

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

EMERGENCY RULE MAKING

Sale of Sliced Cheese at Farmers' Markets

I.D. No. AAM-29-11-00004-E

Filing No. 613

Filing Date: 2011-07-01

Effective Date: 2011-07-01

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

Action taken: Amendment of section 276.4 of Title 1 NYCRR.

Statutory authority: Agriculture and Markets Law, sections 16, 18, 214-b, 251-z-4 and 251-z-9

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

Specific reasons underlying the finding of necessity: The rule exempts persons who slice cheese at farmers' markets from the requirement to obtain a food processing license, as set forth in Agriculture and Markets Law Article 20-C, subject to specified food safety conditions. It is necessary to adopt the rule as an emergency measure in order to eliminate a financial and regulatory burden upon sellers of cheese in farmers' markets, benefit farmers' markets patrons who wish to purchase cheese that has not been pre-packaged, expand local food purchasing options during the farmers' market season, and spur additional and needed economic activity in the State.

Subject: Sale of sliced cheese at farmers' markets.

Purpose: To exempt persons who slice cheese at a farmers' market for sale to consumers from having to obtain a food processing license.

Text of emergency rule: Subdivisions (d) and (e) of section 276.4 of 1 NYCRR are relettered to be subdivisions (e) and (f), respectively.

Section 276.4 of 1 NYCRR is amended by adding thereto a new subdivision (d), to read as follows:

(d) *Slicing and packaging of cheese at farmers' markets.*

(1) *Definitions. As used this subdivision:*

(i) *person means a natural person, partnership, corporation, association, limited liability company or other legal entity that slices cheese which it has manufactured in its own milk plant.*

(ii) *farmers' market means a premises as defined in Agriculture and Markets Law section 260(1). An open-air farmers' market is a farmers' market that does not operate in or under a permanent structure.*

(2) *Any person who slices and packages cheese for sale to consumers at a farmers' market shall be exempt from the licensing requirements of Article 20-C of the Agriculture and Markets Law, provided that:*

(i) *the premises where the cheese is sliced and packaged is maintained in a sanitary condition and in compliance with the provisions of Part 271 of this Title, except that sections 271-6.1, 271-6.6, 271-6.12 through 271-6.17, 271-6.24, 271-7.1 through 271-7.14, and 271-7.16 through 271-7.29 shall not apply to such premises located in an open-air farmers' market; and*

(ii) *no other food processing operations for which licensing under Article 20-C of the Agriculture and Markets Law is required is being conducted at the premises; and*

(iii) *the standardized name of each cheese offered for sale if the cheese meets a standard of identity, or the common or usual name of each cheese offered for sale if the cheese does not meet a standard of identity, is*

a. *affixed or in close proximity to the slice of cheese to be sold to consumers; or*

b. *affixed or in close proximity to the "wheel" of cheese from which a slice thereof is obtained, and the consumer is accurately and adequately informed as to the identity of the "wheel" of cheese from which such slice was obtained.*

(iv) *the price per pound of each cheese offered for sale is prominently displayed so as to be readily observable by consumers, and the price and weight of each slice of cheese sold or offered for sale to consumers is prominently displayed or is clearly disclosed; and*

(v) *the cheese and each slice thereof is transported, maintained, held, handled, processed, and packaged under sanitary conditions.*

This notice is intended to serve only as an emergency adoption, to be valid for 90 days or less. This rule expires September 28, 2011.

Text of rule and any required statements and analyses may be obtained from: Stephen D. Stich, Director, Food Safety and Inspection, New York State Department of Agriculture and Markets, 10B Airline Drive, Albany, New York 12235, (518) 457-4492, email: stephen.stich@agmkt.state.ny.us

Regulatory Impact Statement

A regulatory impact statement is not submitted, but will be published in the *Register* within 30 days of the rule's effective date.

Regulatory Flexibility Analysis

A regulatory flexibility analysis is not submitted, but will be published in the *Register* within 30 days of the rule's effective date

Rural Area Flexibility Analysis

A regulatory flexibility analysis is not submitted, but will be published in the *Register* within 30 days of the rule's effective date

Job Impact Statement

The rule will exempt persons who slice cheese at farmers' markets for sale to consumers from having to obtain food processing licenses, pursuant to Agriculture and Markets Law Article 20-C. The rule will eliminate a regulatory burden upon persons who slice cheese for sale to consumers at farmers' markets and, furthermore, will benefit farmers' markets patrons who wish to purchase cheese that has not been pre-packaged.

The rule is expected to have a positive impact upon jobs and employ-

ment opportunities in the State's cheese industry and at its farmers' markets.

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*.

Museum Collections Management Policies

I.D. No.	Proposed	Expiration Date
EDU-26-10-00002-EP	June 30, 2010	June 30, 2011

Department of Environmental Conservation

PROPOSED RULE MAKING NO HEARING(S) SCHEDULED

Removing a Racially Offensive Term That Appears in the Regulations

I.D. No. ENV-29-11-00003-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 sections 821.6, 847.5 and 878.6 of Title 6 NYCRR.

Statutory authority: Environmental Conservation Law, sections 17-0301 and 17-0303

Subject: Removing a racially offensive term that appears in the regulations.

Purpose: To remove a racially offensive term that appears in the regulations.

Text of proposed rule: 821.6 Table I.

TABLE I

CLASSIFICATION AND STANDARDS OF QUALITY AND PURITY ASSIGNED TO FRESH SURFACE WATERS WITHIN THE UPPER GENESEE RIVER DRAINAGE BASIN, ALLEGANY, CATTARAUGUS, GENESEE, LIVINGSTON, MONROE, ONTARIO, ORLEANS, STEUBEN AND WYOMING COUNTIES, NEW YORK

Item No.	Waters Index Number	Name	Description	Map Ref. No.	Class	Standards
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(Item Nos. 1 through 433 remain unchanged)

434	Ont. 117-178a	[Nigger Spring Run] Tributary of Genesee River		M-8	C	C
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(Item Nos. 435 through 494 remain unchanged)

847.5 Table I

TABLE I

CLASSIFICATIONS AND STANDARDS OF QUALITY AND PURITY ASSIGNED TO FRESH SURFACE WATERS WITHIN THE LAKE ONTARIO DRAINAGE BASIN, CAYUGA, GENESEE, JEFFERSON, LEWIS, MONROE, NIAGARA, ONEIDA, ORLEANS, OSWEGO AND WAYNE COUNTIES, NEW YORK

Item No.	Waters Index Number	Name	Description	Map Ref. No.	Class	Standards
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(Item Nos. 1 through 418 remain unchanged)

419	Ont. 58-9-13-P 48	Coan Pond	Lies at head of Ont. 58-9-13 with outlet [0.2 mile north of Nigger Pond Road and] 1.0 mile east of Amboy-Parish town line.	G-16nw	B	B
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(Item Nos. 420 through 710 remain unchanged)

878.6 Table I.

TABLE I

CLASSIFICATIONS AND STANDARDS OF QUALITY AND PURITY ASSIGNED TO FRESH SURFACE WATERS WITHIN THE EAST CANADA CREEK DRAINAGE BASIN, FULTON, HAMILTON, HERKIMER AND MONTGOMERY COUNTIES, NEW YORK, EXCEPT WATERS CONTAINED WITHIN BOUNDARIES OF STATE-OWNED FOREST PRESERVE LANDS

Item No.	Waters Index Number	Name	Description	Map Ref. No.	Class	Standards
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(Item Nos. 1 through 126 remain unchanged)

127	H-240-144-13-P 717-4 and tribs. Including P 738, P 738a, P 714	Trib. of Canada Lake	[Nigger Lake (P 738).] Mud Lake (P 714). Waters are located within forest preserve.	H-21ne		
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(Item Nos. 128 through 199 remain unchanged)

Map "H-21 ne" is repealed. A new Map "H-21 ne" is adopted. See Appendix in this issue of the *Register*.

Text of proposed rule and any required statements and analyses may be obtained from: Robert Simson, NYS Department of Environmental Conservation, 625 Broadway, Albany, NY 12233-3500, (518) 402-8271, email: rjsimson@gw.dec.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.

Consensus Rule Making Determination

The Department of Environmental Conservation (DEC) is proposing revisions to 6 NYCRR Parts 821, 847 and 878. The revisions will remove racially offensive names contained in these regulations.

DEC has determined that no person is likely to object to the adoption of the rule as written.

Job Impact Statement

The Department of Environmental Conservation (DEC) is proposing revisions to 6 NYCRR Parts 821, 847 and 878. The revisions will remove racially offensive names contained in these regulations.

The changes will not affect the substance of the regulatory requirements. DEC has therefore determined that this rulemaking will not have an impact on jobs and employment opportunities. Accordingly, a job impact statement is not required for this rulemaking.

Department of Health

EMERGENCY RULE MAKING

July 2011 Ambulatory Patient Groups (APGs) Payment Methodology

I.D. No. HLT-29-11-00001-E

Filing No. 592

Filing Date: 2011-06-29

Effective Date: 2011-06-29

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

Action taken: Amendment of Subpart 86-8 of Title 10 NYCRR.

Statutory authority: Public Health Law, section 2807(2-a)(e)

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

Specific reasons underlying the finding of necessity: It is necessary to issue the proposed regulation on an emergency basis in order to meet the regulatory requirement found within the regulation itself to update the Ambulatory Patient Group (APG) weights at least once a year. To meet that requirement, the weights needed to be revised and published in the regulation for January 2010 and updated thereafter. Additionally, the regulation needs to reflect the many software changes made to the APG payment software, known as the APG grouper-pricer, which is a sub-component of the eMedNY Medicaid payment system. These changes include the revised list of If Stand Alone do Not Pay APGs and the ability to reduce APG reimbursement for drugs purchased through the 340B drug benefit program.

There is a compelling interest in enacting these amendments immediately in order to secure federal approval of associated Medicaid State Plan amendments and assure there are no delays in implementation of these provisions. APGs represent the cornerstone to health care reform. Their continued refinement is necessary to assure access to preventive services for all Medicaid recipients.

Subject: July 2011 Ambulatory Patient Groups (APGs) Payment Methodology.

Purpose: To refine the APG payment methodology.

Substance of emergency rule: The amendments to Part 86 of Title 10 (Health) NYCRR are required to update the Ambulatory Patient Groups (APGs) methodology, implemented on December 1, 2008, which governs reimbursement for certain ambulatory care fee-for-service (FFS) Medicaid services. APGs group procedures and medical visits that share similar characteristics and resource utilization patterns so as to pay for services based on relative intensity.

86-8.2 - Definitions

The proposed amendment to section 86-8.2 of Title 10 (Health) NYCRR removes subdivision (r), which defined ambulatory surgery permissible procedures.

86-8.7 - APGs and relative weights

The proposed revision to section 86-8.7 of Title 10 (Health) NYCRR repeals all of section 86-8.7 effective July 1, 2011 and replaces it with a new section 86-8.7 that includes revised APG weights, procedure-based weights, and APG fee schedule fees.

86-8.9 Diagnostic coding and rate computation

The proposed revisions to section 86-8.9 of Title 10 (Health) NYCRR removes subdivision (c), which references ambulatory surgery permissible procedures. Additionally, a new subdivision (c) is added to allow for a reduction of reimbursement for drugs purchased through the 340B drug benefit program. Subdivision (d) is amended to add APG 451 Smoking Cessation Treatment.

86-8.10 Exclusions from payment

The proposed revisions to section 86-8.10 of Title 10 (Health) NYCRR amends subdivision (h) to add APG 465 Class XIII Combined Chemotherapy and Pharmacotherapy and subdivision (i) to add APG 490 Incidental to Medical, Significant Procedure or Therapy Visit to the if stand alone do not pay list.

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 September 26, 2011.

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

Regulatory Impact Statement

Statutory Authority:

Authority for the promulgation of these regulations is contained in section 2807(2-a)(e) of the Public Health Law, as amended by Part C of Chapter 58 of the Laws of 2008 and Part C of Chapter 58 of the Laws of 2009, which authorize the Commissioner of Health to adopt and amend rules and regulations, subject to the approval of the State Director of the Budget, establishing an Ambulatory Patient Groups methodology for determining Medicaid rates of payment for diagnostic and treatment center services, free-standing ambulatory surgery services and general hospital outpatient clinics, emergency departments and ambulatory surgery services.

Legislative Objectives:

The Legislature's mandate is to convert, where appropriate, Medicaid reimbursement of ambulatory care services to a system that pays differential amounts based on the resources required for each patient visit, as determined through Ambulatory Patient Groups ("APGs"). The APGs refer to the Enhanced Ambulatory Patient Grouping classification system which is owned and maintained by 3M Health Information Systems. The Enhanced Ambulatory Group classification system and the clinical logic underlying that classification system, the EAPG software, and the Definitions Manual associated with that classification system, are all proprietary to 3M Health Information Systems. APG-based Medicaid Fee For Service payment systems have been implemented in several states including: Massachusetts, New Hampshire, and Maryland.

Needs and Benefits:

The proposed regulations are in conformance with statutory amendments to provisions of Public Health Law section 2807(2-a), which mandated implementation of a new ambulatory care reimbursement methodology based on APGs.

This reimbursement methodology provides greater reimbursement for high intensity services and relatively less reimbursement for low intensity services. It also allows for greater payment homogeneity for comparable services across all ambulatory care settings (i.e., Outpatient Department, Ambulatory Surgery, Emergency Department, and Diagnostic and Treatment Centers). By linking payments to the specific array of services rendered, APGs will make Medicaid reimbursement more transparent. APGs provide strong fiscal incentives for health care providers to improve the quality of, and access to, preventive and primary care services.

These amendments include updated APG and, procedure-based weights, and APG fee schedule fees, which will provide reimbursement precision and specificity. These amendments also remove all reference to ambulatory surgery permissible procedures list, which no longer exists. Additionally, drugs purchased through the 340B drug benefit program will be reimbursed at a reduced rate and APG 490 INCIDENTAL TO MEDICAL, SIGNIFICANT PROCEDURE OR THERAPY VISIT was added to the If Stand Alone do Not Pay list.

COSTS

Costs for the Implementation of, and Continuing Compliance with this Regulation to the Regulated Entity:

There will be no additional costs to providers as a result of these amendments.

Costs to Local Governments:

There will be no additional costs to local governments as a result of these amendments.

Costs to State Governments:

There will be no additional costs to NYS as a result of these amendments.

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:

There are no local government mandates.

Paperwork:

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

Duplication:

This regulation does not duplicate other state or federal regulations.

Alternatives:

These regulations are in conformance with Public Health Law section 2807(2-a)(e). Although the 2009 amendments to PHL 2807(2-a) authorize the Commissioner to adopt rules to establish alternative payment methodologies or to continue to utilize existing payment methodologies where the APG is not yet appropriate or practical for certain services, the utilization of the APG methodology is in its relative infancy and is otherwise continually monitored, adjusted and evaluated for appropriateness by the Department and the providers. This rulemaking is in response to this continually evaluative process.

Federal Standards:

This amendment does not exceed any minimum standards of the federal government for the same or similar subject areas.

Compliance Schedule:

The proposed amendment will become effective upon filing with the Department of State.

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, diagnostic and treatment centers, and free-standing ambulatory surgery centers. Based on recent data extracted from providers' submitted cost reports, seven hospitals and 245 DTCs 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.

Compliance Costs:

No initial capital costs will be imposed as a result of this rule, nor is there an annual cost of compliance.

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 further reform the outpatient/ambulatory care fee-for-service Medicaid payment system, which is intended to benefit health care providers, including those with fewer than 100 employees.

Minimizing Adverse Impact:

The proposed amendments apply to certain services of general hospitals, diagnostic and treatment centers and freestanding ambulatory surgery centers. 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 that this reimbursement system is mandated in statute.

Small Business and Local Government Participation:

These changes do not affect small businesses and local governments.

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 43 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		

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, recordkeeping, 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 is there an annual cost of compliance.

Minimizing Adverse Impact:

The proposed amendments apply to certain services of general hospitals, diagnostic and treatment centers and freestanding ambulatory surgery centers. The Department of Health considered approaches specified in section 202-bb (2) of the State Administrative Procedure Act in drafting the proposed amendments and rejected them as inappropriate given that the reimbursement system is mandated in statute.

Opportunity for Rural Area Participation:

These changes do not affect rural areas.

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 regulations, that they will not have a substantial adverse impact on jobs or employment opportunities.

**EMERGENCY
RULE MAKING**

Distributions from the Health Care Initiatives Pool for Poison Control Center Operations

I.D. No. HLT-29-11-00002-E

Filing No. 593

Filing Date: 2011-06-29

Effective Date: 2011-06-29

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

Action taken: Amendment of section 68.6 of Title 10 NYCRR.

Statutory authority: Public Health Law, sections 2500-d, 2807-j and 2807-l

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

Specific reasons underlying the finding of necessity: Section 40(e) of Part B of Chapter 109 of the Laws of 2010 authorizes the Commissioner to issue the proposed regulations on an emergency basis in order to meet the timeframes prescribed by the enacted 2010/11 New York State (NYS) Budget related to implementing a statewide consolidation of Regional Poison Control Center (RPCC) services. Section 13 of Part B of Chapter 109 of the Laws of 2010 (10th Extender Bill enacted June 7, 2010) decreased total Health Care Initiatives (HCI) Pool funding to the RPCCs and directed consolidation of PCC services down from five RPCCs statewide to two RPCCs. To implement consolidation, effective January 1, 2011, the Commissioner has removed the designation of three Centers, thereby eliminating their eligibility for HCI Pool grant funding, and designated two RPCCs (one upstate and one downstate) which remain eligible on an ongoing basis for HCI Pool grant monies. Consolidation down to two RPCCs statewide restructured the geographical service area that the surviving RPCCs are now responsible for and rendered the existing HCI Pool funding distribution methodology contained in section 68.6 of 10 NYCRR obsolete. The proposed amendment establishes a new distribution methodology that will allow for more equitable distribution of available HCI Pool funds to the remaining two RPCCs on an ongoing basis effective January 1, 2011.

Subject: Distributions from the Health Care Initiatives Pool for Poison Control Center Operations.

Purpose: Revises the methodology for distributing HCRA grant funding to Regional Poison Control Centers (RPCCs).

Text of emergency rule: Section 68.6 - Distributions from the Health Care Initiatives Pool for Poison Control Center Operations is REPEALED and a new Section 68.6 is added to read as follows:

Section 68.6 - Distributions from the Health Care Initiatives Pool for Poison Control Center Operations

(a) The monies available for distribution from the Health Care Initiatives (HCI) Pool for poison control center operations shall be distributed on a semi-annual basis in accordance with the methodology below:

(1) Population density by county, as established by the latest available decennial census data for New York State (NYS) as determined by the U.S. Census Bureau, shall be the basis for allocating available HCI Pool monies for distribution to the regional poison control centers.

(2) Population density applicable to the total county geographic area served by each regional poison control center shall be determined and the center's percentage to total NYS population density shall be calculated.

(3) Available HCI Pool monies shall be distributed proportionally to each regional poison control center based on the center's percentage population density served to total NYS population density.

(b) *The Commissioner shall consider only those applications for prospective revisions of the projected pool distributions which are in writing and are based on errors, whether mathematical or clerical, made by the department in the pool distribution calculation process. Applications made pursuant to this subdivision must be submitted within thirty days of receipt of notice of the projected pool distribution for the calendar year.*

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 September 26, 2011.

Text of rule and any required statements and analyses may be obtained from: Katherine Ceroalo, DOH, Bureau of House Counsel, Reg. 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 statutory authority for the regulation is contained in sections 2500-d(7), 2807-j, and 2807-l(1)(c)(iv) of the Public Health Law (PHL), which authorizes the Commissioner to make distributions from the Health Care Initiatives (HCI) Pool to the Regional Poison Control Centers (RPCCs). This HCI Pool funding is intended to assist the Centers with meeting the operational costs of providing expert poison call response and poison consultation services on a 24/7 basis to health care professionals and the public statewide.

Legislative Objectives:

The enacted 2010/11 New York State (NYS) Budget (10th Extender Bill, Section 13 of Part B of Chapter 109 of the Laws of 2010) decreased total HCI Pool funding to the RPCCs and directed consolidation of PCC services down from five RPCCs statewide to two RPCCs (one upstate and one downstate). To implement consolidation, effective January 1, 2011, the Commissioner has removed the designation of three Centers, thereby eliminating their eligibility for HCI Pool grant funding, and designated two RPCCs, one located at SUNY Syracuse University Hospital as the upstate RPCC and another located at Bellevue Hospital as the downstate RPCC, which remain eligible on an ongoing basis for HCI Pool grant monies. Consolidation down to two RPCCs restructured the geographical service area the surviving RPCCs are now responsible for and rendered the HCI Pool funding distribution methodology contained in section 68.6 of 10 NYCRR obsolete. Under the current methodology a Center's award is fixed at an amount established based on pre-HCRA (1996) operating costs. The methodology is outdated and provides no sensitivity to reflect current RPCC operations, both from a cost and a programmatic standpoint.

Needs and Benefits:

Effective January 1, 1997, the New York Prospective Hospital Reimbursement Methodology (NYPHRM) system expired and was replaced by a new system established under the Health Care Reform Act (HCRA) of 1996. HCRA substantially deregulated hospital reimbursement, allowing insurers, employers and other health care payers to freely negotiate rates of payment with hospitals, rather than base their payments as previously done on the Medicaid rates. For hospitals that sponsored PCCs, and for Emergency Room (ER) services in particular, the Medicaid ER rate included cost consideration for PCC operations. Under HCRA deregulation and effective January 1, 1997, forward, other payers were no longer obligated to recognize such PCC costs in their reimbursement rates to the sponsoring hospitals, placing financial support for this imperative public health service in jeopardy. To address this concern, enhanced funding for PCC operations was made available to the Centers through HCRA HCI Pool grant funding.

Effective January 1, 1997, forward, the HCI Pool grant amounts calculated for each PCC were determined based on each Center's ratio of projected revenue shortfall created by the expiration of the NYPHRM, plus allocated Medicare costs, to total projected revenue shortfall. PCC cost as reported on the affiliated hospital's 1996 Institutional Cost Report was utilized as the basis for this calculation, and once established the award amount was fixed for the given PCC at the 1996 determined grant dollar amount. This methodology, in place since the implementation of the HCRA, provides no flexibility to appropriately respond to changes in PCC operations over time or to recognize the impact on operating costs of State mandated PCC restructuring, as provided for in the enacted 2010/11 State Budget.

The proposed amendment repeals the existing obsolete provisions and establishes a new distribution methodology that will allow for more equitable distribution of available HCI Pool funds, as appropriated annually by the legislative/budget process, to the remaining two RPCCs on an ongoing basis, effective January 1, 2011.

COSTS:

Costs to State Government:

There will be no additional costs to State government as a result of implementation of the regulation. To the extent that funds are appropri-

ated annually by a given enacted State budget, the proposed amendment serves only to revise the methodology by which such appropriated Pool funds will be distributed to the RPCCs effective January 1, 2011, forward.

Costs to Private Regulated Parties:

There will be no additional costs to private regulated parties.

Costs to Local Government:

There will be no additional costs to local governments as a result of these amendments. The funds are State grants with no local district share of costs (not Medicaid funds).

Costs to the Department of Health:

There will be no additional costs to the Department of Health.

Local Government Mandates:

This regulation does not impose any program, service, duty or other responsibility on 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:

An alternative was evaluated prior to the selection of the proposed distribution methodology that considered the volume of human exposure calls by county as received by the RPCCs over time. Historically, the Centers have not consistently reported such data to the Department over the past decade, particularly as it relates to county specific call volume. The Department acknowledges that the American Association of Poison Control Centers (AAPCC) owns and manages a large database on poison information and human exposure calls. However, the reports they produce are generic in nature and do not offer the requisite state specific, by county, information that would be necessary to serve as a basis for Pool fund distributions. Though customized reports are available for sale, it is unknown whether reporting to the database on all calls is a mandatory requirement of PCC nationwide or to what degree the AAPCC database is inclusive of all poison related calls/services for a given PCC/state (by county). Furthermore, any such special reports would come at a cost to the Department and may not appreciably improve decision making relative to distributing HCI Pool grant funding. Population density related to the geographic areas served by the two RPCCs, as determined by the US Census Bureau's latest decennial survey data, provides a common ground that should fairly reflect each Center's scope of obligation for poison call response (exposure calls), poison consultation services (poison information requests) and poison education responsibilities for their respective service areas.

Federal Standards:

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

Compliance Schedule:

The proposed amendment establishes a revised distribution methodology for HCI Pool grant funds. There is no period of time necessary for regulated parties to achieve compliance with the regulation.

Regulatory Flexibility Analysis

A Regulatory Flexibility Analysis for Small Businesses and Local Governments is not required pursuant to Section 202-b(3)(a) of the State Administrative Procedures Act. It is apparent from the nature of the proposed rule that it does not impose any adverse economic impact on small businesses or local governments, and will not impose any reporting, recordkeeping, or other compliance requirements on small businesses or local governments. The proposed rule revises the methodology for determining Health Care Initiatives (HCI) Pool grant distributions to Regional Poison Control Centers (RPCCs). Effective January 1, 2011, poison control center operations statewide will be downsized from five RPCCs to two RPCCs, rendering the existing grant distribution methodology obsolete. The proposed regulation revises the methodology to reflect population density related to the restructured geographic area served by the surviving RPCCs, rather than continue their grant funding at the amounts that were established in 1997 based on poison control service revenue shortfall established for 1997. The HCI Pool grant funds are 100% State dollars, as appropriated for a given calendar year, and the proposed revised distribution methodology will have no impact on small businesses and local governments.

Rural Area Flexibility Analysis

A Rural Area Flexibility Analysis is not required pursuant to Section 202-bb(4)(a) of the State Administrative Procedure Act. It is apparent from the nature of the proposed rule that it does not impose any adverse economic impact on rural areas, and will not impose any reporting, recordkeeping, or other compliance requirements on public or private entities in rural

areas. The proposed rule revises the methodology for determining Health Care Initiatives (HCI) Pool grant distributions to Regional Poison Control Centers (RPCCs). Effective January 1, 2011, poison control center operations statewide will be downsized from five RPCCs to two RPCCs, rendering the existing grant distribution methodology obsolete. The proposed regulation revises the methodology to reflect population density related to the restructured geographic area served by the surviving RPCCs, rather than continue their grant funding at the amounts that were established in 1997 based on poison control service revenue shortfall established for 1997. The HCI Pool grant funds are 100% State dollars, as appropriated for a given calendar year, and the proposed revised distribution methodology will have no impact rural areas.

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 of the proposed amendment, that it will not have a substantial adverse impact on jobs and employment opportunities. The proposed regulation replaces an existing obsolete methodology for determining grant funding to Regional Poison Control Centers. The proposed regulation will have no implications for job opportunities.

EMERGENCY RULE MAKING

Reduction to Statewide Base Price

I.D. No. HLT-29-11-00007-E

Filing No. 619

Filing Date: 2011-07-01

Effective Date: 2011-07-01

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

Action taken: Amendment of section 86-1.16 of Title 10 NYCRR.

Statutory authority: Public Health Law, section 2807-c(35)

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

Specific reasons underlying the finding of necessity: It is necessary to issue the proposed regulations on an emergency basis in order to meet the statutory timeframes prescribed by Chapter 59 of the Laws of 2011, in a timely manner while the State works with the hospital industry to develop and incorporate quality-related measures pertaining to the appropriate use of cesarean deliveries that will generate future savings. The revised statewide base price is intended to achieve the required savings for this proposal.

Public Health Law section 2807-c(35)(b) specifically provides the Commissioner of Health with authority to issue hospital inpatient rate-setting regulations as emergency regulations.

Further, there is compelling interest in enacting these regulations immediately in order to secure federal approval of the associated Medicaid State Plan Amendment.

Subject: Reduction to Statewide Base Price.

Purpose: Imposes a reduction to the statewide base price as an interim measure.

Text of emergency rule: Section 86-1.16 of Subpart 86-1 of title 10 NYCRR is amended by adding a new subdivision (c), to read as follows:

(c) For the period effective July 1, 2011 through March 31, 2012, the statewide base price shall be adjusted such that total Medicaid payments are decreased by \$24,200,000.

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 September 28, 2011.

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

Regulatory Impact Statement

Statutory Authority:

The requirement to implement a modernized Medicaid reimbursement system for hospital inpatient services based upon 2005 base year operating costs pursuant to regulations is set forth in section 2807-c(35) of the Public Health Law.

Legislative Objectives:

The Legislature and Medicaid Redesign Team adopted a proposal to reduce unnecessary cesarean deliveries to promote quality care and reduce

unnecessary expenditures. Due to industry concerns with the initial proposal it was determined that a more clinically sound method needs to be developed. To generate immediate savings, however, a reduction in the statewide base price is being implemented while an obstetrical workgroup develops a more clinically sound approach to meet Legislative objectives.

Needs and Benefits:

The proposed amendment appropriately implements the provisions of Public Health Law section 2807-c(35)(b)(xii), which authorizes the Commissioner to address the inappropriate use of cesarean deliveries. Cesarean deliveries are surgical procedures that inherently involve risks; however, elective cesarean deliveries increase the risks unnecessarily. Therefore, high rates of cesarean deliveries are increasingly viewed as indicative of quality of care issues.

This amendment, in concert with enacted statute, implements a statewide base price reduction of \$24.2 million dollars to achieve the immediate savings target for unnecessary cesarean deliveries while the state undergoes consultation with affected stakeholders to develop a clinically sound approach to reducing inappropriate cesarean deliveries.

COSTS:

Costs to State Government:

There are no additional costs to State government as a result of this amendment.

Costs of Local Government:

There will be no additional cost to local governments as a result of these amendments.

Costs to the Department of Health:

There will be no additional costs to the Department of Health as a result of this amendment.

Local Government Mandates:

The proposed amendments do not impose any new programs, services, duties or responsibilities 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:

No significant alternatives are available at this time. In collaboration with the hospital industry, the State is in the process of developing a more clinically sound method to achieve this savings. The Department is authorized by the Public Health Law section 2807-c(35)(b)(xiii) to address certain aspects of the hospital reimbursement methodology through regulations.

Federal Standards:

This amendment does not exceed any minimum standards of the federal government for the same or similar subject areas.

Compliance Schedule:

Section 86-1.16 requires that the statewide base price be reduced by \$24,200,000 for the period effective July 1, 2011 through March 31, 2012.

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.

Health care providers subject to the provisions of this regulation under section 2807-c(35) of the Public Health Law will see a minimal decrease in funding as a result of the reduction in the statewide base price.

This rule will have no direct effect on Local Governments.

Compliance Requirements:

No new reporting, recordkeeping or other compliance requirements are being imposed as a result of these rules. Affected health care providers will bill Medicaid using procedure codes and ICD-9 codes approved by the American Medical Association, as is currently required. The rule should have no direct effect on Local Governments.

Professional Services:

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

Compliance Costs:

As a result of the new provision of 86-1.16, overall statewide aggregate hospital Medicaid revenues for hospital inpatient services will decrease in an amount corresponding to the total statewide base price reduction.

Economic and Technological Feasibility:

Small businesses will be able to comply with the economic and technological aspects of this rule. The proposed amendments are technologically feasible because it requires the use of existing technology. The overall economic impact to comply with the requirements of this regulation is expected to be minimal.

Minimizing Adverse Impact:

The proposed amendments reflect statutory intent and requirements.

Small Business and Local Government Participation:

Hospital associations participated in discussions and contributed comments through the State’s Medicaid Redesign Team process regarding these changes.

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 43 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		

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, recordkeeping, 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 is there an annual cost of compliance.

Minimizing Adverse Impact:

The proposed amendments reflect statutory intent and requirements.

Rural Area Participation:

This amendment is the result of ongoing discussions with industry associations as part of the Medicaid Redesign team process. These associations include members from rural areas. As well, the Medicaid Redesign Team held multiple regional hearings and solicited ideas through a public process.

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 rule that it will not have a substantial adverse impact on jobs or employment opportunities. The proposed regulation revises the final statewide base price for the period beginning July 1, 2011 through March 31, 2012. The proposed regulation has no implications for job opportunities.

**EMERGENCY
RULE MAKING**

Medicaid Managed Care Programs

I.D. No. HLT-29-11-00008-E

Filing No. 620

Filing Date: 2011-07-01

Effective Date: 2011-07-01

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

Action taken: Repeal of Subparts 360-10 and 360-11 and sections 300.12 and 360-6.7; and addition of new Subpart 360-10 to Title 18 NYCRR.

Statutory authority: Public Health Law, sections 201 and 206; and Social Services Law, sections 363-a, 364-j and 369-ee

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

Specific reasons underlying the finding of necessity: Chapter 59 of the laws of 2011 enacted a number of proposals recommended by the Medicaid Redesign Team established by the Governor to reduce costs and increase quality and efficiency in the Medicaid program. The changes to Social Services Law section 364-j to expand mandatory enrollment into Medicaid managed care by eliminating many of the prior exemptions and exclusions from enrollment take effect April 1, 2011. Paragraph (t) of section 111 of Part H of Chapter 59 authorizes the Commissioner to promulgate, on an emergency basis, any regulations needed to implement such law. The Commissioner has determined it necessary to file these regulations on an emergency basis to achieve the savings intended to be realized by the Chapter 59 provisions regarding expansion of Medicaid managed care enrollment.

Subject: Medicaid Managed Care Programs.

Purpose: To repeal old and outdated regulations and to consolidate all managed care regulations to make them consistent with statute.

Substance of emergency rule: The proposed rule repeals various sections of Title 18 NYCRR that contain managed care regulations and replaces them with a new Subpart 360-10 that consolidates all managed care regulations in one place and makes the regulations consistent with Section 364-j of the Social Services Law (SSL). Section 364-j of the SSL contains the Medicaid managed care program standards. The new Subpart 360-10 will also apply to the Family Health Plus (FHP) program authorized in Section 369-ee of the Social Services Law. FHP-eligible individuals must enroll in a managed care organization (MCO) to receive services and FHP MCOs must comply with most of the programmatic requirements of Section 364-j of the SSL.

The new Subpart 360-10 identifies the Medicaid populations required to enroll and those that are exempt or excluded from enrollment, defines good cause reasons for changing/disenrolling from an MCO, or changing primary care providers (PCPs), adds enrollee fair hearing rights, adds marketing/outreach and enrollment guidelines, and identifies unacceptable practices and the actions to be taken by the State when an MCO commits an unacceptable practice.

The proposed rule repeals the existing Subparts 360-10 and 360-11 and Sections 300.12 and 360-6.7 of Title 18 NYCRR. Section 300.12 applied to the Monroe County Medicap program, a managed care demonstration project that was undertaken in the mid-1980s and that no longer exists. Section 360-6.7 addresses processes and timeframes for disenrollment from the various types of MCOs and these provisions are included in the new Subpart 360-10. Subpart 360-11 implemented provisions relating to special care plans formerly contained in SSL Section 364-j; these provisions were added by Chapter 165 of the Laws of 1991 and later removed by Chapter 649 of the Laws of 1996.

360-10.1 Introduction

This section provides an introduction to the managed care program. Section 364-j of Social Services Law provides the framework for the Statewide Medicaid managed care program. Certain Medicaid recipients are required to receive services from Medicaid managed care organizations. Section 369-ee added the Family Health Plus (FHP) program to Social Services Law. Individuals eligible for FHP are required to receive services from a managed care plan unless they are participating in the Family Health Plus premium assistance program.

360-10.2 Scope

This section identifies the topics addressed by the Subpart.

360-10.3 Definitions

This section includes definitions necessary to understand the regulations.

360-10.4 Individuals required to enroll in a Medicaid managed care organization

This section identifies the individuals who will be required to enroll in an MCO.

360-10.5 Individuals exempt or excluded from enrolling in a Medicaid mandatory managed care organization

This section identifies the good cause reasons for a Medicaid recipient to be exempt or excluded from enrollment in a mandatory managed care program. The section also includes the procedures for requesting an exemption or exclusion and the timeframes for processing the request. This section also describes the notices that must be provided to a Medicaid recipient if his/her request is denied.

360-10.6 Good cause for changing or disenrolling from an MCO

This section describes the good cause reasons for an enrollee to change MCOs and the process for requesting a change or disenrollment. This section also identifies the timeframes for processing the request and the notices that must be provided to the enrollee regarding his/her request.

360-10.7 Good cause for changing primary care providers

This section describes the good cause reasons for a managed care enrollee to change primary care providers, the process through which the enrollee may request such a change and the timeframes for processing the request.

360-10.8 Fair Hearing Rights

This section identifies the circumstances under which a Medicaid or FHP enrollee may request a fair hearing. Enrollees may request a fair hearing for enrollment decisions made by the local social services district and decisions made by an MCO or its utilization review agent about services. The section describes the notices that must be sent to advise the enrollee of his/her fair hearing rights. The section also explains when aid continuing is available for managed care issues and how the enrollee requests it when requesting a fair hearing.

360-10.9 Appeal Rights for Recipients Enrolled in Medicaid Advantage

This section identifies the Medicaid and Medicare appeal rights that are available for recipients enrolled in a Medicaid Advantage plan.

360-10.10 Marketing/Outreach

This section defines marketing/outreach and establishes marketing/outreach guidelines for MCOs including requiring MCOs to submit a marketing/outreach plan, requiring MCOs to get approval of materials before distribution, and establishing limits for marketing/outreach representative reimbursement.

360-10.11 MCO unacceptable practices

This section identifies additional unacceptable practices for MCOs. These are generally related to marketing/outreach.

360-10.12 MCO sanctions and due process

This section identifies the actions the Department is authorized to take when an MCO commits an infraction.

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 September 28, 2011.

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

Regulatory Impact Statement

Statutory Authority:

Social Services Law (SSL) section 363-a and Public Health Law section 201(1)(v) provide that the Department is the single state agency responsible for supervising the administration of the State's medical assistance ("Medicaid") program and for adopting such regulations, not inconsistent with law, as may be necessary to implement the State's Medicaid program.

Legislative Objectives:

Section 364-j of the SSL governs the Medicaid managed care program, under which certain Medicaid recipients are required or allowed to enroll in and received services through managed care organizations (MCOs). Section 369-ee of Social Services Law authorized the State to implement the Family Health Plus (FHP) program, a managed care program for individuals aged 19 to 64 who have income too high to qualify for Medicaid. The intent of the Legislature in enacting these programs was to assure that low-income citizens of the State receive quality health care and that they obtain necessary medical services in the most effective and efficient manner.

Chapter 59 of the Laws of 2011 amended SSL section 364-j to expand mandatory enrollment into Medicaid managed care by eliminating many of the exemptions and exclusions from enrollment previously contained in the statute.

Needs and Benefits:

The proposed regulations reflect current program practices and requirements, consolidate all managed care regulations in one place, and conform the regulations to the provisions of SSL section 364-j, including the recent

amendments made by Chapter 59 of the Laws of 2011. The proposed regulations identify the individuals required to enroll in Medicaid managed care and identify the populations who are exempt or excluded from enrollment.

The proposed regulations also contain provisions, which apply to both the Medicaid managed care and the FHP programs: specifying good cause criteria for an enrollee to change MCOs or to change their primary care provider; explaining enrollees' rights to challenge actions of their MCO or social services district through the fair hearing process; establishing marketing/outreach guidelines for MCOs; and identifying unacceptable practices and sanctions for MCOs that engage in them.

Costs:

The proposed regulations do not impose any additional costs on local social services districts beyond those imposed by law. The current managed care program operates under a federal Medicaid waiver pursuant to section 1115 of the Social Security Act. Through the waiver, the State receives federal dollars for its Safety Net and FHP populations. Administrative costs associated with implementation of the managed care program incurred at start-up were covered by planning grants. Since 2005, administrative costs for the managed care program have been included with all other Medicaid administrative costs and there is no local share for administrative costs over and above the Medicaid administrative cap.

Local Government Mandates:

The proposed regulations do not create any additional burden to local social services districts beyond those imposed by law.

Paperwork:

Social Services Law requires that Medicaid recipients be advised in writing regarding enrollment, benefits and fair hearing rights. In compliance with the law, the proposed regulations describe the circumstances under which a Medicaid managed care participant should be provided with such notices, who is responsible for sending the notice and what should be included in the notice. There are reporting requirements associated with the program for social service districts and MCOs. The social services district is required to report on exemptions granted, complaints received and other enrollment issues. MCOs must submit network data, complaint reports, financial reports and quality data. These requirements have been in existence since 1997 when the mandatory Medicaid managed care program began. There are no new requirements for the social services districts or the MCOs in the proposed regulations.

Duplication:

The proposed regulations do not duplicate any State or federal requirements unless necessary for clarity.

Alternative Approaches:

The Department is required by SSL section 364-j to promulgate regulations to implement a statewide managed care program. The proposed regulations implement the provisions of SSL section 364-j in a way which balances the needs of MA recipients, managed care providers and local social services districts. No alternatives were considered.

Federal Standards:

Federal managed care regulations are in 42 CFR 438. The proposed regulations do not exceed any minimum standards of the federal government.

Compliance Schedule:

The mandatory Medicaid managed care program has been in operation since 1997. As a result, all counties in the State have some form of managed care. The requirements in the proposed rules have been implemented through the contract between the State or eligible social services and participating MCOs.

Regulatory Flexibility Analysis

Effect on Small Businesses and Local Governments:

Section 364-j of Social Services Law (SSL) authorizes a Statewide Medicaid managed care program that includes mandatory enrollment of most Medicaid beneficiaries. In 1997 the State applied for and received approval of a Federal waiver under Section 1115 of the Social Security Act to implement mandatory enrollment. Section 369-ee of SSL authorizes the Family Health Plus (FHP) program and requires eligible persons to receive services through managed care organizations (MCOs). Currently, all counties have implemented some form of managed care. As of April, 2011, forty-nine counties have a mandatory Medicaid managed care program; nine counties have a voluntary Medicaid managed care program. All counties have a FHP program.

As a result of the implementation of the Medicaid managed care program and FHP programs, most Medicaid recipients and all FHP eligible persons are required to enroll and receive services from providers who contract with a managed care organization (MCO). MCOs must have a provider network that includes a sufficient array and number of providers to serve enrollees, but they are not required to contract with any willing provider. Consequently, local providers may lose some of their patients. However, this loss may be offset by an increase in business as a result of the implementation of FHP.

The proposed regulations do not impose any additional requirements beyond those in law and the benefits of the program outweigh any adverse impact.

Compliance Requirements:

No new requirements are imposed on local governments beyond those included in law and there are no requirements for small businesses.

Professional Services:

No professional services will be necessitated as a result of this rule. However, the services of a professional enrollment broker will be available to counties that choose to access them. The costs of these services are shared by the State and the local districts.

Compliance Costs:

No additional costs for compliance will be incurred as a result of this rule beyond those imposed by law. Administrative costs associated with implementation of the managed care program incurred at start-up were covered by planning grants. Since 2005, administrative costs for the managed care program have been included with all other Medicaid administrative costs and there is no local share for administrative costs over and above the Medicaid administrative cap. Additionally, the 1115 waiver reduced local government costs by authorizing Federal participation for the Safety Net and Family Health Plus (FHP) populations.

Economic and Technological Feasibility:

Administrative costs incurred at program start-up were covered by planning grants. Since 2005, administrative costs for the managed care program are included with all other Medicaid administrative costs and there is no local share for administrative costs over and above the Medicaid administrative cap.

The Medicaid managed care program utilizes existing state systems for operation (Welfare Management System, eMedNY, etc.).

The Department provides ongoing technical assistance to counties to assist in all aspects of planning, implementing and operating the local program.

Minimizing Adverse Impact:

The mandatory Medicaid managed care program is implemented only when there are adequate resources available in a local district to support the program. No new requirements are imposed beyond those included in law.

The benefits of the managed care program outweigh any adverse effects. Managed care programs are designed to improve the relationship between individuals and their health care providers and to ensure the proper delivery of preventive medical care. Such programs help avoid the problem of individuals not receiving needed medical care until the onset of advanced stages of illness, at which time the individual would require higher levels of medical care such as emergency room care or inpatient hospital care. The State has fourteen years of Quality Data that demonstrate that Medicaid beneficiaries enrolled in managed care receive better quality care than those in fee-for-service Medicaid.

Small Business and Local Government Participation:

The regulations do not introduce a new program. Rather, they codify current program policies and requirements and make the regulations consistent with section 364-j of SSL. During the development of the 1115 waiver application and the design of the managed care program, input was obtained from many interested parties.

Rural Area Flexibility Analysis

Effect on Rural Areas:

All rural counties with managed care programs will be affected by this rule. As of April 2011, all rural counties have a Medicaid managed care and Family Health Plus (FHP) program.

Compliance Requirements:

This rule imposes no additional compliance requirements other than those already contained in Section 364-j of the Social Services Law (SSL).

Professional Services:

No professional services will be necessitated as a result of this rule. However, the services of a professional enrollment broker will be available to counties that choose to access them. The costs of these services are shared by the State and the local districts.

Compliance Costs:

No additional costs for compliance will be incurred as a result of this rule beyond those imposed by law. The administrative costs incurred by local governments for implementing the Statewide managed care program are included with all other Medicaid administrative costs and beginning in 2005, there was no local share for administrative costs over and above the administrative cost base of the Medicaid administrative cap. Additionally, the Federal Section 1115 waiver which allowed the State to implement mandatory enrollment, reduced local government costs by authorizing Federal participation for the Safety Net and FHP populations.

Minimizing Adverse Impact:

The benefits of the managed care program outweigh any adverse effects. Managed care programs are designed to improve the relationship between individuals and their health care providers and to ensure the proper

delivery of preventive medical care. Such programs help avoid the problem of individuals not receiving needed medical care until the onset of advanced stages of illness, at which time the individual would require higher levels of medical care such as emergency room care or inpatient hospital care. The State has many years of Quality Data that demonstrate that Medicaid beneficiaries enrolled in managed care receive better quality care than those in fee-for-service Medicaid.

Feasibility Assessment:

Administrative costs incurred at program start-up were covered by planning grants. Since 2005, administrative costs for the managed care program are included with all other Medicaid administrative costs and there is no local share for administrative costs over and above the Medicaid administrative cap.

The Medicaid managed care program utilizes existing state systems for operation (Welfare Management System, eMedNY, etc.).

The Department provides ongoing technical assistance to counties to assist in all aspects of planning, implementing and operating the local program.

Rural Area Participation:

The proposed regulations do not reflect new policy. Rather, they codify current program policies and requirements and make the regulations consistent with section 364-j of the SSL. During the development of the 1115 waiver application and the design of the managed care program, input was obtained from many interested parties.

Job Impact Statement

Nature of Impact:

The rule will have no negative impact on jobs and employment opportunities. The mandatory Medicaid managed care program authorized by Section 364-j of the Social Services Law (SSL) will expand job opportunities by encouraging managed care plans to locate and expand in New York State.

Categories and Numbers Affected:

Not applicable.

Regions of Adverse Impact:

None.

Minimizing Adverse Impact:

Not applicable.

Self-Employment Opportunities:

Not applicable.

**EMERGENCY
RULE MAKING**

Municipal Public Health Services Plan - Radioactive Material and Radiation Equipment

I.D. No. HLT-29-11-00009-E

Filing No. 621

Filing Date: 2011-07-01

Effective Date: 2011-07-01

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

Action taken: Amendment of Part 40 of Title 10 NYCRR.

Statutory authority: Public Health Law, sections 602 and 603

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

Specific reasons underlying the finding of necessity: On July 1, 2011, state funding for municipal programs to conduct inspections of x-ray facilities and regulate and control radioactive material use in New York City will cease and the department, as required by Public Health Law, must take over this work. The department's Bureau of Environmental Radiation Protection is currently understaffed and cannot complete its current workload. As a result, 10,000 medical and academic facilities using x-ray machines and about 350 facilities that use radioactive materials will not be inspected for compliance with state sanitary code requirements. Failure to conduct timely inspections of any of these facilities could result in equipment failure or technician errors going unnoticed and uncorrected for longer periods of time, resulting in radiation overexposure during diagnostic or therapeutic procedures or misadministration of nuclear medicine for patients who require these life-saving health services. Inspection of facilities that use radioactive materials ensures appropriate handling and minimizes exposure to workers, the public and the environment. A security check of high-risk radiation sources is also conducted during these inspections.

In 2009, the cost to the State to continue to fund the municipalities that that are conducting these programs was approximately \$560,000. It is

estimated that the cost to the department to take over these programs would exceed \$3,000,000. It would be fiscally inefficient for the State to take over programs that are already operational in these municipalities, considering the initial cost of transition and the continuous costs of travel for State employees. Thus, this regulation represents both good public health policy as well as sound fiscal policy.

Due to the public health threat presented by radiation, it is imperative that these local governments continue to operate their radiation protection programs. The proposed regulation ensures that municipalities have the resources to protect the public from the environmental health threat posed by radioactive materials and radiation producing equipment.

Subject: Municipal Public Health Services Plan - Radioactive Material and Radiation Equipment.

Purpose: To establish funding for certified counties to inspect radiation equipment and the NYCDOHMH to conduct licensing and inspections.

Text of emergency rule: Subpart 40-3 is REPEALED, in its entirety. Subpart 40-2 is amended and new subdivisions 40-2.240, 40-2.241, 40-2.250, and 40-2.251 are added to read as follows:

40-2.240. *Radioactive materials licensing and inspection program; performance standard.*

The municipal public health services plan shall include a radioactive materials licensing and inspection program containing those provisions set forth in section 40-2.241 of this Subpart, if the Department has authorized the municipality to conduct such a program.

40-2.241. *Radioactive materials licensing and inspection program; authorization.*

The department shall authorize a municipality's radioactive materials licensing and inspection program if such program includes, at a minimum, provisions for:

- (a) *regulating all facilities in the municipality's jurisdiction;*
- (b) *ensuring the technical quality of licensing actions by the municipality;*
- (c) *assessing licensee compliance with Part 16 of the State Sanitary Code and license condition, and ensuring correction of violations; and*
- (d) *inspecting regulated facilities at a frequency established by the department.*

40-2.250. *Radiation-producing equipment program; performance standard.*

The municipal public health services plan shall include a radiation-producing equipment inspection program containing those provisions set forth in section 40-2.551 of this Subpart, if the department has certified such a program for the municipality.

40-2.251 *Radiation-producing equipment program; authorization.*

The department shall certify a municipality's radiation producing equipment inspection program if such program includes, at a minimum, provisions for:

- (a) *inspecting all facilities and equipment in the municipality's jurisdiction; and*
- (b) *performing inspections and issuing reports in accordance with Part 16 of the State Sanitary Code and, in particular, reporting as described in section 16.10.*

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 September 28, 2011.

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

Regulatory Impact Statement

Statutory Authority:

Article 6 of the Public Health Law (PHL) provides statutory authority to provide State aid to municipalities for general public health work (GPHW). PHL § 614(3) defines municipality to be a county or city. PHL § 602(3)(b)(5) provides that GPHW must include certain health services, including environmental health services. PHL § 602(3)(a) authorizes the commissioner to adopt rules and regulations after consulting with the public health and health planning council and county commissioners, boards, and the public health directors, to establish standards of performance for environmental health services delivered under the GPHW program.

Legislative Objectives:

The State Legislature recently amended PHL § 605 to eliminate "optional services" as a category of services eligible for State aid reimbursement. These optional services are still described in the Department's 10 NYCRR subpart 40-3. Repealing subpart 40-3 will eliminate this superfluous language.

However, two of the optional services that are no longer eligible for State aid are regulation of radioactive materials and regulation of radiation producing equipment. The Department recognizes that radioactive materi-

als and radiation producing equipment present significant environmental health hazards to the public. The Department should encourage counties to protect their citizens from the potentially harmful effects of radioactive materials and radiation producing equipment by providing State aid to offset the cost of these services.

The Department further recognizes that not every county has the technical capability to regulate radioactive materials and radiation producing equipment. Counties without such technical capability should not be precluded from receiving State aid for public health work. Accordingly, the proposed regulation provides that a county that wishes to receive State aid must regulate radioactive materials and equipment only if its programs have the technical capability to do so, as authorized or certified by the Department.

Needs and Benefits:

Pursuant to a New York State agreement with the federal Nuclear Regulatory Commission (NRC), radioactive materials must be regulated throughout the State. The New York City Department of Health and Mental Hygiene (DOHMH) is the only municipality certified by the Department to regulate radioactive materials; the State provides this service in all other counties. DOHMH licenses and inspects approximately 350 radioactive material facilities in New York City. By protecting the public from the environmental health hazards from these radioactive materials, DOHMH provides a substantial benefit to the public health.

Additionally, pursuant to Part 16 of the State Sanitary Code, the Department has certified DOHMH and four additional counties (Suffolk, Westchester, Dutchess and Niagara) to inspect radiation producing equipment. DOHMH and these additional counties license and inspect nearly 10,000 radiation equipment facilities. Like the radioactive materials program, these municipalities offer a substantial public health benefit by protecting their citizens from the environmental health hazards potentially created by radiation producing equipment.

Failure to conduct timely inspections of any of these facilities could result in equipment failure or technician errors going unnoticed and uncorrected for longer periods of time, resulting in radiation overexposure during diagnostic or therapeutic procedures or misadministration of nuclear medicine for patients who require these life-saving health services. Inspection of facilities that use radioactive materials ensures appropriate handling and minimizes exposure to workers, the public and the environment. A security check of high-risk radiation sources is also conducted during these inspections.

A recent series of New York Times articles indicate the public's concern over radiation medical events and malpractice has significantly and justifiably increased. Recent events in Japan further indicate that the public is highly concerned about radiation exposure. During the week of March 14, 2011, the Department's Bureau of Environmental Radiation Protection received approximately 40 calls every day from concerned citizens with concerns about exposure. The public rightfully expects a robust regulatory program, which DOHMH and other counties currently provide, through their partnership with the Department of Health.

Due to the public health threat presented by radiation, it is imperative that these local governments continue to operate their radiation protection programs. The proposed regulation ensures that municipalities have the resources to protect the public from the environmental health threat posed by radioactive materials and radiation producing equipment.

Costs to Regulated Parties for the Implementation of, and Continuing Compliance with, the Rule:

Because the regulated municipalities are currently performing these programs, there will be no increase in their costs. Rather, regulated municipalities that wish to continue these programs will save money by continuing to receive State aid. However, without this regulatory change, the costs to municipalities that wish to continue these programs will increase substantially.

Costs to the Agency, the State and Local Governments for the Implementation of the Rule:

The municipalities that operate these programs have indicated they would discontinue the programs if State aid is not provided. By encouraging counties to continue these programs, the Department will save money. As noted, pursuant to the State's agreement with the federal Nuclear Regulatory Commission, if DOHMH ceases to regulate radioactive materials, the State must do so. This will cost substantially more than the \$370,000 in State aid that was paid to New York City in State aid in 2009, which represented only 26% of DOHMH's total costs for regulating radioactive materials. Although the NRC could theoretically take over regulation of radioactive materials, the burden on local businesses to pay federal fees would be more than five (5) times higher than the costs imposed by programs operated by State or local government. Similarly, and as a matter of sound public policy, if municipalities cease to regulate radiation producing equipment the Department would take over these programs.

In 2009, the cost to the State to fund the municipalities that conduct these programs was approximately \$560,000. Specifically, New York

City was reimbursed \$370,000 for its radioactive materials inspection and licensing program and \$119,000 for the radiation producing equipment program, for a total of \$489,000. Two other counties were reimbursed approximately \$71,000 for their radiation producing equipment programs. The remaining two counties recovered enough in fees that year that they exceeded their expenses for their radiation producing equipment programs and did not receive State aid. These costs are not expected to change if the proposed regulations are adopted.

It would be fiscally inefficient for the State to take over programs that are already operational in these municipalities, considering the initial cost of transition and the continuous costs of travel for State employees. Thus, this regulation represents both good public health policy as well as sound fiscal policy.

The Information, Including the Source(s) of Such Information and the Methodology, upon Which the Cost Analysis is Based:

The cost analysis is based on calendar year 2009 State Aid claims provided by municipalities, as currently required by PHL § 618 and 10 NYCRR § 40-1.20(b). An annual summary of State aid is routinely prepared by the program.

Local Government Mandates:

This proposed rule does not impose any program, service, duty or responsibility upon the municipalities that has not already been agreed to and certified by the department.

Paperwork:

The requirements for reporting will remain unchanged.

Duplication:

There are no relevant rules and other legal requirements of the state and federal governments, that duplicate, overlap or conflict with the proposed rule.

Alternatives:

The alternative is for the Department to take over regulation of radioactive materials as well as regulation of radiation producing equipment in those municipalities that discontinue these programs because they are ineligible for State aid. It is estimated that this alternative would cost the State over \$3,000,000, based on the cost of funding the 22 FTEs currently employed by the municipalities to operate these programs. This number does not include clerical, administrative, and management positions that support the municipal programs.

Federal Standards:

There is no federal minimum standard that determines whether the State must supply State aid to municipalities that choose to provide these services. However, the federal government does require that these programs be provided throughout the State.

Compliance Schedule:

The regulations will take effect upon filing with the Department of State.

Regulatory Flexibility Analysis

Effect on Small Business:

This rule will apply to county radiation programs that are certified or become certified in the future. Currently only Dutchess, Niagara, Westchester, Suffolk counties and New York City have such programs. The proposed regulatory change will result in no additional cost to these local governments.

However, without this change, the fees that registered facilities must pay are likely to increase. 10 NYCRR 16.41(c) and (d) indicate the fees for State inspection programs and county inspection programs, respectively. In all cases, the State fees are higher. Thus, if the State is required to take over these programs, the fee costs will increase. This will result in an increase in costs to small businesses. Further, if the federal NRC were to take over regulation of radioactive materials, the cost to small business would be at least five (5) times higher than it is now.

Compliance Requirements:

The certified county programs already meet the requirements and comply with the regulations. Facilities inspected will still be required to meet the requirements of Part 16, regardless of whether they are inspected by county inspectors or State inspectors.

Professional Services:

Certified counties do not need professional services to establish or maintain certification.

Capital Costs and Annual Costs of Compliance:

There are no capital costs associated with this regulation.

Economic and Technological Feasibility:

The proposed regulatory change will result in no additional cost to local governments or impose any new technology requirements or costs.

However, without this change, the fees that registered facilities must pay are likely to increase. 10 NYCRR 16.41(c) and (d) indicate the fees for State inspection programs and county inspection programs, respectively. In all cases, the State fees are higher. Thus, if the State is required to take over these programs, the fee costs will increase. This will result in an increase in costs to small businesses. Further, if the federal

NRC were to take over regulation of radioactive materials, the economic cost to small business would be at least five (5) times higher than it is now.

Minimizing Adverse Impact:

No adverse impact of implementation has been identified. Failure to implement may result in some county programs dropping certification, which will then require the State DOH to implement these programs.

Small Business Input:

No small businesses were surveyed. The proposed changes do not have any direct effect on small business. Failure to implement these changes may result in fee increases for small business.

Rural Area Flexibility Analysis

Types and Estimated Numbers of Rural Areas:

No affected county programs are classified as rural areas (18 counties with less than 200,000 population and 9 counties with certain townships with a population density less than 150 persons/square mile).

Reporting, Recordkeeping and Other Compliance Requirements and Professional Services:

There are no new reporting requirements contained in the proposed regulations. No additional professional service costs are anticipated.

Costs:

No rural counties affected.

Minimizing Adverse Impact:

No rural counties are affected by this regulation.

Rural Area Participation:

No communications were made with rural counties.

Job Impact Statement

Nature of Impact:

No jobs will be adversely affected by adoption of these regulations. The proposal does not change the regulatory requirements on regulated entities.

Categories and Numbers Affected:

The certified counties include Dutchess, Niagara, Westchester, Suffolk and New York City.

Regions of Adverse Impact:

No regions will be adversely impacted by the adoption of these regulations.

Minimizing Adverse Impact:

As stated, no jobs will be adversely affected by the adoption of the proposed changes in the regulations.

EMERGENCY RULE MAKING

Hospital Quality Contribution

I.D. No. HLT-29-11-00010-E

Filing No. 622

Filing Date: 2011-07-01

Effective Date: 2011-07-01

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

Action taken: Amendment of Subpart 86-1 of Title 10 NYCRR.

Statutory authority: Public Health Law, section 2807-d-1

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

Specific reasons underlying the finding of necessity: Emergency regulations are expressly authorized by the provisions of Public Health Law section 2807-d-1. The proposed emergency regulation will implement statutory action to change the rate of the Hospital Quality Contribution from 1.6% to 2.4% for collections during the period of July 1, 2011 through March 31, 2012. The rate will then be reduced to 1.6% effective April 1, 2012 and for each year thereafter.

The change in rate is designed to collect the required thirty million dollars needed for the Medical Indemnity Fund. The contribution is applied to general hospital revenue that is received for the provision of inpatient obstetrical patient care services.

The original rate of 1.6% was calculated on a full annual amount and on both inpatient obstetrical and newborn revenues. The first Hospital Quality Contribution, for the period July 1, 2011 through March 31, 2012, is not a full annual collection period.

The Department will conduct a reconciliation for the Hospital Quality Contribution after all collections have been processed for the period of July 1, 2011 through March 31, 2012. If the collection amount exceeds or is less than expected, the rate will be reevaluated.

Subject: Hospital Quality Contribution.

Purpose: To collect thirty million dollars annually for the Medical Indemnity Fund.

Text of emergency rule: Subpart 86-1 of 10 NYCRR is amended by adding a new section 86-1.41, to read as follows:

86-1.41 Hospital Quality Contribution.

(a) For the period July 1, 2011 through March 31, 2012 a quality contribution shall be imposed on the inpatient revenue of each general hospital that is received for the provision of inpatient obstetrical patient care services in an amount equal to 2.4% of such revenue, as defined in § 2807-d(3)(a) of the Public Health Law.

(b) For the period on and after April 1, 2012, a quality contribution shall be imposed on the inpatient revenue of each general hospital that is received for the provision of inpatient obstetrical patient care services in an amount equal to 1.6% of such revenue, as defined in § 2807-d(3)(a) of the Public Health Law.

(c) For the purposes of computing revenue subject to this section, inpatient obstetrical patient care services shall also include services related to the care of newborns, but shall exclude neonatal intensive care services.

(d) The funds collected pursuant to this section shall be subject to and administered in accordance with the provisions of § 2807-d-1 of the Public Health Law.

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 September 28, 2011.

Text of rule and any required statements and analyses may be obtained from: Katherine Ceroalo, DOH, Bureau of House Counsel, Reg. 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 authorization to change the rate of the Hospital Quality Contribution is set forth in section 2807-d-1 of the Public Health Law.

Legislative Objectives:

The express provisions of PHL section 2807-d-1 requires the Department to collect thirty million dollars annually for the Medical Indemnity Fund.

Needs and Benefits:

The proposed emergency amendment increases the rate of the Hospital Quality Contribution from 1.6% to 2.4% for the period of July 1, 2011 through March 31, 2012. According to data provided by the New York State Department of Health, this increase is required to meet the required thirty million dollar collection target for such period.

Costs:

There are no additional administrative costs to the implementation of and continuing compliance with this amendment. There are no additional costs to the Department of Health, state government, or local governments for the implementation of and continuing compliance of this amendment.

Local Government Mandates:

The proposed amendment does not impose any new programs, services, duties or responsibilities upon and 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 the amendment.

Duplication:

These regulations do not duplicate existing state or federal regulations.

Alternatives:

No significant alternatives are available. The Department is required by the Public Health Law section 2807-d-1 to promulgate implementing regulations.

Federal Standards:

This amendment does not exceed any minimum standards of the federal government for the same or similar subject areas.

Compliance Schedule:

Section 86-1.41 requires the Department of Health to adjust the Hospital Quality Contribution rate to collections to 2.4% for the period of July 1, 2011 through March 31, 2012 and to 1.6% for the period of April 1, 2012 through March 31, 2013. No further action is required by the providers to achieve compliance with this rule.

Regulatory Flexibility Analysis

Effect of Rule:

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. This rule will have no effect on Local Governments.

Compliance Requirements:

There are no reporting, recordkeeping or other affirmative acts that small business or local governments will need to undertake to comply with the proposed rule. A small business regulation is not required.

Professional Services:

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

Compliance Costs:

There are no initial capital costs required to comply with the proposed rules, and there are no annual costs for continuing compliance.

Economic and Technological Feasibility:

As the proposed rule affects only the rate applied to the Hospital Quality Contribution paid by General Hospitals, compliance by small businesses and local government is not expected to have any economic or technological implication.

Minimizing Adverse Impact:

The proposed amendment reflects statutory intent and requirements.

Small Business and Local Government Participation:

The proposed rule resulted from the 2011-12 budget and is based on the recommendation of the Medicaid Redesign Team created by Executive Order. The recommendations process allowed for input from Medicaid industry stakeholders, including large and small providers, and the general public, through statewide hearings and website outreach.

Rural Area Flexibility Analysis

Types and Estimated Numbers of 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 43 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		

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

Reporting, Recordkeeping and Other Compliance Requirements; and Professional Services:

No new reporting, recordkeeping, or other compliance requirements are being imposed as a result of the proposal. No additional professional services will be required for this compliance.

Costs:

There are no initial capital costs or additional annual costs which are required to comply with this proposal.

Minimizing Adverse Impact:

The proposed amendment reflects statutory intent and requirements.

Rural Area Participation:

The proposed rule resulted from the 2011-12 budget and is based on the recommendations of the Medicaid Redesign Team created by Executive Order. The recommendation process allowed for input from Medicaid stakeholders from all areas of the state, including rural areas, through regional hearings and website outreach.

Job Impact Statement

Nature of Impact:

The proposed emergency regulation will implement statutory action to change the rate of the Hospital Quality Contribution from 1.6% to 2.4% for collections during the period of July 1, 2011 through March 31, 2012. The rate will then be reduced back to 1.6% effective April 1, 2012.

Categories and Numbers Affected:

It is apparent, from the nature and purpose of the proposed rule, that it will not have a substantial adverse impact on jobs or employment opportunities.

Regions of Adverse Impact:

The proposed regulations have no implications for job opportunities for any region.

Minimizing Adverse Impact:

No minimizing measures are required.

**EMERGENCY
RULE MAKING**

Audits of Institutional Cost Reports (ICR)

I.D. No. HLT-29-11-00016-E

Filing No. 623

Filing Date: 2011-07-05

Effective Date: 2011-07-05

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

Action taken: Amendment of Subpart 86-1 of Title 10 NYCRR.

Statutory authority: Public Health Law, section 2807-c(35)

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

Specific reasons underlying the finding of necessity: It is necessary to issue the proposed regulations on an emergency basis in order to implement Public Health Law section 2807-c(35)(b)(xiii), as amended by Chapter 59 of the Laws of 2011, in a timely manner related to imposing a fee schedule associated with filing institutional cost reports, which is intended to fund the costs of auditing institutional cost reports. In addition, this regulation eliminates the need for hospitals to submit a CPA certification of their cost reports for years ended on and after December 31, 2010. To avoid these costs, hospitals need to be advised of the elimination of this requirement.

Public Health Law section 2807-c(35), as amended by Chapter 59 of the Laws of 2011, Part H, § 36, specifically provides the Commissioner of Health with authority to issue these emergency regulations.

Further, there is compelling interest in enacting these regulations immediately in order to secure federal approval of associated Medicaid State Plan amendments and assure there are no delays in implementation of these new policies related to fee obligations for filing institutional cost reports.

Subject: Audits of Institutional Cost Reports (ICR).

Purpose: To impose a fee schedule on general hospitals related to the filing of ICRs sufficient to cover the costs of auditing the ICRs.

Text of emergency rule: Subdivision (k) of section 86-1.2 of title 10 of NYCRR is amended to read as follows:

(k) Accountant's certification. *With regard to institutional cost reports filed for report years prior to 2010, [T]he institutional cost report shall be certified by an independent licensed public accountant or an independent certified public accountant. The minimum standard for the term independent shall be the standard used by the State Board of Public Accountancy.*

Subdivision (b) of section 86-1.4 of title 10 of NYCRR is amended and a new subdivision (i) is added to read as follows:

(b) Subsequent to the filing of fiscal and statistical reports, field audits [shall] *may* be conducted of the records of medical facilities in a time, manner and place to be determined by the State Department of Health. [Where feasible, the department shall enter into an agreement to use a combined audit (Medicare-Medicaid and other organizations and agencies having audit responsibilities) to satisfy the department's auditing needs. In this respect, the State Department of Health reserves the right, after entering into an agreement to use a combined audit, to reject the audit findings of other organizations and agencies having audit responsibilities and to perform a limited scope or comprehensive audit of their own for the same fiscal period audited by the organization and/or agency.] *Alternatively or in addition the Department may, in its sole discretion, conduct desk audits of such fiscal and statistical reports.*

(i)(1) *Effective for institutional cost reports filed for report periods ending on and after December 31, 2010, the Department shall establish a fee schedule for the purpose of funding audit activities authorized pursuant to this section. Such fee schedule shall be published on the Department's Health website at <http://www.health.state.ny.us>. The amount of such fees shall be based upon the relative amount of the total costs reported by each facility, provided, however, that minimum and maximum fee levels may be established.*

(2) *Additional fees shall be established for facilities filing more than two institutional costs reports for a cost period. The Department may, upon written application submitted prior to the submission of such additional institutional cost reports, waive all or part of such additional fees based on a showing of financial hardship or for other good cause shown. Such a waiver must be in writing.*

(3) *Fees shall be submitted at the time of the submission of the institutional cost reports. A failure to pay such fees may be deemed by the Department as constituting the non-filing of the institutional cost report and subject the facility to the rate reduction authorized pursuant to section 86-1.2(c) of this Subpart. Failure to pay the additional fee associated with the filing of additional institutional cost reports as described in paragraph (2) of this subdivision shall result in the non-utilization of such revised cost reports by the Department. Delinquent fees may be collected by the Department in accordance with the provisions of Public Health Law section 2807-c(18)(h).*

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 October 2, 2011.

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

Regulatory Impact Statement

Statutory Authority:

Public Health Law section 2807-c(35)(b)(xiii) authorizes the Commissioner to impose a fee, by regulation, on general hospitals that is sufficient to cover the costs of auditing the institutional cost reports submitted by such hospitals.

Legislative Objectives:

The Legislature authorized the Commissioner to impose fees sufficient to cover the costs of auditing institutional cost reports for fiscal purposes and to improve the data integrity of information reported by hospitals. Such information is used to make both policy and financial decisions related to the Medicaid program.

Needs and Benefits:

The proposed rule implementing the provisions of Public Health Law section 2807-c(35)(b)(xiii) provides for the establishment and implementation of a new fee schedule to support the costs of auditing institutional cost reports. The rule also details how the audit process will be implemented. At the same time the Department is exercising its discretion under its pre-existing hospital rate-setting regulation authority pursuant to PHL section 2807-c(35)(b) to eliminate the requirement that hospitals secure certification of their cost reports by an independent licensed CPA.

COSTS:

Costs to State Government:
There are no additional costs to State government as a result of this amendment.

Costs of Local Government:
There will be no additional cost to local governments as a result of these amendments.

Costs to the Department of Health:
There will be no additional costs to the Department of Health as a result of this amendment.

Local Government Mandates:
The proposed amendments do not impose any new programs, services, duties or responsibilities 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:
No significant alternatives are available. The Department is authorized by the Public Health Law section 2807-c(35)(b) to address certain aspects of the hospital reimbursement methodology through regulations.

Federal Standards:
This amendment does not exceed any minimum standards of the federal government for the same or similar subject areas.

Compliance Schedule:
The proposed amendments to Section 86-1.2 limits the requirement that institutional cost reports be certified by an independent licensed or certified public accountant to cost periods prior to 2010. Regulated parties must continue to comply with this provision when filing institutional cost reports for cost periods prior to 2010.

The proposed amendments to Section 86-1.4 allows the Department to impose fees on general hospitals sufficient to cover the costs of auditing the institutional cost reports submitted by general hospitals for cost periods on and after December 31, 2010. Regulated parties must comply with this provision at the time of submission of the institutional cost report. Failure to comply may subject the facility to a rate reduction. In addition, general hospitals that fail to pay the additional fee associated with filing more than two institutional cost reports for a reporting period will be subject to an additional fee.

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.

All health care providers who file Institutional Cost Reports with the Department, including the seven hospitals identified as small businesses, are subject to the provisions of this regulation under section 2807-c(35)(b) of the Public Health Law. However, this rule also eliminates the requirement for all hospitals that annual cost reports be certified by an independent CPA, thus reducing the costs and administrative burdens resulting from that current requirement. In addition, provisions are made to waive or reduce some of the new fees for institutions who demonstrate financial hardship and good cause and who apply for such in writing.

This rule will have no direct effect on Local Governments.
Compliance Requirements:
No new reporting, recordkeeping or other compliance requirements are being imposed as a result of this rule. Affected health care providers will bill Medicaid using procedure codes and ICD-9 codes approved by the American Medical Association, as is currently required. The rule should have no direct effect on Local Governments.

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

Compliance Costs:
While fee obligations related to the filing of institutional cost reports represent a cost for general hospitals, this is offset by the reduction in costs resulting from the elimination of the requirement that reports be certified by an independent certified public accountant. No capital costs will be imposed as a result of this rule, nor will there be an annual cost of compliance.

Economic and Technological Feasibility:
Small businesses will be able to comply with the economic and technological aspects of this rule. The proposed amendments are technologically feasible because it requires the use of existing technology. The overall economic impact to comply with the requirements of this regulation is expected to be minimal.

Minimizing Adverse Impact:

The proposed amendments reflect statutory intent and requirements.

Small Business and Local Government Participation:

Hospital associations participated in discussions and contributed comments through the State’s Medicaid Redesign Team process regarding these changes.

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 43 counties have a population less than 200,000:

Allegany	Hamilton	Schenectady
Cattaraugus	Herkimer	Schoharie
Cayuga	Jefferson	Schuylar
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		

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, recordkeeping, 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 is there an annual cost of compliance.

Minimizing Adverse Impact:

The proposed amendments reflect statutory intent and requirements.

Rural Area Participation:

This amendment is the result of ongoing discussions with industry associations as part of the Medicaid Redesign team process. These associations include members from rural areas. As well, the Medicaid Redesign Team held multiple regional hearings and solicited ideas through a public process.

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 allow for the Department to perform field or desk audits of the fiscal and statistical records of medical facilities, establish a fee schedule for filing institutional cost reports for report periods on and after December 31, 2010, and require accountant’s certification only for institutional cost reports filed for cost years prior to 2010. The proposed regulations have no implications for job opportunities.

**EMERGENCY
RULE MAKING**

Medicaid Benefit Limits for Enteral Formula, Prescription Footwear, and Compression Stockings

I.D. No. HLT-29-11-00017-E

Filing No. 624

Filing Date: 2011-07-05

Effective Date: 2011-07-05

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

Action taken: Amendment of Parts 505 and 513 of Title 18 NYCRR.

Statutory authority: Public Health Law, sections 201 and 206; and Social Services Law, sections 363-a and 365-a(2)

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

Specific reasons underlying the finding of necessity: Chapter 59 of the laws of 2011 enacted a number of proposals recommended by the Medicaid Redesign Team established by the Governor to reduce costs and increase quality and efficiency in the Medicaid program. The changes to SSL section 365-a(2)(g) that establish benefit limits for enteral formula, prescription footwear, and compression stockings take effect April 1, 2011. Paragraph (t) of section 111 of Part H of Chapter 59 authorizes the Commissioner to promulgate, on an emergency basis, any regulations needed to implement such law. The Commissioner has determined it necessary to file these regulations on an emergency basis to achieve the savings intended to be realized by the Chapter 59 provisions regarding benefits limits.

Subject: Medicaid Benefit Limits for Enteral Formula, Prescription Footwear, and Compression Stockings.

Purpose: To impose benefit limitations on Medicaid coverage of enteral formula, prescription footwear, and compression stockings.

Text of emergency rule: Paragraph (2) of subdivision (b) of section 505.1 is amended, and a new paragraph (3) is added to read as follows:

- (2) the identification card on its face:
 - (i) restricts an individual recipient to a single provider; or
 - (ii) requires prior authorization for all ambulatory medical services and supplies except emergency care [.] ; or
 - (3) *the service exceeds benefit limitations as established by the department.*

The opening language of paragraph (4) of subdivision (a) of section 505.5 is amended to read as follows:

(4) Orthopedic footwear means shoes, shoe modifications, or shoe additions which are used as follows: *in the treatment of children*, to correct, accommodate or prevent a physical deformity or range of motion malfunction in a diseased or injured part of the ankle or foot; *in the treatment of children*, to support a weak or deformed structure of the ankle or foot; *as a component of a comprehensive diabetic treatment plan to treat amputation, ulceration, pre-ulcerative calluses, peripheral neuropathy with evidence of callus formation, a foot deformity or poor circulation*; or to form an integral part of an orthotic brace. Orthopedic shoes must have, at a minimum, the following features:

Subparagraph (ii) of paragraph (4) of subdivision (b) of section 505.5 is amended to read as follows:

(ii) The maximum number of refills permitted for medical/surgical supplies is found in the fee schedule for durable medical equipment, medical/surgical supplies, orthotic and prosthetic appliances and orthopedic footwear. The fee schedule for such equipment and supplies is available *free of charge* from the [department] *Medicaid fiscal agent's website*. [and is also contained in the department's Medicaid Management Information System (MMIS) provider Manual (Durable Medical Equipment, Medical and Surgical Supplies, Prosthetic and Orthotic Appliances). Copies of the manual may be obtained by writing Computer Sciences Corporation, Health and Administrative Services Division, 800 North Pearl St., Albany, NY 12204. Copies may also be obtained from the Department of Social Services, 40 North Pearl St., Albany, NY 12243. The manuals are provided free of charge to every provider of durable medical equipment, medical/surgical supplies, orthotic and prosthetic appliances and orthopedic footwear at the time of enrollment in the MA program.]

Subparagraph (vi) of paragraph (1) of subdivision (d) of section 505.5 is amended to read as follows:

(vi) [All items not listed in the department's fee schedule for durable medical equipment, medical/surgical supplies, prosthetic and orthotic appliances and orthopedic footwear require prior approval from the New

York State Department of Health. The fee schedule for such equipment and supplies is available from the department and is also contained in the department's MMIS Provider Manual (Durable Medical Equipment, Medical/Surgical Supplies, Prosthetic and Orthotic Appliances). Copies of the manual may be obtained by writing Computer Sciences Corporation, Health and Administrative Services Division, 800 North Pearl St., Albany, NY 12204. Copies may also be obtained from the Department of Social Services, 40 North Pearl St., Albany, NY 12243. The manuals are provided free of charge to every provider of durable medical equipment, medical/surgical supplies, orthotic and prosthetic appliances and orthopedic footwear at the time of enrollment in the MA program.] Reimbursement amounts for unlisted items are determined by the New York State Department of Health and must not exceed the lower of: (a) the acquisition cost to the provider plus 50 percent; or (b) the usual and customary price charged to the general public.

Subparagraph (iii) of paragraph (4) of subdivision (d) of Section 505.5 is amended to read as follows:

(iii) The fee schedule for orthotic and prosthetic appliances and devices is available *free of charge* from the *Medicaid* [department and is also contained in the department's MMIS Provider Manual (Durable Medical Equipment, Medical and Surgical Supplies, Prosthetic and Orthotic Appliances). Copies of the manual may be obtained by writing Computer Sciences Corporation, Health and Administrative Services Division, 800 North Pearl St., Albany, NY 12204. Copies may also be obtained from the Department of Social Services, 40 North Pearl St., Albany, NY 12243. The manuals are provided free of charge to every provider of durable medical equipment, medical/surgical supplies, orthotic and prosthetic appliances and orthopedic footwear at the time of enrollment in the MA program] *fiscal agent's website*.

Subparagraph (i) of paragraph (5) of subdivision (d) of section 505.5 is amended to read as follows:

- (i) Payment for orthopedic footwear must not exceed the lower of:
 - (a) [the acquisition cost to the provider plus 50%] *the maximum reimbursable amount as shown in the fee schedule for durable medical equipment, medical/surgical supplies, orthotics and prosthetic appliances and orthopedic footwear; the maximum reimbursable amount will be determined for each item of footwear based on an average cost of products representative of that item; or*
 - (b) the usual and customary price charged to the general public *for the same or similar products.*

Paragraph (1) of subdivision (e) of section 505.5 is amended to read as follows:

(1) [The following items] *Items* of durable medical equipment, medical/surgical supplies, orthotic and prosthetic appliances and devices, and orthopedic footwear are limited in their amount and frequency and may require prior authorization. *Service limits and prior authorization requirements are listed in the provider manual at the Medicaid fiscal agent's website.*

[ITEM	LIMIT
Cane	1 every 3 yrs.
Cane, Quad or three prong	1 every 3 yrs.
Flare heels (each)	2 pair per yr.
Cork lifts	2 pair per yr.
Steindler heel corrections	2 pair per yr.
Spenco Insert	2 pair per yr. per child
Heel wedge	2 pair per yr.
Foot, insert, removable, molded to patient model, longitudinal arch support, each	2 per yr. per adult
Foot, insert, removable, molded to patient model, longitudinal/metatarsal support, each	2 per yr. per adult
Foot, arch support, removable, premolded, longitudinal, each	2 per yr. per adult
Foot, arch support, removable, premolded, longitudinal/metatarsal, each	2 per yr. per adult
Longitudinal arch support	1 pair per yr. per adult
Foot, arch support	2 pair per yr. per adult
Removable mold/Levi mold	1 pair per yr. per adult
Elastic stocking/below knee medium wt.	4 pair per yr.
Elastic stocking/below knee heavy wt.	4 pair per yr.
Elastic stocking/above knee medium wt.	4 pair per yr.

Elastic stocking/above knee heavy wt.	4 pair per yr.
Elastic stocking/full length medium wt.	4 pair per yr.
Elastic stocking/full length heavy wt.	4 pair per yr.
Elastic stocking/leotards	4 pair per yr.
Elastic stocking/garter belt	4 pair per yr.
Surgical stocking/below knee	4 pair per yr.
Surgical stocking/thigh length	4 pair per yr.
Surgical stocking/full length	4 pair per yr.
Corset, Sacroiliac 2 per yr. Corset, Lumbar	2 per yr.
Handheld shower head	1 every 3 yrs.
Bed pan, fracture	1 every 3 yrs.
Urinary suspensory	1 every 5 yrs.
Emesis basin	1 every 5 yrs.
Sitz bath	1 every 5 yrs.
Urinal, female, any material	1 every 5 yrs.
Urinal, male, any material	1 every 5 yrs.
Commode pad	1 every 5 yrs.
Flotation pad	1 per yr.
Humidifier, cold air	1 every 3 yrs.
Vaporizer, room type	1 every 3 yrs.
Standard adult wheelchair	1 every 3 yrs.
Electric heating pad standard	1 every 3 yrs.
Hot fomentation heating pads	1 every 3 yrs.
Orthopedic shoes	2 pair per yr.]

A new subdivision (g) of section 505.5 is added to read as follows:

(g) *Benefit limitations. The department shall establish defined benefit limits for certain Medicaid services as part of its Medicaid State Plan. The department shall not allow exceptions to defined benefit limitations. The department has established defined benefit limits on the following services:*

(1) *Compression and surgical stockings are limited to coverage during pregnancy and for venous stasis ulcers.*

(2) *Orthopedic footwear is limited to coverage in the treatment of children to correct, accommodate or prevent a physical deformity or range of motion malfunction in a diseased or injured part of the ankle or foot; in the treatment of children to support a weak or deformed structure of the ankle or foot; as a component of a comprehensive diabetic treatment plan to treat amputation, ulceration, pre-ulcerative calluses, peripheral neuropathy with evidence of callus formation, a foot deformity or poor circulation; or to form an integral part of an orthotic brace.*

(3) *Enteral nutritional formulas are limited to coverage for tube-fed individuals who cannot chew or swallow food and must obtain nutrition through formula via tube; individuals with rare inborn metabolic disorders requiring specific medical formulas to provide essential nutrients not available through any other means; and for children under age 21 when caloric and dietary nutrients from food cannot be absorbed or metabolized.*

Paragraph (1) of subdivision (b) of section 513.0 is amended to read as follows:

(1) The department, as the single State agency supervising the administration of the MA program, has entered into an interagency agreement with the Department of Health whereby that department will review and approve selected medical, dental and remedial care, services and supplies prior to their being furnished. The purpose of this process is to assure that: the requested medical, dental and remedial care, services or supplies are medically necessary and appropriate for the individual recipient's medical needs; other adequate and less expensive alternatives have been explored and, where appropriate and cost effective, are approved; *the request does not exceed benefit limitations as promulgated by the department;* and the medical, dental and remedial care, services or supplies to be provided conform to accepted professional standards. *The department shall not allow exceptions to defined benefit limitations.*

A new subdivision (h) of section 513.1 is added to read as follows:

(h) *Benefit limits means specified Medicaid coverage limits which cannot be exceeded by obtaining prior approval or authorizations and for which no exceptions are allowed.*

Paragraph (1) of subdivision (a) of section 513.6 is amended to read as follows:

(1) the specific statutory and regulatory standards *and benefit limits* governing the furnishing of the requested care, services, or supplies;

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 October 2, 2011.

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

Regulatory Impact Statement

Statutory Authority:

Social Services Law (SSL) section 363-a and Public Health Law section 201(1)(v) provide that the Department is the single state agency responsible for supervising the administration of the State's medical assistance ("Medicaid") program and for adopting such regulations, not inconsistent with law, as may be necessary to implement the State's Medicaid program.

Legislative Objective:

The legislative objective, expressed through SSL section 365-a(2)(g), is to impose benefit limitations on Medicaid coverage of enteral formula, prescription footwear, and compression stockings.

Needs and Benefits:

Enteral formula. Enterals are ordered by practitioners and dispensed by pharmacy or durable medical equipment providers. Medicaid reimburses the cost of enteral formulas for administration via tube or as a liquid oral nutritional therapy when there is a documented diagnostic condition where caloric and dietary nutrients from food cannot be absorbed or metabolized. When prescribed for oral supplementation in adults who can chew and swallow their food, it is objectively difficult to assess medical necessity for the enteral formula and to prevent such reimbursement when used strictly as a convenient food supplement and not due to medical necessity to treat a clinical condition. In the Medicare program enterals are covered for tube-fed individuals only.

Medicaid has attempted to put controls into place such as Card Swipe Prior Authorization and Automated Telephone Prior Authorization. Medicaid has also continued to monitor (through reporting systems) and correct provider prescribing and dispensing activity. In 2004, the enteral pricing methodology was changed, resulting in a 10-20 percent reduction in fees. Despite these measures, total yearly Medicaid utilization and expenditures for enteral nutrition have risen from less than \$11 million per year in 1997 to over \$70 million using the current coverage guidelines and procedures.

By limiting the benefit to specific medical necessity criteria for tube-fed individuals who cannot chew or swallow food, and must obtain nutrition through formula via tube, for individuals with rare inborn metabolic disorders requiring specific medical formulas to provide essential nutrients not available through any other means, and for children when there is a documented diagnostic condition where caloric and dietary nutrients from food cannot be absorbed or metabolized, the regulation will help reduce Medicaid costs by \$15.4 million state and local share annually while continuing to meet intensive medical needs of individual beneficiaries with serious medical conditions.

Orthopedic footwear. Orthopedic footwear is ordered by practitioners and dispensed by durable medical equipment providers. Medicaid currently reimburses the cost of footwear for treatment of any physical deformity, range of motion malfunction, or foot or ankle weakness. A significant portion of utilization under the current benefit is for individuals whose needs can be met with off the shelf footwear. When prescribed for these less serious purposes, it is objectively difficult to assess medical necessity for the footwear and to prevent such reimbursement. Medicare reimburses footwear only for treatment of diabetes complications. Additionally, footwear is currently manually priced at invoice cost plus 50 percent, resulting in paper claims.

By limiting the benefit based on medical necessity criteria and adopting the new reimbursement methodology, the regulation will reduce Medicaid costs by \$7.35 million state and local share in State Fiscal Year 2011-12 while continuing to meet intensive medical needs of individual beneficiaries with serious medical conditions.

Compression stockings. Compression stockings are ordered by practitioners and dispensed by pharmacy or durable medical equipment providers. Medicaid currently reimburses the costs of stockings for treatment of clinically significant medical conditions such as open wounds, and complications in pregnancy. Medicaid also currently reimburses the cost of stockings that have been prescribed for relatively less serious purposes such as circulatory improvement and wound prevention. When prescribed for these less serious purposes, it is objectively difficult to assess medical necessity for the stockings and to prevent their reimbursement when used strictly for comfort or convenience instead of medically necessary treatment for a clinical condition. Medicare reimburses for stockings only for treatment of open wounds.

By limiting the benefit based on diagnoses of pregnancy or open wounds, the regulation will help reduce Medicaid costs while continuing to meet intensive medical needs of individual beneficiaries with serious medical conditions.

In addition to the changes described above, the regulation amends sections 513.0, 513.1 and 513.6 to clarify that the new benefit limitations are not subject to exception through prior approval. Also, the regulation updates outdated language in section 505.5 regarding how durable medical equipment providers could obtain a hard copy of the Medicaid Provider Manual; such Manual is currently made available to providers online.

COSTS:

Costs for the Implementation of, and Continuing Compliance with the Regulation to the Regulated Entity:

This amendment will not increase costs to the regulated parties. It will reduce revenues to the extent providers are furnishing enteral formula, prescription footwear, or compression stockings beyond the scope of the benefit limit.

Costs to State and Local Government:

This amendment will not increase costs to the State or local governments. Savings to the Medicaid Program will be achieved by establishing these benefit limits.

Costs to the Department of Health:

There will be no additional costs to the Department.

Local Government Mandates:

This amendment will not impose any program, service, duty, additional cost, or responsibility on any county, city, town, village, school district, fire district, or other special district.

Paperwork:

This amendment will not impose any additional paperwork for providers of enteral formula, prescription footwear, or compression stockings.

Duplication:

There are no duplicative or conflicting rules identified.

Alternatives:

The benefit limits on enteral formula, prescription footwear, and compression stockings are mandated by section 365-a(2)(g) of the SSL. No alternatives were considered.

Federal Standards:

The proposed regulations do not exceed any minimum federal standards.

Compliance Schedule:

Social services districts and fiscal intermediaries should be able to comply with the proposed regulations when they become effective.

Regulatory Flexibility Analysis

Effect of Rule:

This amendment affects the 3,123 pharmacies and 369 durable medical equipment providers enrolled in the Medicaid program who actively bill Medicaid for enteral formula. The amendment will limit the enteral benefit, which will reduce Medicaid utilization and billable claims to these businesses, some of which are small. The Department is anticipating a \$15.40 million reduction in enteral expenditures in State Fiscal Year (SFY) 2011-12 and thereafter.

This amendment affects the 955 durable medical equipment providers enrolled in the Medicaid program who actively bill Medicaid for footwear. The amendment will limit the footwear benefit, which will reduce Medicaid utilization and billable claims to these businesses, some of which are small. The Department is anticipating a \$7.35 million reduction in footwear expenditures in SFY 2011-12 and \$16 million annually thereafter.

This amendment affects the 1196 pharmacies and 441 durable medical equipment providers enrolled in the Medicaid program who actively bill Medicaid for stockings. The amendment will limit the stocking benefit, which will reduce Medicaid utilization and billable claims to these businesses, some of which are small. The Department is anticipating a \$1.07 million reduction in stocking expenditures in SFY 2011-12 and thereafter.

The fifty-eight local social services districts share in the costs of services provided to eligible beneficiaries who receive Medicaid through their districts.

Compliance Requirements:

This amendment does not impose new reporting, recordkeeping or other compliance requirements on small businesses or local governments.

Professional Services:

No new professional services are required as a result of this amendment.

Compliance Costs:

There are no direct costs of compliance with this amendment. However, affected providers will realize reduced Medicaid billings for enteral formula, prescription footwear, and compression stockings. Local social service districts will experience decreased costs in their share of medical expenses for these items as a result of overall decreases in utilization.

Economic and Technological Feasibility:

The amendment will not change the way providers bill for services or affect the way the local districts contribute their local share of Medicaid

expenses for enteral formula, prescription footwear, or compression stockings. Therefore, there should be no technological difficulties associated with compliance with the proposed regulation.

Minimizing Adverse Impact:

SSL section 365-a(2)(g) requires a benefit limit on the coverage of enteral formula, prescription footwear, and compression stockings. These limits will affect providers by reducing payable Medicaid claims for such items. This impact cannot be avoided given the statutory mandate.

Small Business and Local Government Participation:

Local government officials have consistently urged the Department to implement Medicaid cost savings programs. The Department also meets on a regular basis with provider groups such as the New York Medical Equipment Providers (NYMEP). NYMEP has been informed of the proposed changes and has indicated its concerns regarding adequate notice to beneficiaries and practitioners on the revised benefits. Upon promulgating the regulation, the Department will inform the industry of the changes and assist as necessary with the transition to the new benefit limits.

Rural Area Flexibility Analysis

Types and Estimated Number of Rural Areas:

The benefit limit on enteral formula will apply to 3123 pharmacies and 369 durable medical equipment providers in New York State. The benefit limit on prescription footwear will apply to 955 durable medical equipment providers in New York State. The benefit limit on compression stockings will apply to 1196 pharmacies and 441 durable medical equipment providers in New York State. These businesses are located in rural, as well as suburban and metropolitan areas of the State.

Reporting, Recordkeeping and Other Compliance Requirements and Professional Services:

No new reporting, recordkeeping or other compliance requirements and professional services are needed in a rural area to comply with the proposed rule.

Costs:

There are no direct costs associated with compliance. However, affected providers will realize reduced Medicaid billable claims for enteral formula, prescription footwear, and compression stockings.

Minimizing Adverse Impact:

The Department considered the approaches in Section 202-bb(2)(b) of the State Administrative Procedure Act and found them to be inappropriate given the legislative objective.

Rural Area Participation:

The Department meets on a regular basis with provider groups such as the New York Medical Equipment Providers (NYMEP), who represents some rural providers, to discuss reimbursement issues. NYMEP has indicated its concerns regarding adequate notice to beneficiaries and practitioners on the revised benefits. Upon promulgating the regulation, the Department will inform the industry of the changes and assist as necessary with the transition to the new benefit limits.

Job Impact Statement

Nature of Impact:

This rule will result in decreased Medicaid billable claims for providers of enteral formula, prescription footwear, and compression stockings. This decreased revenue will not likely have an adverse impact on jobs and employment opportunities within these businesses as they offer a wide variety of services which are reimbursed by Medicaid.

Categories and Numbers Affected:

This rule, which decreases Medicaid revenue, will not likely affect employment opportunities within providers who provide enteral formula, prescription footwear, and compression stockings.

The dispensing of enteral formula and compression stockings requires store clerk level staff, not licensed professionals.

The dispensing of prescription footwear requires staff certification from a national orthotic and prosthetic accreditation and training body. Support staff require no special training.

Regions of Adverse Impact:

This rule will affect all regions within the State and businesses out of New York State that are enrolled in the Medicaid Program to provide enteral formula, prescription footwear, and compression stockings.

Minimizing Adverse Impact:

SSL section 365-a(2)(g) requires a benefit limit on the coverage of enteral formula, prescription footwear, and compression stockings. These limits will affect providers by reducing payable Medicaid claims for such items. This impact cannot be avoided given the statutory mandate.

Self-Employment Opportunities:

The rule is expected to have minimal impact on self-employment opportunities since the majority of providers that will be affected by the rule are not small businesses or sole proprietorships whose sole business is dispensing enteral formula, prescription footwear, or compression stockings.

Assessment of Public Comment

Public comment was received from 3 commentators, the Cystic Fibrosis Center at SUNY-Upstate, SAPS Drug Wholesale, Inc., and Abbott Nutrition, a manufacturer of enteral nutritional formulas.

Comments received were focused on one area of the emergency regulations:

Subdivision (g)(2) of section 505.5 benefit limitations for enteral nutritional formulas:

The Cystic Fibrosis Center at SUNY-Upstate stated that they have obtained authorization for enteral nutritional formula in the treatment of cystic fibrosis, an inborn metabolic disease, but the provider could not dispense because the formula ordered was not an inborn metabolic formula. Some cystic fibrosis patients require greatly increased caloric intake through standard oral formulas because of the nature of the disease. The Department subsequently manually authorized the formula to allow payment and plans to institute automated prior authorization system changes to avert potential delays in treatment. The Department has also reached out to Cystic Fibrosis centers to inform them of the temporary workaround and long term solution. SAPS Drug Wholesale expressed concern that the State is not offering coverage for oral nutritional formulas for HIV/AIDS and chemotherapy patients and those who have lost significant weight. They stated that coverage for adults should not be limited to tube feeding and suggested that patients will now use the emergency room for treatment. The Department plans to publish links to resources for health care practitioners and beneficiaries regarding good nutrition practices and food assistance programs that will assist in meeting special nutritional requirements to maintain good health.

Abbott Nutrition expressed concern that coverage for children had been dropped and that there was a stark contrast between the statutory language and the regulatory language. Additionally Abbott stated its belief that the regulation is more limiting than the statute and excludes coverage for children with growth and development needs. Abbott stated that the Medicaid Redesign Team's proposal language also dropped coverage for children.

The Department and the MRT process did not nor has intention to drop or change enteral nutritional formula coverage or prior authorization criteria for children. The statutory language cited by Abbott was inserted during the legislative process to assure that coverage for children would not change. In the regulatory language, the Department reiterated its longstanding medical criteria for children that formulas are covered when nutrients from food cannot be absorbed or metabolized. Growth and development issues remain covered by Medicaid under the provisions of Social Services Law Article 5 Title 11 Section 365-a (3), early periodic screening, diagnosis and treatment (EPSDT).

The Department refers the commentator to the New York State Medicaid Program Enteral Formula Prior Authorization Prescriber Worksheet (revised May 2011) which contains, as did previous versions, the criteria regarding individuals under the age of 21. Specifically, medical conditions that prevent consumption normal table, and softened, mashed, pureed, or blenderized foods, documentation of alternatives tried but not successful, significant unintentional weight loss or no weight gain in six months and other objective medical evidence in the medical record to support the need for enteral nutritional formulas. The worksheet is available at: http://www.emedny.org/ProviderManuals/communications/Prescriber__Worksheet-20110504.pdf

Office of Mental Health

EMERGENCY RULE MAKING

Medical Assistance Rates of Payment for Residential Treatment Facilities for Children and Youth

I.D. No. OMH-29-11-00005-E

Filing No. 617

Filing Date: 2011-07-01

Effective Date: 2011-07-01

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

Action taken: Amendment of Part 578 of Title 14 NYCRR.

Statutory authority: Mental Hygiene Law, sections 7.09 and 43.02

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

Specific reasons underlying the finding of necessity: The rulemaking

serves to amend two separate provisions within 14 NYCRR Part 578. The first amendment provides consistency with the enacted State budget by freezing the rate of payments received by residential treatment facilities (RTF), effective July 1, 2011. The second amendment provides for a change in the reimbursement methodology for eligible pharmaceutical costs for RTFs that would be effective on or after January 1, 2011, and upon receipt of federal approval. Due to the implementation dates of these provisions and the need for RTF providers to be aware of these amendments, it was determined that this rule warrants emergency filing.

Subject: Medical Assistance Rates of Payment for Residential Treatment Facilities for Children and Youth.

Purpose: Amend reimbursement methodology for eligible pharmaceutical costs for RTFs and freeze the rates of payments effective 7/1/11.

Text of emergency rule: 1. Subdivision (a) of Section 578.8 of Title 14 NYCRR is amended to read as follows:

(a) The rate of payment shall consist of an operating cost per diem and a capital cost per diem, computed from allowable costs and subject to cost category standards. The rate year shall be the 12-month period from July 1st through June 30th. The rate of payment effective July 1, 1995 through June 30, 1996 shall be a continuance of the rate of payment effective July 1, 1994 through June 30, 1995. *The rate of payment effective July 1, 2011 through June 30, 2012 shall be a continuance of the rate of payment in effect on June 30, 2011, except to the extent necessary to adjust such payments pursuant to the provisions of subdivision (o) of Section 578.14 of this Part.*

2. Subdivision (o) of Section 578.14 of Title 14 NYCRR is amended to read as follows:

(o) Effective on or after January 1, 2011, and contingent upon federal approval, allowable operating costs shall not include the costs of pharmaceuticals listed on the New York State Medicaid formulary, *except for such costs incurred during the first 90 days after admission to the residential treatment facility or until Medicaid eligibility is established for the recipient, whichever comes first.* [Such costs] *Pharmaceuticals for which the cost is so excluded may be reimbursed, as appropriate, on a fee-for-service basis by the Medicaid program.*

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 September 28, 2011.

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: Joyce.Donohue@omh.ny.gov

Regulatory Impact Statement

1. Statutory Authority: 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.

Section 43.02 of the Mental Hygiene Law provides that the Commissioner has the power to establish standards and methods for determining rates of payment made by government agencies pursuant to Title 11 of Article 5 of the Social Services Law for services provided by facilities, including residential treatment facilities for children and youth licensed by the Office of Mental Health (Office).

2. Legislative Objectives: Article 7 of the Mental Hygiene Law reflects the Commissioner's authority to establish regulations regarding mental health programs. Allowable operating costs are subject to the review and approval of the Office, including eligible pharmaceutical costs. The rule provides for a change in the reimbursement methodology for eligible pharmaceutical costs for Residential Treatment Facilities (RTF) for children and youth. In addition, this rule provides consistency with the enacted State budget by freezing the rate of payments received by RTF providers for the year July 1, 2011 through June 30, 2012.

3. Needs and Benefits: This rulemaking addresses two separate provisions within 14 NYCRR Part 578. The first amendment reflects a freeze of the rates paid to RTF providers for the year July 1, 2011 through June 30, 2012. This continuation of current rates is consistent with the 2011-2012 enacted State budget and is the result of the serious fiscal condition of the State.

The other amendment concerns costs of pharmaceuticals for residents of an RTF. On February 2, 2011, the Office adopted as final amendments to this Part which specified that, on or after January 1, 2011, and contingent upon federal approval, allowable operating costs for RTFs for children and youth licensed by the Office shall not include the costs of pharmaceuticals listed on the New York State Medicaid formulary. The regulation further stated that, "Such costs may be reimbursed, as appropriate, on a fee-for-service basis by the Medicaid program." After this rule was promulgated, it was determined that a change is necessary due to the fact that when children are admitted to an RTF, there may be a significant lag of up to 90 days before they are deemed to be Medicaid eligible. In or-

der to ensure that children receive their necessary medications, the Office is amending this regulation to provide that allowable operating costs for the RTFs will include pharmaceutical costs incurred during the first 90 days after a child's admission to an RTF or until Medicaid eligibility is established for the individual, whichever comes first. It is important to note that this provision is effective upon federal approval.

4. Costs:

(a) cost to State government: These regulatory amendments will not result in any additional costs to State government. It is anticipated that the rate freeze will result in a full annual savings to State government in the amount of \$1,169,951, and that the pharmaceutical carve out will result in a full annual savings to State government in the amount of \$375,000.

(b) cost to local government: These regulatory amendments will not result in any additional costs to local government.

(c) cost to regulated parties: The gross estimated reimbursable costs to providers for the lag in Medicaid eligibility could be as much as \$1,000,000. Providers will be reimbursed for all but approximately \$350,000 of this increase through adjustments to their reimbursement rates.

5. Local Government Mandates: These regulatory amendments will not 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: As noted above, this rulemaking serves two purposes. The first amendment serves to freeze the rates paid to providers for the period July 1, 2011 through June 30, 2012. This amendment is consistent with the enacted State budget and is a reflection of the serious fiscal condition of the State. The second amendment provides, upon federal approval, for an exception to the exclusion of the costs of pharmaceuticals from the allowable operating costs of providers for 90 days after an individual's admission to an RTF or until Medicaid eligibility is established, whichever occurs first. This amendment will serve to ensure that children who have been admitted to an RTF will continue to have a means for having their medications reimbursed while their Medicaid eligibility is being established. While providers will initially incur the costs associated with these medications, those costs will be reimbursed by a subsequent adjustment in their rate of payment over the following two years, assuming the providers' overall administration maintenance and support costs do not surpass allowable amounts. Currently, it is anticipated that four providers may exceed these amounts, thereby resulting in the \$350,000 amount in the "cost to regulated parties" section above. No other alternative was 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: The regulatory amendments would become effective immediately upon adoption.

Regulatory Flexibility Analysis

The rule provides consistency with the 2011-2012 enacted State budget by freezing the rate of payments received by residential treatment facilities for children and youth, effective July 1, 2011. The rule also amends the reimbursement methodology for eligible pharmaceutical costs by permitting an exemption to the exclusion of the costs of pharmaceuticals from the allowable operating costs of RTF providers for 90 days after an individual's admission to an RTF, or until Medicaid eligibility is established, whichever comes first. While providers will initially incur costs associated with these medications, those costs will be reimbursed by a subsequent adjustment in their rate of payment over the following two years, assuming the providers' overall administration maintenance and support costs do not surpass allowable amounts. It is expected that the majority of RTF providers will not exceed allowable amounts; therefore, it is anticipated that the majority of providers will be reimbursed for the pharmaceutical costs by a rate adjustment over the subsequent two years. As no adverse economic impact upon small businesses or local governments is anticipated, a regulatory flexibility analysis is not submitted with this notice.

Rural Area Flexibility Analysis

The purpose of this rulemaking is twofold. The rule freezes the rate of payments received by residential treatment facilities for children and youth, effective July 1, 2011. This amendment is consistent with the 2011-2012 enacted State budget and reflects the serious fiscal condition of the State. The rule also amends the reimbursement methodology for eligible pharmaceutical costs by permitting an exemption to the exclusion of the costs of pharmaceuticals from the allowable operating costs of RTF providers for 90 days after an individual's admission to an RTF, or until

Medicaid eligibility is established, whichever comes first. While providers will initially incur costs associated with these medications, those costs will be reimbursed by a subsequent adjustment in their rate of payment over the following two years, assuming the providers' overall administration maintenance and support costs do not surpass allowable amounts. It is expected that the majority of RTF providers will not exceed allowable amounts; therefore, it is anticipated that the majority of providers will be reimbursed for the pharmaceutical costs by a rate adjustment over the subsequent two years. As there is not expected to be an adverse economic impact upon rural areas, a rural area flexibility analysis is not included in this rulemaking.

Job Impact Statement

A Job Impact Statement is not submitted with this notice because it is evident from the subject matter of the rulemaking that there will be no impact upon jobs and employment opportunities. The rule serves two purposes. First, it provides consistency with the enacted State budget by freezing rates of payments to providers of residential treatment facilities (RTF) for children and youth, effective July 1, 2011. Secondly, it amends the reimbursement methodology for eligible pharmaceutical costs for RTFS, effective on or after January 1, 2011 and pending federal approval.

Office for People with Developmental Disabilities

EMERGENCY RULE MAKING

Provider Allocation of OPWDD Funding

I.D. No. PDD-29-11-00006-E

Filing No. 618

Filing Date: 2011-07-01

Effective Date: 2011-07-01

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

Action taken: Amendment of sections 635-10.5, 671.7 and 681.14 of Title 14 NYCRR.

Statutory authority: Mental Hygiene Law, sections 13.09(b) and 43.02

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

Specific reasons underlying the finding of necessity: This emergency rule is being promulgated on July 1, 2011 to delay from July 1, 2011 to September 30, 2011 implementation of a specific provision in various rules concerning efficiency adjustments in rate setting methodologies that are being adopted on July 1, 2011.

The rules concerning efficiency adjustments reduce the operating components of reimbursement to providers of supervised residential habilitation services, group day habilitation and supplemental group day habilitation services, prevocational services, and under 31-bed ICF/DDs.

These rules concerning efficiency adjustments contain a stipulation that would restrict providers from allocating funds to administrative expenses if they were not designated for administrative costs in the price or rate. Subsequent to publication of the proposed regulations, providers indicated that, in the context of the various July 1, 2011 price and rate reductions, such restrictions could have a severe impact on those providers already demonstrating the greatest level of administrative efficiencies in their operations. For some providers, the restriction could compound and/or exacerbate the effects of the administrative aspects of reductions.

OPWDD is temporarily suspending this provision because it could potentially severely hamper a provider's ability to sustain necessary administrative aspects of operations, and the restriction, if left intact could potentially cripple a provider's ability to provide services and continue operations. OPWDD will use the delay in order to conduct an analysis of the possible negative impacts of this restriction on providers and to deliberate on whether to proceed with adoption, revocation or modification of this restriction. OPWDD is opting to err on the side of caution and to examine the feasibility of alternatives before imposing this restriction. Thus, it is necessary for the health, welfare and safety of individuals these providers serve to delay the effective date of the restriction.

Subject: Provider allocation of OPWDD funding.

Purpose: To delay implementation of a restriction on allocation of resources while OPWDD conducts impact assessments.

Text of emergency rule: Paragraph 635-10.5(b)(22) is amended as follows:

(22) *Effective September 30, 2011*, revenues realized by providers from reimbursement attributable to components of the price other than the administrative component shall not be used to fund administrative expenses.

- Paragraph 635-10.5(c)(17) is amended as follows:

(17) *Effective September 30, 2011*, revenues realized by providers from reimbursement attributable to components of the price other than the administrative component shall not be used to fund administrative expenses.

- Paragraph 635-10.5(e)(12) is amended as follows:

(12) *Effective September 30, 2011*, revenues realized by providers from reimbursement attributable to components of the price other than the administrative component shall not be used to fund administrative expenses.

- Paragraph 671.7(a)(14) is amended as follows:

(14) *Effective September 30, 2011*, revenues realized by providers from reimbursement attributable to components of the price other than the administrative component shall not be used to fund administrative expenses.

- Subparagraph 681.14(d)(1)(iii) is amended as follows:

(iii) *Effective September 30, 2011*, revenues realized by providers from reimbursement attributable to components of the rate other than the administrative component shall not be used to fund administrative expenses.

This notice is intended to serve only as an emergency adoption, to be valid for 90 days or less. This rule expires September 28, 2011.

Text of rule and any required statements and analyses may be obtained from: Barbara Brundage, Director, OPWDD Regulatory Affairs Unit, 44 Holland Avenue, Albany, New York 12229, (518) 474-1830, email: barbara.brundage@opwdd.ny.gov

Additional matter required by statute: Pursuant to the requirements of the State Environmental Quality Review Act, OPWDD, as lead agency, has determined that the action described herein will have no effect on the environment, and an E.I.S. is not needed.

Regulatory Impact Statement

1. Statutory Authority:

a. OPWDD has the statutory authority to adopt rules and regulations necessary and proper to implement any matter under its jurisdiction as stated in the New York State Mental Hygiene Law Section 13.09(b).

b. OPWDD has the statutory responsibility for setting Medicaid rates and fees for services in facilities licensed or operated by OPWDD, as stated in section 43.02 of the Mental Hygiene Law.

2. Legislative Objectives: These emergency amendments further the legislative objectives embodied in sections 13.09(b) and 43.02 of the Mental Hygiene Law. The emergency amendments concern changes in the way in which providers may allocate revenues to administrative expenses.

3. Needs and Benefits: Four regulations being adopted on July 1, 2011 implement efficiency adjustments and impact supervised Individual Residential Alternatives (IRAs), supervised community residences (CRs), group day habilitation, supplemental group day habilitation, prevocational services, and ICF/DDs with bed capacities of 30 or less. Possible reductions in operating reimbursement range from zero to ten percent.

All four of these regulations contain a provision that prohibits providers from allocating funding to administrative expenses that was designated in the price or rate for other than administrative expenses. Effective July 1, 2011, these emergency amendments delay the implementation of this provision until September 30, 2011 and thereby prevent the restriction from taking effect on July 1, 2011.

Providers have pointed out that, in the context of the July 1, 2011 reductions in reimbursement, a restriction on the application of funding to administrative expenses could have a severe impact on those providers already demonstrating the greatest efficiencies in their operations. For some, this would compound and/or exacerbate the effects of the reductions, especially when those reductions targeted the administrative component of reimbursement. To potentially avoid harmful effects that could threaten a provider's ability to continue operations, OPWDD is postponing the implementation of this restriction. OPWDD has opted to err on the side of caution. The temporary delay gives OPWDD the opportunity to conduct analysis in order to determine the degree to which implementation of the restriction might cause negative consequences for providers. Moreover, OPWDD will examine the alternatives including modifying the restriction, keeping it intact or repealing it altogether.

4. Costs:

- a. Costs to the agency and to the State and its local governments: The

emergency amendments do not change reimbursement levels. There is therefore no cost to OPWDD, to the State, or to local governments. The emergency amendments eliminate the potential to recover monies OPWDD allocates to other categories and that providers spend on administrative expenses. However, it is impossible to know how much money, if any, would have been spent in violation of the interchange restriction and subsequently recovered.

b. Costs to private regulated parties: There are neither initial capital investment costs nor initial non-capital expenses. There are no additional costs associated with implementation and continued compliance with the rule.

5. Local Government Mandates: There are no new requirements imposed by the rule on any county, city, town, village; or school, fire, or other special district.

6. Paperwork: The emergency amendments do not require any additional paperwork to be completed by providers.

7. Duplication: The emergency amendments do not duplicate any existing State or Federal requirements that are applicable to services for persons with developmental disabilities.

8. Alternatives: OPWDD considered leaving the provision regarding interchange intact by not promulgating this emergency regulation. However, OPWDD recognized that some providers could have been severely impacted by retention of the provision and therefore decided to proceed with the emergency regulation to allow time for a more thorough examination of the consequences.

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

10. Compliance Schedule: The emergency amendments are effective July 1, 2011. They delay compliance with the interchange restriction until September 30, 2011.

Regulatory Flexibility Analysis

1. Effect on small business: The emergency regulations apply to providers of residential habilitation delivered in supervised Individualized Residential Alternative (IRAs) and Community Residences (CRs), group and supplemental group day habilitation services, prevocational services, and under 31-bed ICF/DD services. OPWDD has determined, through a review of the certified cost reports, that most providers are non-profit agencies which employ more than 100 people overall. However, some smaller agencies which employ fewer than 100 employees overall would be classified as small businesses. Currently, there are approximately 255 providers that offer supervised residential habilitation; 290 that offer group and supplemental group day habilitation; 100 that offer prevocational services; and 102 that operate ICF/DDs. Providers which offer a combination of services may be represented in more than one of these counts. OPWDD is unable to estimate the portion of these providers that may be considered to be small businesses.

The emergency amendments have been reviewed by OPWDD in light of their impact on small businesses. By delaying the implementation of a restrictive provision, the emergency amendments allow providers to temporarily retain the flexibility they have in allocating their OPWDD funding and to avoid any negative impact this provision, if enacted, might have engendered. Because it essentially precludes a negative impact from occurring, there is a positive impact to providers. The purpose of the delay is to afford OPWDD time to conduct an analysis of the potential consequences the restriction might cause and, thereafter, to deliberate on the best approach—whether it is feasible to adopt or rescind the restriction or to modify it to reduce potential negative impacts.

OPWDD has determined that these amendments do not create any increased costs for additional services or increased compliance requirements.

2. Compliance requirements: The emergency amendments do not impose any additional compliance requirements on providers.

The amendments will have no effect on local governments.

3. Professional services: There are no additional professional services required as a result of these amendments and the amendments do not add to the professional service needs of local governments.

4. Compliance costs: There are no compliance costs since the emergency amendments do not impose any additional compliance requirements on providers.

5. Economic and technological feasibility: The emergency amendments do not impose the use of any new technological processes on regulated parties.

6. Minimizing adverse economic impact: The purpose of these emergency amendments is to temporarily suspend the provisions in OPWDD's July 1, 2011 regulations that would have restricted the ability of providers to use resources for administrative expenses and to maintain the flexibility providers have experienced in the process of allocating resources. With respect to resource allocation, this amendment preserves through September 29, 2011 the status that existed on June 30, 2011.

7. Small business participation: The elimination of the restriction was recommended by representatives of providers, including the New York State Association of Community and Residential Agencies (NYSACRA), at a meeting that occurred on April 18, 2011. Some of the members of NYSACRA have fewer than 100 employees. Finally, OPWDD has mailed these emergency amendments to all providers, including providers that are small businesses, and will be inviting public comment on the advisability of the restriction and possible modifications to it.

Rural Area Flexibility Analysis

A rural area flexibility analysis for these emergency amendments is not being submitted because the amendments do not impose any adverse impact or reporting, recordkeeping or other compliance requirements on public or private entities in rural areas. There are no professional services, capital, or other compliance costs imposed on public or private entities in rural areas as a result of the emergency amendments.

The emergency amendments postpone the implementation of a provision from an original effective date of July 1, 2011 until September 30, 2011. The provision is intended to limit providers' abilities to allocate resources and could have a negative impact on some providers. From OPWDD's perspective, these emergency amendments with an effective date of July 1, 2011 keep the revenue allocation process temporarily intact, unaltered and undisturbed. The temporary impact to providers will be positive because it simply prevents any negative impact from the restriction from occurring. OPWDD will use the delay to conduct an analysis of the potential consequences of this restriction in order to determine the feasibility of adopting, revoking or modifying it.

Job Impact Statement

OPWDD is not submitting a Job Impact Statement for this emergency rule making because the rule making does not have a substantial adverse impact on jobs or employment opportunities.

The emergency rule delays the implementation of a provision contained in four regulations that impact providers of residential habilitation in supervised Individual Residential Alternatives (IRAs) and Community Residences (CRs), group and supplemental group day habilitation services, prevocational services, and under 31-bed ICF/DDs. Upon adoption of those four regulations on July 1, 2011, the provision limits a provider's ability to allocate resources. By postponing the provision's effective date to September 30, 2011, the status of providers' allocation process is temporarily unaltered and undisturbed.

The impact to providers is positive as it precludes any negative impact from the restriction from occurring. The purpose of the postponement is to afford OPWDD the time to conduct an analysis to determine potential negative consequences to providers and to deliberate on whether to adopt, revoke or modify the restriction.

Comments were received from the City of New York, Westchester County, the Port Authority of New York and Jersey ("Port Authority"), and the Metropolitan Transportation Authority. Based on those comments and staff's analysis, except for certain changes regarding Port Authority production rates, the Authority adopts the rate redesign as originally proposed. The implementation of production minimum billing will be delayed until the 2012 rate year in order to allow Customers more time to understand the impact of these provisions. The rate redesign will become effective for the service period commencing July 2011.

Final rule as compared with last published rule: Substantial revisions were made in section A, part 6.

Text of rule and any required statements and analyses may be obtained from: Karen Delince, Corporate Secretary, Power Authority of the State of New York, 123 Main Street, 11-P, White Plains, New York 10601, (914) 390-8085, email: secretarys.office@nypa.gov

Revised Regulatory Impact Statement

A revised regulatory impact statement is not submitted with this notice because the rule is within the definition contained in section 102(2)(a)(ii) of the State Administrative Procedure Act.

Revised Regulatory Flexibility Analysis

A revised regulatory flexibility analysis is not submitted with this notice because the rule is within the definition contained in section 102(2)(a)(ii) of the State Administrative Procedure Act.

Revised Rural Area Flexibility Analysis

A revised rural area flexibility analysis is not submitted with this notice because the rule is within the definition contained in section 102(2)(a)(ii) of the State Administrative Procedure Act.

Revised Job Impact Statement

A revised job impact statement is not submitted with this notice because the rule is within the definition contained in section 102(2)(a)(ii) of the State Administrative Procedure Act.

Assessment of Public Comment

An assessment of public comment is not submitted with this notice because the rule is within the definition contained in section 102(2)(a)(ii) of the State Administrative Procedure Act.

Power Authority of the State of New York

NOTICE OF ADOPTION

Rates for Production and Delivery Services

I.D. No. PAS-15-11-00020-A

Filing Date: 2011-06-30

Effective Date: 2011-06-30

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

Action taken: Redesign rates for production and delivery services charged to New York City Governmental Customers and Westchester County Governmental Customers.

Statutory authority: Public Authorities Law, section 1005(6) and (11)

Subject: Rates for production and delivery services.

Purpose: To properly align costs with rates.

Substance of final rule: The Power Authority's Notice of Proposed Rulemaking published on April 13, 2011 proposed to redesign rates for both production and delivery services charged to New York City Governmental Customers and Westchester County Governmental Customers (collectively "Customers") and to implement related tariff changes. This rate redesign will properly align costs with rates and is revenue neutral to the Authority. For production, the rate redesign immediately aligns cost with rates for Authority Customers. For delivery, the rate redesign gradually aligns costs with rates through a four-year phase-in.

Public Service Commission

NOTICE OF WITHDRAWAL

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

The following rule makings have been withdrawn from consideration:

I.D. No.	Publication Date of Proposal
PSC-28-00-00017-P	July 12, 2000
PSC-13-01-00011-P	March 28, 2001
PSC-17-01-00008-P	April 25, 2001
PSC-22-01-00009-P	May 30, 2001
PSC-48-01-00013-P	November 28, 2001
PSC-05-02-00006-P	January 30, 2002
PSC-05-02-00007-P	January 30, 2002
PSC-05-02-00008-P	January 30, 2002
PSC-13-02-00024-P	March 27, 2002
PSC-13-02-00025-P	March 27, 2002
PSC-16-02-00021-P	April 17, 2002
PSC-22-02-00021-P	May 29, 2002
PSC-22-02-00022-P	May 29, 2002
PSC-36-02-00015-P	September 4, 2002
PSC-48-02-00014-P	November 27, 2002
PSC-04-03-00008-P	January 29, 2003
PSC-06-03-00028-P	February 12, 2003
PSC-22-03-00027-P	June 4, 2003
PSC-26-03-00022-P	July 2, 2003
PSC-28-03-00021-P	July 16, 2003
PSC-28-03-00022-P	July 16, 2003
PSC-30-03-00012-P	July 30, 2003

PSC-13-04-00010-P	March 31, 2004
PSC-13-04-00012-P	March 31, 2004
PSC-26-04-00009-P	June 30, 2004
PSC-41-04-00005-P	October 13, 2004
PSC-06-05-00023-P	February 9, 2005
PSC-26-05-00010-P	June 29, 2005
PSC-31-05-00013-P	August 3, 2005
PSC-31-06-00025-P	August 2, 2006
PSC-45-06-00018-P	November 8, 2006
PSC-49-06-00013-P	December 6, 2006
PSC-51-06-00022-P	December 20, 2006
PSC-18-07-00021-P	May 2, 2007
PSC-29-07-00030-P	July 18, 2007
PSC-48-07-00012-P	November 28, 2007
PSC-22-08-00006-P	May 28, 2008
PSC-33-08-00011-P	August 13, 2008
PSC-02-09-00012-P	January 14, 2009
PSC-10-09-00012-P	March 11, 2009
PSC-11-10-00005-P	March 17, 2010

PROPOSED RULE MAKING NO HEARING(S) SCHEDULED

Petition Requesting the Commission Reconsider its May 19, 2011 Order and Conduct a Hearing, and Petition to Stay Said Order

I.D. No. PSC-29-11-00011-P

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

Proposed Action: The Commission is considering whether to grant or deny, in whole or in part, a June 17, 2011 Windstream New York, Inc. Petition for Reconsideration and Hearing of a Petition to Stay the Commission's May 19, 2011 Order Directing Tariff Amendment.

Statutory authority: Public Service Law, sections 94(2), 91(1), 92(2) and 97

Subject: Petition requesting the Commission reconsider its May 19, 2011 Order and conduct a hearing, and petition to stay said Order.

Purpose: To consider whether to grant or deny, in whole or in part, Windstream New York's Petition For Reconsideration and Rehearing.

Substance of proposed rule: The Commission is considering whether to grant, deny, or modify in whole or in part, a June 17, 2011 Petition by Windstream New York, Inc. (Windstream) for Reconsideration and Hearing of a Petition to Stay the Commission's May 19, 2011 Order Directing Tariff Amendment. The Commission's Order directed Windstream to file a tariff amendment within 30 days from the date of the issuance of the Order that requires Windstream to prorate a local exchange customer's final bill when service is terminated on a date prior to the last day of the billing cycle. Windstream's petition requests that the Commission reconsider its May 19, 2011 Order to conduct a hearing and stay the Order. The petition further says that: the Order includes errors of fact and law; and that new circumstances have arisen after the Commission's Order was issued.

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: Secretary@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.

(10-C-0650SP1)

PROPOSED RULE MAKING NO HEARING(S) SCHEDULED

Net Metering

I.D. No. PSC-29-11-00012-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 a proposed filing by the Village of Freeport to make various changes in the rates, charges, rules and regulations contained in its Schedule for Electric Service, P.S.C. No. 9—Electricity.

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

Subject: Net Metering.

Purpose: To establish net metering provisions for customers who own or operate solar or wind electric generating equipment.

Substance of proposed rule: The Commission is considering a proposal filed by the Village of Freeport (Freeport) to establish net metering provisions for customers of Service Classification No. 1 – Residential Service and Service Classification No. 2 – General Service who own or operate solar or wind electric generating equipment. The proposed amendments have an effective date of November 1, 2011. The Commission may adopt in whole or in part, modify or reject Freeport's proposal, and may apply its decision to other utilities.

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: Secretary@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.

(11-E-0341SP1)

PROPOSED RULE MAKING NO HEARING(S) SCHEDULED

Issuance of and Sale of Preferred Stock, Bonds, and Other Forms of Indebtedness

I.D. No. PSC-29-11-00013-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 deny in whole or in part a petition of New York State Electric & Gas Corporation seeking authorization of the issuance of long-term indebtedness, preferred stock and hybrid securities.

Statutory authority: Public Service Law, section 69

Subject: Issuance of and sale of preferred stock, bonds, and other forms of indebtedness.

Purpose: To permit New York State Electric & Gas Corporation to finance transactions for purposes authorized under PSL Section 69.

Substance of proposed rule: The Public Service Commission is deciding whether to grant, modify or deny, in whole or in part, New York State Electric & Gas Corporation's petition seeking authority to issue up to \$515 million of long-term indebtedness, preferred stock, and hybrid securities under PSL Section 69. The Commission shall consider all other related matters.

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: secretary@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.

(11-M-0342SP1)

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

Petition for the Submetering of Electricity

I.D. No. PSC-29-11-00014-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 grant, deny or modify, in whole or part, the petition filed by Extell West 57th Street, LLC to submeter electricity at 157 West 57th Street, New York, New York.

Statutory authority: Public Service Law, sections 2, 4(1), 30, 32-48, 52, 53, 65(1), 66(1), (2), (3), (4), (12) and (14)

Subject: Petition for the submetering of electricity.

Purpose: To consider the request of Extell West 57th Street, LLC to submeter electricity at 157 West 57th Street, New York, New York.

Substance of proposed rule: The Public Service Commission is considering whether to grant, deny or modify, in whole or part, the petition filed by Extell West 57th Street, LLC to submeter electricity at 157 West 57th Street, New York, New York, located in the territory of Consolidated Edison Company of New York, Inc.

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: Secretary@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.

(11-E-0346SP1)

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

Natural Gas Vehicle (NGV) and Distributed Generation (DG) Pilot Programs

I.D. No. PSC-29-11-00015-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 proposed tariff filing by National Fuel Gas Distribution Corporation to make various changes in its rates, charges, rules and regulations contained in its Schedule for PSC No. 8—Gas.

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

Subject: Natural Gas Vehicle (NGV) and Distributed Generation (DG) Pilot Programs.

Purpose: To add NGV applications to the existing Partnership for DG Pilot Program and to extend authorization for both to March 31, 2015.

Substance of proposed rule: The Commission is considering whether to approve, modify or reject, in whole or in part, a tariff filing by National

Fuel Gas Distribution Corporation (the Company) to add Natural Gas Vehicle applications to the Company's existing Partnership for Distributed Generation Pilot Program and to extend authorization for these programs to March 31, 2015. The proposed filing has an effective date of November 1, 2011. The Commission may apply its decision in this case to other utilities.

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: Secretary@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.

(11-G-0348SP1)