reduction to the grant funding used in the rate calculation will be made;

(ii) if the rate supplement immediately prior to January 1, 2009 is greater than or equal to \$100 but less than \$250, a reduction of 3 percent shall be made to the grant funding used in the rate calculation, provided, however, that the resultant rate calculated effective January 1, 2009 in accordance with paragraph (3) of this subdivision shall not result in a rate lower than the highest rate for the providers described in subparagraph (i) of this paragraph;

(iii) if the rate supplement immediately prior to January 1, 2009 is greater than or equal to \$250 but less than \$300, a reduction of 5 percent shall be made to the grant funding used in the rate calculation, provided, however, that the resultant rate calculated effective January 1, 2009 in accordance with paragraph (3) of this subdivision shall not result in a rate lower than the highest rate for the providers described in subparagraph (ii) of this paragraph;

(iv) if the rate supplement immediately prior to January 1, 2009 is greater than or equal to \$300, a reduction shall be made to the grant funding used in the rate calculation that is the greater of 10 percent of the grant funding or an amount necessary to reduce the rate supplement to \$300, provided, however, that the resultant rate calculated effective January 1, 2009 in accordance with paragraph (3) of this subdivision shall not result in a rate lower than the highest rate for the providers described in subparagraph (iii) of this paragraph.

(3) The sum of grants received by the provider, as recalculated under paragraph (1) or (2) of this subdivision as applicable, shall be divided by the projected number of annual visits to the provider's designated programs. The projected number of annual visits shall be calculated as follows:

(i) For outpatient programs other than clinic treatment programs, the [The] combined total of outpatient mental health program visits reimbursed by medical assistance for each provider shall be calculated by using the average number of visits provided in the most recent three fiscal years multiplied by 90.9 percent. These visits shall include all visits reimbursed by Medicaid, including visits partially reimbursed by Medicare. Providers, who in the three most recent fiscal years earned less than the full Medicaid supplemental rate on visits partially reimbursed by Medicare, shall have the projected number of annual visits adjusted to reflect the lower supplemental revenue earned on Medicare/Medicaid dually eligible visits. The calculation of the Medicare/Medicaid adjusted visits shall be based on the percentage of Medicaid supplemental payments earned on Medicare/Medicaid dually eligible visits provided during the three most recent fiscal years and the number of dually eligible visits provided in the three most recent fiscal years. The Medicare/Medicaid adjusted visits are calculated by multiplying the projected annual volume of dually eligible visits by the average percentage of Medicaid supplemental revenue earned on these visits during the three most recent fiscal years.

(ii) For clinic treatment programs, the combined total of outpatient mental health program visits reimbursed by medical assistance for each provider shall be calculated by using the average number of visits provided in the most recent three fiscal years multiplied by 90.9 percent, for rates effective prior to July 1, 2008. For rates effective July 1, 2008 and January 1, 2009, the higher of the number of paid visits from calendar year 2007 or the average number of paid visits provided in the calendar years 2005 - 2007, multiplied by 90.9 percent, shall be used. These visits shall include all visits reimbursed by Medicaid, including visits partially reimbursed by Medicare, and those for which payment has been made or approved by a Medicaid managed care organization. Providers, who in the three most recent fiscal years earned less than the full Medicaid supplemental rate on visits partially reimbursed by Medicare, shall have the projected number of annual visits adjusted to reflect the lower supplemental revenue earned on Medicare/Medicaid dually eligible visits. The calculation of the Medicare/Medicaid adjusted visits shall be based on the percentage of Medicaid supplemental payments earned on Medicare/Medicaid dually eligible visits provided during the three most recent fiscal years and the number of dually eligible visits provided in the three most recent fiscal years. The Medicare/Medicaid adjusted visits are calculated by multiplying the projected annual volume of dually eligible visits by the average percentage of Medicaid supplemental revenue earned on these visits during the three most recent fiscal years.

(iii) Rates calculated pursuant to [subparagraph] subparagraphs (i) or (ii) of this paragraph are subject to appeal by the local governmental unit, or by the provider with the approval of the local governmental unit. Appeals pursuant to this paragraph shall be made within [one year] 120 days after receipt of initial notification of the most recent supplemental reimbursement rate calculation. However, under no circumstances may the recalculated rate be higher than the rate cap set forth in paragraph [(3)] (4) of this subdivision.

[(3)](4) The supplemental rate for a provider operating a licensed

outpatient mental health program shall be the lesser of the rate calculated in paragraph [(2)] (3) of this subdivision or a rate cap as established by the Commissioner of Mental Health and approved by the Director of the Division of the Budget. Effective January 1, 2009, the rate cap that shall be used in the calculation of the supplemental rate shall be \$300.00 per visit.

(d) Excess supplemental payments shall be recouped as follows:

(1) For outpatient programs other than clinic treatment programs, in [In] order to recoup supplemental payments for those visits in excess of 110 percent of the number of visits used to calculate the supplemental rate for a Level I provider, the Office of Mental Health may adjust the supplemental rates for the period in which the excess visits occurred. Such adjustments shall be made no more frequently than quarterly during the year. The Office of Mental Health may recover such funds by requesting that the Department of Health withhold such funds from future Medicaid payments to the provider.

(2) For clinic treatment programs, in order to recoup supplemental payments for those visits provided prior to July 1, 2008 in excess of 110 percent of the number of visits used to calculate the supplemental rate for a Level I program, the Office of Mental Health may adjust the supplemental rates for the period in which the excess visits occurred. Such adjustments shall be made no more frequently than quarterly during the year. The Office of Mental Health may recover such funds by requesting that the Department of Health withhold such funds from future Medicaid payments to the provider. For services provided July 1, 2008, and thereafter, the Office of Mental Health will no longer recover supplemental payments in excess of 110 percent of the number of visits used to calculate the supplemental rate of a Level I provider.

(k) When a clinic treatment provider opens a new clinic program location, the supplemental rate shall be re-calculated to include the volume of Medicaid visits projected for the location in the provider's approved Application for Prior Approval Review. The funding used in calculation of the supplemental rate shall be increased by the amount calculated by multiplying the increased volume of Medicaid visits from the approved Application for Prior Approval Review by the Level II COPS supplement for the applicable program/region.

(l) Each general hospital, as defined by article 28 of the Public Health Law, which is operated by the New York City Health and Hospitals Corporation, which received a grant pursuant to section 41.47 of the Mental Hygiene Law for the local fiscal year ending in 1989, shall be designated as a Level I comprehensive outpatient program for all outpatient programs licensed pursuant to Part 587 of this Title. For purposes of calculating supplemental Medicaid rates pursuant to this Part, all such programs in the New York City Health and Hospitals Corporation are combined for a uniform supplemental Medical Assistance program rate.

2. Subdivision (b) is amended and a new subdivision (c) is added to section 592.10 of Title 14 NYCRR as follows:

(b) In order to recoup supplemental payments for those visits in excess of the number of visits used to calculate the supplemental rate under this section, the Office of Mental Health may adjust the supplemental rates for the period in which the excess visits occurred. Such adjustments shall be made no more frequently than quarterly during the year. Effective with all services rendered July 1, 2008 and thereafter, no such recoupment of supplemental payments to clinic treatment programs shall be made.

(c) Any program eligible to receive supplemental medical assistance reimbursement as a Level II Comprehensive Outpatient Program which fails at any time to meet the requirements set forth in this section shall have its supplemental medical assistance payments suspended until such time as the program substantially meets such requirements, as determined by the Commissioner. For purposes of this subdivision, a program which has failed to receive a renewed operating certificate of at least six months duration may be deemed to have met such requirement if it has submitted a plan of corrective action that has been approved by the Commissioner or his/her designee; has been visited to verify implementation of such plan; and has been issued an operating certificate of at least six months in duration.

This notice is intended to serve only as a notice of emergency adoption. This agency intends to adopt this emergency rule as a permanent rule and will publish a notice of proposed rule making in the *State Register* at some future date. The emergency rule will expire March 28, 2009.

Text of rule and any required statements and analyses may be obtained from: Joyce Donohue, NYS Office of Mental Health, 44 Holland Avenue, Albany, NY 12229, (518) 474-1331, email: cocbjdd@omh.state.ny.us

Regulatory Impact Statement

1. Statutory Authority: Subdivision (b) of Section 7.09 of the Mental Hygiene Law grants the Commissioner of the Office of Mental Health the authority and responsibility to adopt regulations that are necessary and proper to implement matters under his or her jurisdiction.

Subdivision (a) of Section 31.04 of the Mental Hygiene Law empowers

the Commissioner to issue regulations setting standards for licensed programs for the provision of services for persons with mental illness.

Subdivision (a) of Section 43.02 of the Mental Hygiene Law grants the Commissioner the power to set rates for facilities licensed under Article 31 of the Mental Hygiene Law.

Sections 364 and 364-a of the Social Services Law give the Office of Mental Health responsibility for establishing and maintaining standards for care and services eligible for Medicaid reimbursement in facilities under its jurisdiction, in accordance with cooperative arrangements with the Department of Health.

Chapter 54 of the Laws of 2008 provides adjusted funding appropriations in support of amendments to Part 592. (Section 1, State Agencies, Office of Mental Health, lines 18-29 on page 393, lines 46-50 on page 403, and lines 1-7 on page 404.)

2. **Legislative Objectives:** Articles 7 and 31 of the Mental Hygiene Law reflect the Commissioner's authority to establish regulations regarding mental health programs. The amendments to Part 592 adjust the Medicaid reimbursement associated with certain outpatient treatment programs regulated by the Office of Mental Health (OMH) consistent with the enacted 2008-2009 state budget. These changes will be targeted in such a way as to provide general fiscal relief to providers most in need, as well as improve the quality and availability of services, all while recognizing the serious fiscal condition of the State. They will also equalize reimbursement fees for clinic treatment within geographic areas, as approved by the Division of Budget.

3. **Needs and Benefits:** The enacted state budget for State Fiscal Year 2008-2009 provided for an approximately \$5 million increase for clinic treatment programs in State share of Medicaid (\$10 million gross Medicaid funds) through adjustments to the Medicaid fee supplements calculated in accordance with Part 592. This funding would have had a full annual value of \$10 million in State share of Medicaid (\$20 million in gross Medicaid funds) but was adjusted to reduce the highest rate supplements. This resulted in an increase of \$4.48 million State share of Medicaid funds, with a full annual value of \$7.92 million State share of Medicaid funds (\$15.84 million in gross Medicaid funds). Clinic treatment programs provide outpatient treatment designed to reduce symptoms, improve functioning and provide ongoing support to adults and children admitted to the program with a diagnosis of a designated mental illness. This rulemaking includes provisions to increase certain programs to a minimum payment level and removes the requirement to recover monies generated by paid visits in excess of 110 percent of the visits used to calculate the rate supplement effective July 1, 2008. As a result of other actions proposed in the Financial Management Plan, there will be reductions made to the highest rate supplements. Providers with current rate supplements above \$300 will have the funding used in the supplement calculation reduced by 10 percent; providers with rate supplements of \$250-\$300 will have the funding used in the supplement calculation reduced by 5 percent; and providers with rate supplements of \$100-\$250 will have the funding used in the supplement calculation reduced by 3 percent. OMH's intent in these proposals is to begin to move the reimbursement for mental health clinic services toward a more uniform reimbursement system, by raising the reimbursement amounts for the lowest paid providers and lowering the reimbursement amounts for the providers with the highest rates.

4. **Costs:**

a) **Costs to regulated parties:** The reduction of funding used in the calculation of the rate supplements will impact approximately one third of the programs currently receiving such a supplement. The impact of these reductions totals \$4.16 million in gross Medicaid funds for the providers impacted by the reductions.

b) **Costs to State and Local government and the agency:** Medicaid services typically involve both a State and County share in matching the Federal portion. The annual State share of these outpatient initiatives is \$7.92 million, with no impact to local governments, after netting the increase to provide general fiscal relief to providers most in need, with reductions to those providers with the highest rate supplements. The increase is being implemented after the local share Medicaid cap is already in place. (The local share Medicaid cap was an initiative included in the enacted State budget for 2005-2006, under which the state pays for increases in the local share of Medicaid after January 1, 2006.) The proposed changes to increase certain programs to a minimum payment level and remove the requirement to recover monies generated by paid visits in excess of 110 percent of the visits used to calculate the rate supplement were implemented effective July 1, 2008. The proposed changes to reduce the funding used in the calculation of the rate supplements for the providers with the highest supplement rates shall be effective January 1, 2009.

5. **Local Government Mandates:** These regulatory amendments will not involve or result in any additional imposition of duties or responsibilities upon county, city, town, village, school or fire districts.

6. **Paperwork:** This rule should not substantially increase the paperwork requirements of affected providers.

7. **Duplication:** These regulatory amendments do not duplicate existing State or federal requirements.

8. **Alternatives:** The application of the increased funding for certain outpatient programs consistent with the 2008-2009 enacted State budget resulted in increases for certain clinic treatment programs, and allows clinic treatment programs to retain additional Medicaid rate supplement payments, should they increase the number of services they provide. The determination of the methodology to implement the supplement changes and the decision to allow clinic treatment programs to retain additional Medicaid rate supplement payments were made in consultation with the New York State Division of Budget, to be consistent with the enacted state budget. This allows for the continued strengthening and expansion of the ambulatory mental health system and supports a movement away from more expensive modalities of treatment. Two Emergency rulemakings were adopted since July 1, 2008, to affect these changes, with the goal of providing fiscal relief to needed providers. However, to address the serious fiscal condition of New York State, the Special Session of the Legislature included reductions in rate payments. Therefore, it is now necessary to affect reductions in the aforementioned emergency rulemakings. The only alternative would have been to not promulgate emergency rulemakings allowing for certain increases to providers in need, thereby enabling no fiscal relief to those providers. Therefore, that alternative was not considered.

9. **Federal Standards:** The regulatory amendments do not exceed any minimum standards of the federal government for the same or similar subject areas.

10. **Compliance Schedule:** This rulemaking is effective upon adoption.

Regulatory Flexibility Analysis

The proposed rule will adjust the Medicaid reimbursement associated with certain outpatient treatment programs regulated by the Office of Mental Health. These changes are consistent with the 2008-09 enacted State budget. The changes are targeted in such a way as to provide general fiscal relief to providers most in need and improve the quality and availability of services, all while recognizing the serious fiscal condition of the State. The amendments equalize reimbursement fees for clinic treatment within geographic areas, as approved by the Division of Budget, and allow for movement toward establishing a more uniform reimbursement system by raising the reimbursements amounts for the lowest paid providers and lowering the reimbursement amounts for providers with the highest rates. There will be no adverse economic impact on small businesses or local governments, therefore, a regulatory flexibility analysis is not submitted with this notice.

Rural Area Flexibility Analysis

A Rural Area Flexibility Analysis is not submitted with this notice because the proposed rule, which serves to adjust Medicaid reimbursement associated with certain outpatient treatment providers, will not impose any adverse economic impact on rural areas. These changes are consistent with the 2008-09 enacted State budget. The changes are targeted in such a way as to provide general fiscal relief to providers most in need and improve the quality and availability of services, all while recognizing the serious fiscal condition of the State. The amendments equalize reimbursement fees for clinic treatment within geographic areas, as approved by the Division of Budget, and allow for movement toward establishing a more uniform reimbursement system by raising the reimbursements amounts for the lowest paid providers and lowering the reimbursement amounts for providers with the highest rates.

Job Impact Statement

A Job Impact Statement is not submitted with this notice because the proposed regulation adjusts the Medicaid reimbursement associated with certain outpatient treatment programs regulated by the Office of Mental Health. These changes are consistent with the 2008-09 enacted State budget. There will be no adverse impact on jobs and employment opportunities.

Public Service Commission

PROPOSED RULE MAKING HEARING(S) SCHEDULED

To Provide the Commission a Forum in Which to Consider the Disposition of the Tax Refund

I.D. No. PSC-02-09-00013-P

PURSUANT TO THE PROVISIONS OF THE State Administrative Procedure Act, NOTICE is hereby given of the following proposed rule:

Proposed Action: The Commission is considering a proposal by Long Island Water Corporation to allocate, between customers and shareholders, a \$3,421,367.50 property tax refund from Nassau County.

Statutory authority: Public Service Law, section 113(2)

Subject: To provide the Commission a forum in which to consider the disposition of the tax refund.

Purpose: To consider whether the tax refund should be allocated, in whole or part, to customers.

Public hearing(s) will be held at: 10:00 a.m., March 3, 2009* at Department of Public Service, Three Empire State Plaza, 3rd. Fl., Hearing Rm., Albany, NY.

* On occasion there are requests to reschedule or postpone evidentiary hearing dates. If such a request is granted, notification of any subsequent scheduling changes will be available at the DPS Web Site (www.dps.state.ny.us) under Case 08-W-1251.

Interpreter Service: Interpreter services will be made available to hearing impaired persons, at no charge, upon written request submitted within reasonable time prior to the scheduled public hearing. The written request must be addressed to the agency representative designated in the paragraph below.

Accessibility: All public hearings have been scheduled at places reasonably accessible to persons with a mobility impairment.

Substance of proposed rule: The Public Service Commission is considering whether to approve or reject, in whole or part, the petition of Long Island Water Corporation d/b/a Long Island American Water, pursuant to Public Service Law Section 113(2), for approval of a proposed allocation of a \$3,421,367.50 property tax refund from Nassau County.

Text of proposed rule and any required statements and analyses may be obtained by filing a Document Request Form (F-96) located on our website <http://www.dps.state.ny.us/f96dir.htm>. For questions, contact: Leann Ayer, Public Service Commission, 3 Empire State Plaza, Albany, New York 12223-1350, (518) 486-2655, email: leann_ayer@dps.state.ny.us

Data, views or arguments may be submitted to: Jaclyn A. Brillling, Secretary, Public Service Commission, 3 Empire State Plaza, Albany, New York 12223-1350, (518) 474-6530, email: jaclyn_brillling@dps.state.ny.us

Public comment will be received until: 45 days after publication of this notice.

Regulatory Impact Statement, Regulatory Flexibility Analysis, Rural Area Flexibility Analysis and Job Impact Statement

Statements and analyses are not submitted with this notice because the proposed rule is within the definition contained in section 102(2)(a)(ii) of the State Administrative Procedure Act.

(08-W-1251SA1)

PROPOSED RULE MAKING NO HEARING(S) SCHEDULED

Interconnection of the Networks between Frontier Ogden Tele. Co. and MCImetro for Local Exchange Service and Exchange Access

I.D. No. PSC-02-09-00006-P

PURSUANT TO THE PROVISIONS OF THE State Administrative Procedure Act, NOTICE is hereby given of the following proposed rule:

Proposed Action: The Public Service Commission is considering whether to approve or reject, in whole or in part, a proposal filed by Frontier Ogden

Tele. Co. and MCImetro Access Transmission for approval of a Mutual Traffic Exchange Agreement executed on Sept. 3, 2008.

Statutory authority: Public Service Law, section 94(2)

Subject: Interconnection of the networks between Frontier Ogden Tele. Co. and MCImetro for local exchange service and exchange access.

Purpose: To review the terms and conditions of the negotiated agreement between Frontier Ogden Tele. Co. and MCImetro.

Substance of proposed rule: Ogden Telephone Company d/b/a Frontier Ogden Telephone Company, LLC and MCImetro Access Transmission Services, LLC have reached a negotiated agreement whereby Ogden Telephone Company d/b/a Frontier Ogden Telephone Company, LLC and MCImetro Access Transmission Services, LLC will interconnect their networks at mutually agreed upon points of interconnection to exchange local traffic.

Text of proposed rule and any required statements and analyses may be obtained by filing a Document Request Form (F-96) located on our website <http://www.dps.state.ny.us/f96dir.htm>. For questions, contact: Leann Ayer, Public Service Commission, 3 Empire State Plaza, Albany, New York 12223-1350, (518) 486-2655, email: leann_ayer@dps.state.ny.us

Data, views or arguments may be submitted to: Jaclyn A. Brillling, Secretary, Public Service Commission, 3 Empire State Plaza, Albany, New York 12223-1350, (518) 474-6530, email: jaclyn_brillling@dps.state.ny.us

Public comment will be received until: 45 days after publication of this notice.

Regulatory Impact Statement, Regulatory Flexibility Analysis, Rural Area Flexibility Analysis and Job Impact Statement

Statements and analyses are not submitted with this notice because the proposed rule is within the definition contained in section 102(2)(a)(ii) of the State Administrative Procedure Act.

(08-C-1428SA1)

PROPOSED RULE MAKING NO HEARING(S) SCHEDULED

Interconnection of the Networks between Frontier and MCImetro Access for Local Exchange Service and Exchange Access

I.D. No. PSC-02-09-00007-P

PURSUANT TO THE PROVISIONS OF THE State Administrative Procedure Act, NOTICE is hereby given of the following proposed rule:

Proposed Action: The Public Service Commission is considering whether to approve or reject, in whole or in part, a proposal filed by Frontier Comm. of Seneca—Gorham and MCImetro Access for approval of a Mutual Traffic Exchange Agreement executed on Sept. 3, 2008.

Statutory authority: Public Service Law, section 94(2)

Subject: Interconnection of the networks between Frontier and MCImetro Access for local exchange service and exchange access.

Purpose: To review the terms and conditions of the negotiated agreement between Frontier and MCImetro Access.

Substance of proposed rule: Frontier Communications of Seneca-Gorham, Inc. and MCImetro Access Transmission Services, LLC have reached a negotiated agreement whereby Frontier Communications of Seneca-Gorham, Inc. and MCImetro Access Transmission Services, LLC will interconnect their networks at mutually agreed upon points of interconnection to exchange local traffic.

Text of proposed rule and any required statements and analyses may be obtained by filing a Document Request Form (F-96) located on our website <http://www.dps.state.ny.us/f96dir.htm>. For questions, contact: Leann Ayer, Public Service Commission, 3 Empire State Plaza, Albany, New York 12223-1350, (518) 486-2655, email: leann_ayer@dps.state.ny.us

Data, views or arguments may be submitted to: Jaclyn A. Brillling, Secretary, Public Service Commission, 3 Empire State Plaza, Albany, New York 12223-1350, (518) 474-6530, email: jaclyn_brillling@dps.state.ny.us

Public comment will be received until: 45 days after publication of this notice.

Regulatory Impact Statement, Regulatory Flexibility Analysis, Rural Area Flexibility Analysis and Job Impact Statement

Statements and analyses are not submitted with this notice because the proposed rule is within the definition contained in section 102(2)(a)(ii) of the State Administrative Procedure Act.

(08-C-1429SA1)

**PROPOSED RULE MAKING
NO HEARING(S) SCHEDULED**

Intercarrier Agreement to Interconnect Telephone Networks for the Provisioning of Local Exchange Service

I.D. No. PSC-02-09-00008-P

PURSUANT TO THE PROVISIONS OF THE State Administrative Procedure Act, NOTICE is hereby given of the following proposed rule:

Proposed Action: The Public Service Commission is considering whether to approve or reject, in whole or in part, a modification filed by Verizon New York Inc. and Neutral Tandem—New York, LLC to revise the interconnection agreement effective on July 1, 2008.

Statutory authority: Public Service Law, section 94(2)

Subject: Intercarrier agreement to interconnect telephone networks for the provisioning of local exchange service.

Purpose: To amend the Verizon New York Inc. and Neutral Tandem—New York, LLC interconnection agreement.

Substance of proposed rule: Verizon New York Inc. and Neutral Tandem—New York, LLC have reached a negotiated agreement whereby Verizon New York Inc. and Neutral Tandem—New York, LLC will interconnect their networks at mutually agreed upon points of interconnection to exchange local traffic.

Text of proposed rule and any required statements and analyses may be obtained by filing a Document Request Form (F-96) located on our website <http://www.dps.state.ny.us/f96dir.htm>. For questions, contact: Leann Ayer, Public Service Commission, 3 Empire State Plaza, Albany, New York 12223-1350, (518) 486-2655, email: leann_ayer@dps.state.ny.us

Data, views or arguments may be submitted to: Jaclyn A. Brillling, Secretary, Public Service Commission, 3 Empire State Plaza, Albany, New York 12223-1350, (518) 474-6530, email: jaclyn_brillling@dps.state.ny.us

Public comment will be received until: 45 days after publication of this notice.

Regulatory Impact Statement, Regulatory Flexibility Analysis, Rural Area Flexibility Analysis and Job Impact Statement

Statements and analyses are not submitted with this notice because the proposed rule is within the definition contained in section 102(2)(a)(ii) of the State Administrative Procedure Act.

(07-C-0022SA3)

**PROPOSED RULE MAKING
NO HEARING(S) SCHEDULED**

Reactive Power Provision

I.D. No. PSC-02-09-00009-P

PURSUANT TO THE PROVISIONS OF THE State Administrative Procedure Act, NOTICE is hereby given of the following proposed rule:

Proposed Action: The Commission is considering a proposal filed by New York State Electric & Gas Corporation to make various tariff changes contained in its Schedule for Electric Service—P.S.C. No. 120 regarding its reactive power provision.

Statutory authority: Public Service Law, section 66(12)

Subject: Reactive Power Provision.

Purpose: A report and tariff changes revising its Reactive Power Provision filed pursuant to Commission Orders in Case 08-E-0751.

Substance of proposed rule: The Commission is considering a report and tariff revisions filed by New York State Electric & Gas Corporation (NYSEG) in compliance with Commission Orders in Case 08-E-0751 issued June 23 and July 17, 2008. The report contains an analysis of reactive power provisions and charges contained in its tariffs and recommendations for any changes to the rates, charges and classes to which the rates should apply. In compliance with these Commission Orders, NYSEG also filed tariff amendments revising the power factor correction level for billing purposes from 95% to 97% and to reduce the reactive charge. The Commission may approve, reject or modify, in whole or in part, NYSEG's request.

Text of proposed rule and any required statements and analyses may be obtained by filing a Document Request Form (F-96) located on our website <http://www.dps.state.ny.us/f96dir.htm>. For questions, contact: Leann Ayer, Public Service Commission, 3 Empire State Plaza, Albany,

New York 12223-1350, (518) 486-2655, email: leann_ayer@dps.state.ny.us

Data, views or arguments may be submitted to: Jaclyn A. Brillling, Secretary, Public Service Commission, 3 Empire State Plaza, Albany, New York 12223-1350, (518) 474-6530, email: jaclyn_brillling@dps.state.ny.us

Public comment will be received until: 45 days after publication of this notice.

Regulatory Impact Statement, Regulatory Flexibility Analysis, Rural Area Flexibility Analysis and Job Impact Statement

Statements and analyses are not submitted with this notice because the proposed rule is within the definition contained in section 102(2)(a)(ii) of the State Administrative Procedure Act.

(08-E-0751SA1)

**PROPOSED RULE MAKING
NO HEARING(S) SCHEDULED**

Competitive Classification of Independent Local Exchange Company, and Regulatory Relief Appropriate Thereto

I.D. No. PSC-02-09-00010-P

PURSUANT TO THE PROVISIONS OF THE State Administrative Procedure Act, NOTICE is hereby given of the following proposed rule:

Proposed Action: The PSC is considering a petition filed by Chazy & Westport Telephone Corporation seeking reclassification from scenario 2 to scenario 1 as determined in Case 07-C-0349, the Framework for Regulatory Relief case.

Statutory authority: Public Service Law, section 92

Subject: Competitive classification of independent local exchange company, and regulatory relief appropriate thereto.

Purpose: To determine if Chazy & Westport Telephone Corporation more appropriately belongs in scenario 1 rather than scenario 2.

Substance of proposed rule: By petition dated December 17, 2008, Chazy & Westport Telephone Corporation (company) sought reclassification from scenario 2 to scenario 1 pursuant to the criteria used in the Framework for Regulatory Relief, Case 07-C-0349. The company claims that it corrected errors in its initial calculation of its return on equity, and now qualifies as a scenario 1 company. The Commission is considering whether to grant or deny, in whole or in part, the reclassification of the company.

Text of proposed rule and any required statements and analyses may be obtained by filing a Document Request Form (F-96) located on our website <http://www.dps.state.ny.us/f96dir.htm>. For questions, contact: Leann Ayer, Public Service Commission, 3 Empire State Plaza, Albany, New York 12223-1350, (518) 486-2655, email: leann_ayer@dps.state.ny.us

Data, views or arguments may be submitted to: Jaclyn A. Brillling, Secretary, Public Service Commission, 3 Empire State Plaza, Albany, New York 12223-1350, (518) 474-6530, email: jaclyn_brillling@dps.state.ny.us

Public comment will be received until: 45 days after publication of this notice.

Regulatory Impact Statement, Regulatory Flexibility Analysis, Rural Area Flexibility Analysis and Job Impact Statement

Statements and analyses are not submitted with this notice because the proposed rule is within the definition contained in section 102(2)(a)(ii) of the State Administrative Procedure Act.

(08-C-1497SA1)

**PROPOSED RULE MAKING
NO HEARING(S) SCHEDULED**

The Commission Will Determine Whether to Grant a Certificate of Environmental Compatibility and Public Need

I.D. No. PSC-02-09-00011-P

PURSUANT TO THE PROVISIONS OF THE State Administrative Procedure Act, NOTICE is hereby given of the following proposed rule:

Proposed Action: The Commission will determine whether to waive some of the application information and filing requirements applicable to the Long Island Power Authority's proposed electric transmission facility.

Statutory authority: Public Service Law, article VII, section 122(1)

Subject: The Commission will determine whether to grant a Certificate of Environmental Compatibility and Public Need.

Purpose: The Commission will determine the form and content of the application.

Substance of proposed rule: On November 24, 2008, the Long Island Power Authority filed an application for a Certificate of Environmental Compatibility and Public Need for an underground transmission facility that will be constructed and operated between the Riverhead and Canal Substations. The applicant has requested that the Commission waive several information and filing requirements otherwise required for the submission of the electric transmission facility application. The Commission will decide whether or not to grant the request to waive some of the filing requirements.

Text of proposed rule and any required statements and analyses may be obtained by filing a Document Request Form (F-96) located on our website <http://www.dps.state.ny.us/f96dir.htm>. For questions, contact: Leann Ayer, Public Service Commission, 3 Empire State Plaza, Albany, New York 12223-1350, (518) 486-2655, email: leann_ayer@dps.state.ny.us

Data, views or arguments may be submitted to: Jaclyn A. Brillling, Secretary, Public Service Commission, 3 Empire State Plaza, Albany, New York 12223-1350, (518) 474-6530, email: jaclyn_brillling@dps.state.ny.us

Public comment will be received until: 45 days after publication of this notice.

Regulatory Impact Statement, Regulatory Flexibility Analysis, Rural Area Flexibility Analysis and Job Impact Statement

Statements and analyses are not submitted with this notice because the proposed rule is within the definition contained in section 102(2)(a)(ii) of the State Administrative Procedure Act.

(08-T-1388SA1)

**PROPOSED RULE MAKING
NO HEARING(S) SCHEDULED**

The Operation of the Groman Shores, LLC Water System

I.D. No. PSC-02-09-00012-P

PURSUANT TO THE PROVISIONS OF THE State Administrative Procedure Act, NOTICE is hereby given of the following proposed rule:

Proposed Action: The Commission is considering whether to appoint a homeowners' association as operator of the Groman Shores, LLC water system.

Statutory authority: Public Service Law, sections 89-c, 89-h and 5

Subject: the operation of the Groman Shores, LLC water system.

Purpose: The transfer of operation of the Groman Shores, LLC water system to a homeowners' association.

Substance of proposed rule: Groman Shores, LLC (Groman Shores) is a water system in the Town of Sandy Creek, Oswego County providing seasonal service to approximately 50 homeowners and a neighboring campground. A homeowners' association comprised of the system's ratepayers is seeking, with the consent of Groman Shores' owners, to be appointed operator of the system. The Commission is considering whether it is in the public interest to appoint the homeowners' association as operator of the system.

Text of proposed rule and any required statements and analyses may be obtained by filing a Document Request Form (F-96) located on our website <http://www.dps.state.ny.us/f96dir.htm>. For questions, contact: Leann Ayer, Public Service Commission, 3 Empire State Plaza, Albany, New York 12223-1350, (518) 486-2655, email: leann_ayer@dps.state.ny.us

Data, views or arguments may be submitted to: Jaclyn A. Brillling, Secretary, Public Service Commission, 3 Empire State Plaza, Albany, New York 12223-1350, (518) 474-6530, email: jaclyn_brillling@dps.state.ny.us

Public comment will be received until: 45 days after publication of this notice.

Regulatory Impact Statement, Regulatory Flexibility Analysis, Rural Area Flexibility Analysis and Job Impact Statement

Statements and analyses are not submitted with this notice because the proposed rule is within the definition contained in section 102(2)(a)(ii) of the State Administrative Procedure Act.

(08-W-1170SA2)

**Office of Temporary and
Disability Assistance**

NOTICE OF ADOPTION

Public Assistance

I.D. No. TDA-25-08-00009-A

Filing No. 1358

Filing Date: 2008-12-30

Effective Date: 2009-01-14

PURSUANT TO THE PROVISIONS OF THE State Administrative Procedure Act, NOTICE is hereby given of the following action:

Action taken: Amendment of section 352.18(c) of Title 18 NYCRR.

Statutory authority: Social Services Law, sections 20(3)(d), 34(3)(f) and 131-a(8) and (10)

Subject: Public Assistance.

Purpose: To provide that all of the earned income of a dependent child who is a full-time or part-time student is exempt and must not be counted as income when determining eligibility for public assistance.

Text or summary was published in the June 18, 2008 issue of the Register, I.D. No. TDA-25-08-00009-P.

Final rule as compared with last published rule: No changes.

Text of rule and any required statements and analyses may be obtained from: Jeanine Stander Behuniak, New York State Office of Temporary and Disability Assistance, 40 North Pearl Street 16C, Albany, New York 12243-0001, (518) 474-9779, email: Jeanine.Behuniak@OTDA.state.ny.us

Assessment of Public Comment

During the public comment period for the proposed rule which provides that all of the earned income of a dependent child who is a full-time or part-time student is exempt and must not be counted as income when determining eligibility for public assistance, the Office of Temporary and Disability Assistance received one comment in support of the proposal.

NOTICE OF ADOPTION

Shelter Allowances

I.D. No. TDA-36-08-00001-A

Filing No. 1359

Filing Date: 2008-12-30

Effective Date: 2009-01-14

PURSUANT TO THE PROVISIONS OF THE State Administrative Procedure Act, NOTICE is hereby given of the following action:

Action taken: Amendment of section 352.3 of Title 18 NYCRR.

Statutory authority: Social Services Law, sections 20(3)(d), 34 and 131-a

Subject: Shelter Allowances.

Purpose: Sets forth the new calculation of shelter allowances for individuals and families receiving public assistance and residing in city, State or federally aided public housing.

Text or summary was published in the September 3, 2008 issue of the Register, I.D. No. TDA-36-08-00001-P.

Final rule as compared with last published rule: No changes.

Text of rule and any required statements and analyses may be obtained from: Jeanine Stander Behuniak, New York State Office of Temporary and Disability Assistance, 40 North Pearl Street 16C, Albany, New York 12243-0001, (518) 474-9779, email: Jeanine.Behuniak@OTDA.state.ny.us

Assessment of Public Comment

During the public comment period for the proposed rule which sets forth the new calculation of shelter allowances for individuals and families receiving public assistance and residing in city, State or federally aided public housing, the Office of Temporary and Disability Assistance (OTDA) received one comment from a social services district (district). The district wrote that it had no objections to the proposed amendments, and it set forth some of the benefits of having maximum shelter allowances that are the same for public housing and private housing.