

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.

Office of Alcoholism and Substance Abuse Services

NOTICE OF ADOPTION

Service Standards for Chemical Dependence Outpatient and Opioid Treatment Programs

I.D. No. ASA-15-11-00005-A

Filing No. 533

Filing Date: 2011-06-14

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 Parts 822 and 828; and addition of new Part 822 to Title 14 NYCRR.

Statutory authority: Mental Hygiene Law, sections 19.07(c), (e), 1909(b), 1916, 19.21(b), 19.40, 32.01, 32.07(a), 32.05(b) and 32.09(b)

Subject: Service standards for chemical dependence outpatient and opioid treatment programs.

Purpose: Combine service standards of outpatient and opioid services and implement a new more cost effective payment methodology.

Substance of final rule: The proposed amendments to the above named regulation are being submitted for public review and comment. The proposed amendments include REPEAL of current Parts 822 and 828 and concurrent promulgation of a new regulation combining amended versions of Parts 822 and 828 as subparts of a new Part 822 regulating the majority of outpatient services (Part 816 - outpatient detoxification and Part 823- outpatient services for youth remain separate Parts). The proposed regulations include technical amendments as well as substantive

changes prompted by the evolution of treatment practices and social attitudes that affect policies and program goals of NYS Office of Alcoholism and Substance Abuse (OASAS) for outpatient treatment and medically assisted treatment. The new Part 822 also implements a new structure for billing and amending the OASAS State Plan for Medicaid known as Ambulatory Patient Groups (APG). This required significant redefinition of services and review of programs for maximum regulatory compliance as well as maximum clinical success.

The proposed new Part 822, is divided into subparts; Subparts 822-1, 822-2 and 822-3 are applicable to all outpatient services certified as chemical dependence outpatient programs or opioid treatment programs (OTP). Subpart 822-1 contains general provisions including background, legal base, incorporation by reference, a savings and renewal clause, effective date and severability provisions. Subpart 822-2 contains six subsections. The first subsection is a definitions section incorporating old definitions from the former Part 822 and Part 828. It also adds new definitions including: clinical staff, medical staff, peer advocates, episode of care, visit, patient, and various services which may be provided in outpatient or opioid treatment facilities. There are new subsections establishing recordkeeping requirements applicable to all outpatient providers and those specific to each type of provider (outpatient chemical dependence, outpatient rehabilitation, and OTP). There is a new subsection containing detailed requirements governing how programs document specific treatment services. Finally, the subsection governing the provision of services in excess of the clinical needs of a patient has been relocated to this Section. Subpart 822-3 sets forth the requirements for submission of Medicaid claims. This section also limits the volume of services that can be billed to Medicaid during a daily visit and throughout a patient's episode of care. Subpart 822-4 contains the programmatic requirements for outpatient programs and incorporates provisions necessary to utilize the APG services and billing methodologies. Subpart 822-5 contains the programmatic requirements for OTP's and incorporates the provisions necessary to utilize the APG services and billing methodologies. Programmatic changes were incorporated into the recently promulgated Part 828 (effective by emergency) that conformed OASAS regulations to new federal rules promulgated in 2001. Proposed changes also reflect agency policy and research supported treatment developments that recognize opioid addiction as a chronic illness that can be treated effectively with certain medications (medication assisted treatment) in conjunction with supportive services such as psychosocial counseling, treatment for co-occurring disorders, medical services and, vocational rehabilitation. Amendments throughout the new Part 822 reflect agency policy goals related to recovery services, language consistency, improved efficiency for providers, elevated professionalism of treatment clinicians, and more effective agency regulation.

Merging the regulations governing outpatient chemical dependence services and medication assisted treatment will continue to reinforce the consolidation of drug and alcohol treatment into a unified system of chemical dependence treatment that began in 1992 (Chapter 223 of the Laws of 1992) with the creation of OASAS. It is the consensus of participants in an OASAS-provider consultation process that the following proposed amendments would advance the goals of guaranteeing patients the best care and treatment delivered in a manner that is also cost effective and accountable:

- 822-4: Chemical Dependence Outpatient Services
- Allow three pre-admission assessment visits to allow more time for data collection and establishing counselor-patient trust
 - Define primary focus of a pre-admission assessment
 1. Chemical use assessment;
 2. Screening for co-occurring disorders; and
 3. Other priority issues based on presenting complaint and circumstances
 - Focus on immediate issues addressed in the initial assessment
 - Eliminate the regulatory need for Level of Care for Alcohol and Drug Treatment Referral (LOCADTR)
 - Increase the stringency of diagnostic and admission criteria

- Require a multidisciplinary team case conference to approve the comprehensive treatment/recovery plan
- Link the comprehensive evaluation and treatment/recovery plan more tightly together; both due within 45 days of admission and containing similar criteria
- Extend time for physician signature on the treatment/recovery plan to ten days (if he/she is not part of the multi-disciplinary team)
- Permit programs to defer a treatment/recovery plan goal if clinically justified and focus on functional areas where a problem was identified through the evaluation
- Require a progress note for each session; clarifies more specific criteria expected in notes on individual counseling or group sessions
- Clarify the programmatic and billing requirements specific to programs certified to provide Outpatient rehabilitation services
- Re-number sections for greater ease in reading and understanding
- Better define and specify Quality Improvement activities
- Include patient-centered language
- Require medical directors to become certified in an areas of addiction medicine
- Provide for alternative assessment for referrals from an OASAS approved DWI provider/practitioner to eliminate redundancy
- 822-5: Opioid Treatment Programs
 - Conform OASAS regulations to federal regulations (42 CFR Part 8) regarding certification of opioid treatment programs (OTP)
 - Add regulations related to buprenorphine (methadone alternative) treatment, removing an obstacle to physicians to administer buprenorphine in OTPs where clients may receive supportive services
 - Provide for opioid medical maintenance (OMM), pursuant to federal waiver, for certain qualified opioid patients and providers
 - Provide guidelines for certified providers to provide services at additional locations
 - Require medical directors to become certified in an area of addiction medicine
 - Requires testing for Hepatitis only where clinically indicated and makes testing for STDs optional
 - Increase flexibility in toxicology testing
 - Eliminate the requirement for OASAS approval for methadone dosage increases above 200 milligrams
 - Recognize that treatment for opioid addiction may be provided in a residential or in-patient setting and makes provisions for regulation of such services
 - Add language that states only clients with a primary diagnosis of opioid addiction may be admitted to an OTP
 - Give OTP's discretion to allow patient to go to their private physician for the required annual physical a
 - Add new language to accommodate transfer patients
 - Provide greater flexibility in counselor to patient staffing ratios
 - Allow added flexibility for providing patients with take home medication and remove agency approval on a one-time basis for up to 30 days take home dose
 - Add recall to reduce diversion
 - Define role of security guards at the OTP
 - Define aftercare
 - State specialized services that are not defined by regulation must be approved by OASAS prior to implementation
 - Require provider to establish a community relations policy and committee
 - Detail the requirements for a quality improvement policy
 - Requires 50% of the counseling staff to be CASAC or CASAC-T within four years

The proposed amendments also contain provisions developed in consultation with an agency/provider work group tasked with effectuating a reduction in paperwork for both OASAS and its certified providers. For example, the proposed regulations will reduce the number of individual patient exemptions and general waivers from current regulation, saving providers and the agency costly administrative time. An estimated monthly average of 10 requests for waivers would be eliminated. The proposed regulation allows more flexibility in take home medication and clinic schedule changes, two areas that represent the highest number of individual patient exemptions. The proposed regulation removes a requirement for OASAS approval for methadone dosage increases above 200 milligrams. This change was based on the review of several available studies. In January 2007, 103 of 115 certified clinics requested a waiver from OASAS regarding prior OASAS approval for methadone dosage increases; granting the waiver resulted in 114 fewer individual patient exemptions regarding dosage increases during 2007. The proposed draft regulations eliminate the need for providers to submit this waiver renewal upon recertification.

OASAS solicited comments on the proposed regulations and possible alternatives from a cross-section of New York's upstate and downstate

treatment provider community, as well as urban and rural programs. OASAS utilized statewide coalition groups, Alcoholism and Substance Abuse Providers of New York State (ASAP) and the Committee of Methadone Program Administrators (COMP), to distribute the proposed regulation to its members and collect comments. All comments received were reviewed and incorporated wherever appropriate. The proposed regulations were also shared with the National Alliance of Methadone Advocates (NAMA), New York States Council of Local Mental Hygiene Directors, and New York State's Advisory Council, as well as posted on the OASAS website.

Final rule as compared with last published rule: Nonsubstantial changes were made in Subparts 822-2, 822-3, 822-4 and 822-5.

Text of rule and any required statements and analyses may be obtained from: Trisha R. Schell-Guy, Office of Alcoholism and Substance Abuse Services, 1450 Western Avenue, Albany, NY 12203, (518) 485-6244, email: trishaguy@oasas.ny.gov

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

The changes made to the Part 822 regulations now being submitted do not include any substantial changes and are generally clarifications, grammatical and technical corrections.

None of the changes made will affect the statements made in the previously submitted Regulatory Impact Statement (RIS), as there were no changes that would affect needs/benefits, costs, local government mandates, paperwork/reporting, compliance schedules or any other statements made therein.

None of the changes made will have a substantial adverse impact on jobs or economic opportunities in New York State or cause a reduction in the number of jobs and employment opportunities in the State and therefore a revised JIE is not necessary.

None of the changes made will affect the statements made in the previously submitted Rural Area Flexibility Analysis (RAFA).

None of the changes made will affect the statements made in the previously submitted Regulatory Flexibility Analysis for Small Businesses and Local Governments (RFASB).

Assessment of Public Comment

OASAS received comments on the above proposed rule making from six different sources, including trade organizations and individuals. All comments were reviewed and assessed and a few clarifications, technical and grammatical changes and corrections were made and incorporated into the text of the final rule. No substantial revisions were made.

OASAS received numerous comments from an individual that primarily concerned the commenter's preferred language usage, requests for clarification and/or preferred location of the regulatory elements within the proposed Part. Numerous suggestions made by the commenter were based on an old version of the regulation. Comments that require further explanation are:

Comment: 822-2.1(m) "Individual counseling" should be revised to include family members.

Response: Clarified to include a service between a clinical staff member and a patient or a patient and collateral persons(s).

Comment: 822-2.1(v) "Outreach" is takes place away from the program premises. This should be in the definition.

Response: Clinics cannot bill Medicaid for services provided outside of the clinic. Outreach is a non-billable service. 822-3.1 clarified.

Comment: 822-2.1(ab) Definition of "Routine medication management" sounds like definition of "Medication management."

Response: Routine medication management removed.

Comment: 822-2.3 and 822-2.4 Add day rehabilitation services.

Response: Agrees clarification necessary. Definition of outpatient programs clarified.

Comment: 822-2.4(d) 30 days is too long for documentation and not be acceptable to outside auditors/reviewers.

Response: OASAS engaged in significant dialogue with providers. This will afford greater flexibility and effectuate better patient care. Disagree - Audit review criteria is derived from regulation.

Comment: 822-2.6(e) & 822-3.1 What is the difference between Part 841 and Subpart 822-3?

Response: Part 841 governs Medicaid reimbursement methodology. Part 822-3 contains Medicaid billing rules.

Comment: 822-3.1(h)(5), (8), (12) If the documentation of need is only in the case record, how will MMIS know whether to pay?

Response: Documentation must be maintained for audit and evaluation. MMIS is an electronic billing and payment system and does not require documentation.

Comment: The terms provider, program and service in this Part are used inappropriately.

Response: OASAS maintains that the regulation appropriately uses and

identifies these terms in accordance with the statewide scheme of APG's in outpatient clinic settings. Provider is a legal entity that operates one or more programs. A program is certified to deliver particular services which are individually defined.

Comment: 822-4.3(h) This shouldn't be limited to DDP providers.

Response: This is appropriate given recent OASAS involvement with DDP.

Comment: 822-4.9(a) & (b) are contradictory.

Response: Clarified and (a)(2) removed.

Comment: 822-4.11(b) allows programs to treat chemically dependent persons only for gambling.

Response: Disagree. Section says an "outpatient program that provides gambling treatment services." which is defined as a program that provides outpatient services to those who suffer from chemical dependence.

Comment: 822-4.11(f) 42 CFR Part 2 should be removed.

Response: Disagree. Problem gambling records maintained separate from chemical dependence records are not subject to 42 CFR Part 2.

Comment: 822-5.6(d) Subdivision duplicates federal regulation should be deleted. Dosage provisions are inappropriate in regulation and conflicts with 822-5.6(f). There is no definition of split dose.

Response: Regulation encompasses a significant patient safety issue and warrants repetition. Subdivisions do not conflict; (d) refers to initial dosage and (f) refers to dosage stabilization. Split dose is a common term and necessary.

Comment: 822-5.9(j) The two year period has already ended.

Response: Given the regulation was an emergency period extended.

Second Commenter

Comment: 822-2.1(n) Timeframe for initial services not stated and creates audit vulnerabilities.

Response: Initial services are services identified during an assessment.

Comment: 822-2.2 (e) Medicaid requires case records be retained for 7 years.

Response: CMS has a seven year record retention policy for all of its records. NYS DOH requires that NYS providers maintain Medicaid records for 6 years.

Comment: 822-3.1(h) Is a provider required to bill IOS code for a client that needs IOS?

Response: Where IOS is the appropriate level of care, IOS codes should be billed. Flexibility was incorporated to allow billing for services where a patient fails to receive a full daily increment of IOS.

Comment: 822-4.3(d)(5) Is LOCDTR/ASAM level of care criteria is optional?

Response: Programs may utilize LOCADTR, ASAM, or provide a summary of patient functioning supporting the outpatient level of care.

Comment: 822-4.5 Requiring the entire multidisciplinary team to sign and date the treatment/recovery plan is excessive.

Response: Given the 45 day timeframe this is not excessive.

Comment: Commenter suggested several additional clarifications.

Response: See OASAS clinical and billing guidance document

<http://www.oasas.state.ny.us/admin/hcf/APG/documents/APGManual-April2011.pdf>

Third Commenter

Comment: 822-4.7 Provide an exemption for providers licensed under Article 28 of the Public Health Law.

Response: Modified. Existing hospital committee may perform the functions of a quality improvement committee if member of the CD program serves on the committee.

Comment: 822-1.1 Most payers do not pay for counseling, they pay for verbal therapy.

Response: Definitions of group and individual counseling clarified to include verbal therapy.

Comment: Concerns about the distinctions between OASAS and OMH regulations.

Response: OASAS, OMH and other state agencies are currently working to better align clinic regulations, ease regulatory duplicity and eliminate financial burdens.

Fourth Commenter

Comment: Reduction methadone maintenance programs from 50/1 to 40/1 counselor to patient ratio.

Response: OASAS is currently engaged in 3 demonstration projects in this area. Given the system wide transformation occurring with APG implementation, these demonstrations should continue to enable data collection to will help determine appropriate clinical and administrative ratios. 40:1 ratio would be an unfunded mandate requiring programs to hire additional staff. OASAS does not currently possess sufficient funding to support compliance with such a requirement.

Fifth Commenter

Comment: Commenter's program is part of NYSCRI paperwork pilot which does not support a diagnosis in the treatment plan.

Response: This requirement remains unchanged from former Part 822.

As was done before, OASAS will waive this requirement for programs in the pilot. OASAS is working with OMH to amend the forms in the pilot for consistency with this regulation.

Comment: How can staff assess literacy level?

Response: Staff must only assess approximate literacy level. See OASAS clinical and billing guidance document.

Sixth Commenter

Comment: 822-2.1(l) Add consensus based intervention in the definition of evidence based.

Response: Consensus based intervention is not the same as evidence based.

Comment: 822-3.1 - Expand additional billable services where clinically appropriate and necessary, or mandated. Allow billing for more than one group counseling per day.

Response: Current limitations were established after lengthy consultation and collaboration with stakeholders and are clinically appropriate/fiscally sound. The limit on group counseling is consistent with overall rule APG billing rule that programs cannot bill Medicaid for a second visit of the same procedure type. These prohibitions are Medicaid billing rules, not prohibitions on delivering clinically appropriate services. Where clinically appropriate, a provider can provide a second group services but cannot bill Medicaid. Patients who are routinely appropriate for multiple groups should be considered for IOS.

Comment: 822-4.5(a)(2) Parent involvement in the development of a treatment/recovery plan for a minor should not be mandatory.

Response: This subdivision only requires parental participation where a minor is treated with parental consent. When parents consent, they should be involved in plan development.

Comment: 822-4.5(g) & 822-5.5(f) - The timeframes are difficult to comply with using electronic records and more stringent than prior OASAS regulations. Revisions to treatment/recovery plan necessitate a change in the schedule plan updates.

Response: Regulations are not more stringent. They require treatment/recovery plans review at least every 90 days for the first year and then at least every 180 days thereafter. This does not require completion on a specific date. The language provides flexibility for review of a treatment/recovery plan at any time before the deadline. Revisions to the treatment/recovery plan will not trigger a reset of the plan review process.

Comment: 822-4.6(d)(4) This mandatory requirement should be modified to address situations where significant others and/or family members are not identified or involved in treatment.

Response: Agreed. Clarified to include "where applicable."

Comment: 822-5.2(e) "Continuing care treatment" should be changed to "methadone maintenance taper," then patients transitioning to buprenorphine can receive this.

Response: This language cannot be changed. Continuing care is not appropriate for patients on narcotics. It is a protocol for an individual who has completed maintenance taper or is no longer receiving prescribed medication.

Comment: 822-5.4(q)(3), 822-5.5(f), 822-5.8(c) & (d) NYS regulations should match the federal standards governing methadone treatment providers and to the extent NYS regulations are stricter, they should be revised.

Response: OASAS recognizes that in some instances, providers are held to a higher standard than the federal standards. Federal regulations (42 CFR 8.11) specifically state that they are not intended to limit the authority of States... to regulate the use of opioid drugs in the treatment of opioid addiction. Federal regulations are minimum standards. Based on New York's extensive experience in treating over 40,000 patients in our methadone system, OASAS believes our regulatory standards provide optimum patient care and better clinical outcomes.

Comment: 822-5.6(b) - Increase the timeframe from 48 hours to 72 hours, as in the prior regulation.

Response: Agreed. Change made.

Comment: 822-5.6(g)(3) - Add language to permit take-home medication of 13 or more days to be dispensed in dry tablet form in a single bottle.

Response: Agreed. subdivision (g) clarified.

Comment: 822-5.13(a) Revise to allow Opioid medical maintenance (OMM) to be provided in clinic.

Response: Commenter appears to misunderstand OMM, which is office based treatment provided by a physician to patients who are discharged from a methadone clinic.

Comment: 822-5.14(a)(2) Change language to reflect the same language as 822-5.7(i).

Response: Agreed. Language changed.

Comment: 822-5.16(b) The potential requirement of a community committee should be removed.

Response: Committee is only required if requested by OASAS. This is necessary to promote better community relations.

Comment: 822-5.18(b) - Should not be disparity in the requirements for additional locations between outpatient and opioid treatment providers.

Requirement that additional locations be provided in the same or continuous counties discriminates against rural counties.

Response: Distinctions in the requirements for outpatient and opioid treatment providers are warranted, given the differences in the patient populations. Further, given the likelihood of shared staff and services between main and additional locations, it is not prudent to allow providers to have additional locations in distant counties. Provider can submit an application for a full clinic. Further, OASAS has authority to waive this requirement in the event that an unmet need exists in a rural or other location.

Comment: 822-5.10 - Requiring patients to return take home bottles is too stringent.

Response: Agreed. Now says "should."

Multiple Commenters

Comment: Further integration and consistency of regulatory requirements should be made to dispel continued disparities between outpatient and opioid programs.

Response: OASAS acknowledges that differences remain in regulatory standards for outpatient and opioid programs; however numerous changes were made to combine sections that contained similar requirements and make requirements uniform where appropriate. Given the enormity of the changes made by the implementation of the ambulatory patient group billing methodology, OASAS did not want to overwhelm providers by attempting to completely integrate the outpatient and opioid systems, which have traditionally been separate and distinct. OASAS is committed to further exploring integration.

Comment: Objections to the requirement that a medical director employed by a program must hold or obtain within four years a subspecialty board certification in addiction medicine.

Response: OASAS acknowledges this is a new requirement; however, given the mandates imposed by the federal government related to health care reform, such a standard is intended to elevate the field to a level of documented expertise that supports both the specialized work in addiction that is the foundation of our programs, and more fully prepares the field to compete in the arena of health care reform and potential operation as a health home. In recognition of the difficulties programs may have in recruiting qualified physicians, OASAS exempted medical directors employed prior to adoption of this regulations and gives new medical director's four years to obtain the necessary credentials. Further, programs may apply for a waiver of such requirement if extenuating circumstances exist, such as the inability to recruit a qualified medical director.

NOTICE OF ADOPTION

Ambulatory Patient Group Outpatient Rate Reimbursement Methodology

I.D. No. ASA-15-11-00006-A

Filing No. 531

Filing Date: 2011-06-14

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 841 of Title 14 NYCRR.

Statutory authority: Social Services Law, section 364; Mental Hygiene Law, sections 19.07(e), 19.09(b), 19.15(a), 19.40, 32.01, 32.07(a) and 32.09; and L. 2009, ch. 58, part C, subpart 23

Subject: Ambulatory Patient Group Outpatient Rate Reimbursement Methodology.

Purpose: Implement a new more cost effective payment methodology for outpatient providers.

Text or summary was published in the April 13, 2011 issue of the Register, I.D. No. ASA-15-11-00006-P.

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

Text of rule and any required statements and analyses may be obtained from: Trisha R. Schell-Guy, Office of Alcoholism and Substance Abuse Services, 1450 Western Avenue, Albany, NY 12203, (518) 485-6244, email: trishaguy@oasas.ny.gov

Assessment of Public Comment

OASAS received one letter from an individual containing comments on the above proposed rule making published in the NYS Register, April 13, 2011.

Comment: Part 841 – There is no point to adding the term co-certified, it introduces confusion.

Response: OASAS disagrees. Given that this regulation is intended to apply to some OASAS providers commonly known as D&TC's which are co-certified but are not hospital based, this language is necessary.

Comment: 841.14(c)(1), (2) & (3) - patient characteristics should be deleted, weights are applied to services and procedures provided which accumulates to an APG payment, not as described here.

Response: These terms and definitions mirror those used by the NYS Department of Health in the State Plan Amendment corresponding to clinic reimbursement through NYS. While some of the definitions have no current application in the OASAS system, they may be used in the future and were included for that purpose. The definition of APG weight is correct and is only one component to be used in the calculation of an APG payment.

Comment: 841.14(f) – most of the services listed in (e)(1) would require regulations to be provided and billed and only some are currently allowable in an OASAS setting. The list should be limited to codes authorized to be used.

Response: This list identifies "APG categories specific to chemical dependency outpatient and opioid treatment services." All categories listed in paragraph (f)(1) may be billed by an OASAS clinic, assuming they are clinically appropriate and conducted within the scope of practice of the clinician.

Banking Department

NOTICE OF ADOPTION

Payment of Interest on Commercial Bank Deposits

I.D. No. BNK-14-11-00004-A

Filing No. 513

Filing Date: 2011-06-13

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: Repeal of Part 20 of Title 3 NYCRR.

Statutory authority: Banking Law, section 14

Subject: Payment of Interest on Commercial Bank Deposits.

Purpose: To repeal prohibition against certain banking organizations paying interest on demand accounts.

Text or summary was published in the April 6, 2011 issue of the Register, I.D. No. BNK-14-11-00004-P.

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

Text of rule and any required statements and analyses may be obtained from: Sam L. Abram, New York State Banking Department, One State Street, New York, NY 10004-1417, (212) 709-1658, email: sam.abram@banking.state.ny.us

Assessment of Public Comment

One public comment was received. It was submitted by a banking industry association and supported the proposed repeal of Part 20 of the Department's regulations.

Education Department

PROPOSED RULE MAKING NO HEARING(S) SCHEDULED

Student Eligibility for the Higher Education Opportunity Program

I.D. No. EDU-26-11-00003-P

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

Proposed Action: Amendment of section 27-1.1 of Title 8 NYCRR.

Statutory authority: Education Law, sections 207 and 6451(1)

Subject: Student eligibility for the Higher Education Opportunity Program.

Purpose: Update current criteria for determining student economic eligibility for Higher Education Opportunity Program.

Text of proposed rule: Subdivision (b) of section 27-1.1 of the Rules of the Board of Regents is amended, effective October 5, 2011, as follows:

(b) Economically disadvantaged.

(1) For students first entering college between July 1, 2005 and June 30, 2012. A student is economically disadvantaged if he or she is a member of a household supported by one member thereof with a total annual income which does not exceed the applicable amount set forth in the following tables; or of a household supported solely by one member thereof who is employed by two or more employers at the same time, if the total annual income of such household does not exceed the applicable amount set forth in the following tables for the number of members in the household plus the second job allowance; or of a household supported by more than one worker thereof, or a household in which one worker is the sole support of a one-parent family, if the total annual income of such household does not exceed the applicable amount set forth in the following tables for the number of members in the household plus the employment allowance. For the purposes of this subdivision, the number of members of a household shall be determined by ascertaining the number of individuals living in the student's residence who are economically dependent on the income, as defined in subdivision (c) of this section, supporting the student.

[Table I

For students first entering college between July 1, 2005 and June 30, 2008

Number of members in household (including head of household)	Total annual income in preceding calendar year
1	\$14,100
2	19,600
3	22,350
4	27,800
5	32,850
6	38,550
7 or more	42,900 plus \$4,350 for each family member in excess of 7
Second Job Allowance	\$1,800
Employment Allowance	\$4,800

Table II

For students first entering college between July 1, 2008 and June 30, 2009

Number of members in household (including head of household)	Total annual income in preceding calendar year
1	\$15,140
2	20,390
3	25,650
4	30,900
5	36,150
6	41,410
7 or more	46,660 plus \$5,250 for each family member in excess of 7
Second Job Allowance	\$2,630
Employment Allowance	\$5,250

Table III

For students first entering college between July 1, 2009 and June 30, 2010

Number of members in household (including head of household)	Total annual income in preceding calendar year
1	\$15,590
2	21,000
3	26,420
4	31,830
5	37,240
6	42,650
7 or more	48,060 plus \$5,410 for each family member in excess of 7

Second Job Allowance	\$2,710
Employment Allowance	\$5,410]

Table [IV] I

For students first entering college [on or after] between July 1, 2010 and June 30, 2012

Number of members in household (including head of household)	Total annual income in preceding calendar year
1	\$16,060
2	21,630
3	27,210
4	32,790
5	38,360
6	43,960
7 or more	49,500 plus \$5,570 for each family member in excess of 7
Second Job Allowance	\$2,790
Employment Allowance	\$5,570

The income figures in [Tables I, II, III, and IV] *Table I* of this paragraph apply to the student applicant's income only when he or she is an independent student. For purposes of this Part, an independent student means a student who:

(i) is 24 years of age or older by December 31st of the program year; or

(ii) is an orphan or ward of the court (A student is considered independent if he or she is a ward of the court or was a ward of the court until the individual reached the age of eighteen); or

(iii) is a veteran of the Armed Forces of the United States who has engaged in the active duty in the United States Army, Navy, Air Force, Marines, or Coast Guard and was released under a condition other than dishonorable; or

(iv) is a married individual; or

(v) has legal dependents other than a spouse; or

(vi) is a student for whom an opportunity program and financial aid administrator has made a satisfactory documented determination of independence by reason of other extraordinary circumstances.

(2) For students first entering college on or after July 1, 2012, a student is economically disadvantaged if he or she is a member of a household where the total annual income of such household is equal to or less than 185 percent of the amount under the annual United States Department of Health and Human Services poverty guidelines for the applicant's family size. Federal poverty guidelines are published annually by the Department of Health and Human Services in the Federal Register. The income guidelines in this paragraph apply to the student applicant's income only when he or she is an independent student. For purposes of this Part, an independent student means a student who:

(i) is 24 years of age or older by December 31st of the program year; or

(ii) is an orphan or ward of the court (A student is considered independent if he or she is a ward of the court or was a ward of the court until the individual reached the age of eighteen); or

(iii) is a veteran of the U.S. Armed Forces; or

(iv) is currently an emancipated minor as determined by a court;

or

(v) is currently in legal guardianship as determined by a court; or

(vi) is a married individual; or

(vii) has legal dependents other than a spouse; or

(viii) is a student for whom an opportunity program and financial aid administrator has made a satisfactory documented determination of independence by reason of other extraordinary circumstances;

[(2)] (3)...

[(3)] (4)...

[(4)] (5)...

[(5)] (6)...

Text of proposed rule and any required statements and analyses may be obtained from: Christine Moore, NYS Education Department, Office of Counsel, 89 Washington Avenue, Room 112, Albany, NY 12234, (518) 473-8296, email: cmoore@mail.nysed.gov

Data, views or arguments may be submitted to: Peg Rivers, New York State Education Department, 89 Washington Avenue, Albany, New York 12234, (518) 408-1189, email: privers@mail.nysed.gov

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

Regulatory Impact Statement**1. STATUTORY AUTHORITY:**

Section 207 of the Education Law grants general rule-making authority to the Board of Regents to carry into effect the law and policies of the State relating to education.

Subdivision (1) of section 6451 of the Education Law establishes the Higher Education Opportunity Program to advance the cause of educational opportunity in nonpublic institutions of higher education for State residents who are "economically and educationally disadvantaged" as defined by the Board of Regents.

2. LEGISLATIVE OBJECTIVES:

The proposed amendment carries out the legislative objectives set forth in the aforementioned statutes in that it will revise the current criteria for determining student economic eligibility for the Higher Education Opportunity Program.

3. NEEDS AND BENEFITS:

The proposed rule is needed in order to update the current criteria for determining student economic eligibility for the Higher Education Opportunity Program by: (1) taking into account inflationary conditions and changes in annual income; (2) accounting for New York State and local taxes and regional maintenance costs; (3) assuring consistency across the State-supported postsecondary opportunity programs; and (4) maintaining the continuing linkage of these eligibility criteria with federally approved methods of needs analysis.

The amendment will update the existing definition of "economically disadvantaged," which has become outdated because of inflationary factors. It will prevent a reduction in the pool of eligible students due to inflation and other factors. The amendment will ensure that the appropriate pool of students will be eligible for the program.

The proposed changes in the economic income guidelines will apply to students first entering college on or after July 2012. The income level for the household of one was determined based on 185 percent of an income at poverty level as established by U.S. Department of Health and Human Services poverty guidelines. These guidelines are based on poverty measures issued by the U.S. Census Bureau.

The proposed amendment is also needed to update the definition of an independent student, to be more consistent with the federal definition of independent student for purposes of the needs analysis for federal student financial aid programs.

The proposed amendment was developed by a statewide task force of representatives from the City University of New York, the State University of New York, independent colleges and universities and the State Education Department's Office of Higher Education. This task force met and reached a consensus on the proposed amendment.

4. COSTS:

a. Costs to the State government. The proposed amendment will not impose additional costs on State government. The amendment simply updates the income criteria for determining student eligibility for participation in the Higher Education Opportunity Program. State funding for this program is determined by an annual legislative appropriation, which determines the number of students that may participate.

b. Costs to local government. None.

c. Costs to private regulatory parties. The proposed amendment will not impose any capital costs on the nonpublic colleges and universities that operate a Higher Education Opportunity Program. It will impose minimal costs on them to update information brochures concerning the Higher Education Opportunity Program.

d. Costs to the regulatory agency. None. The proposed amendment, which simply updates the criteria for determining economic eligibility for participation in the Higher Education Opportunity Program, will not add any new responsibilities for the State Education Department to administer. The Department will administer the program using existing staff and resources.

5. LOCAL GOVERNMENT MANDATES:

The proposed amendment will not impose any new mandates on local governments.

6. PAPERWORK:

The proposed amendment does not include any new reporting requirements for regulated parties. The paperwork requirements for nonpublic institutions of higher education that participate in the program will not change. In addition, the amendment will not increase the paperwork requirements for students who apply to participate in the Higher Education Opportunity Program at nonpublic colleges and universities.

7. DUPLICATION:

The proposed amendment does not duplicate any other existing State or Federal requirements.

8. ALTERNATIVES:

There are no viable alternatives to the proposed amendment at this time. The Task Force group that developed the economic eligibility levels in the proposed amendment discussed using U.S. Department of Health and Hu-

man Services poverty guidelines to determine eligibility for all household sizes at 200% of an income at poverty level. However, the task force determined that it needed to do additional research before recommending such an alternative approach.

9. FEDERAL STANDARDS:

The proposed amendment concerns the criteria for a State student aid program. While Federal standards are inapplicable, the Department considered and incorporated elements of the methodology approved by the U.S. Department of Education for needs analysis used for Federal student financial aid programs.

10. COMPLIANCE SCHEDULE:

Students first entering college on or after July 1, 2012 will be subject to the amended economic criteria. Nonpublic institutions of higher education must comply with the regulation on its effective date. No additional period of time is necessary to permit regulated parties to meet the requirements of the proposed amendment.

Regulatory Flexibility Analysis

The proposed amendment concerns income criteria for determining student eligibility to participate in the Higher Education Opportunity Program at nonpublic institutions of higher education. It will affect students who want to participate in this program and nonpublic colleges and universities that administer the programs. It is evident from the subject matter of the amendment that it will have no effect on local governments. The amendment will also have no effect on small businesses. All of institutions that participate in the program, except one, are not-for-profit colleges and universities. Accordingly, they are not small businesses. The one for-profit institution that participates in the program employs more than 100 individuals. Therefore, it is not a small business, as defined in section 102(8) of the State Administrative Procedure Act.

The amendment will not impose any adverse economic impact, recordkeeping, reporting, or other compliance requirements on small businesses or local governments. Because it is evident from the nature of the proposed amendment that it will not affect small businesses or local governments, no further steps were needed to ascertain that fact and none were taken. Accordingly, a regulatory flexibility analysis is not required and one has not been prepared.

Rural Area Flexibility Analysis**1. TYPES AND ESTIMATED NUMBER OF RURAL AREAS:**

The proposed amendment applies to nonpublic colleges and universities in New York State that contract with the State Education Department to operate Higher Education Opportunity Programs and students that apply to participate in the Higher Education Opportunity Programs. In the 2005-2006 academic year, 12 such colleges and universities were located in rural areas, defined as the 44 rural counties with less than 200,000 inhabitants and the 71 towns in urban counties with a population density of 150 per square mile or less. In that same year, 696 students participated in the Higher Education Opportunity Program at these colleges and universities.

2. REPORTING, RECORDKEEPING AND OTHER COMPLIANCE REQUIREMENTS, AND PROFESSIONAL SERVICES:

The proposed amendment updates the existing definition of "economically disadvantaged," which has become outdated because of inflationary factors. It also changes the economic income guidelines that will apply to students first entering college on or after July 2012. The income level is based on 185 percent of an income at poverty level as established by U.S. Department of Health and Human Services poverty guidelines. These guidelines are based on poverty measures issued by the U.S. Census Bureau.

The proposed amendment is also needed to update the definition of an independent student, to be more consistent with the federal definition of independent student for purposes of the needs analysis for federal student financial aid programs.

The amendment does not add or alter reporting or recordkeeping requirements for nonpublic colleges and universities that administer Higher Education Opportunity Programs, including those located in rural areas, or impose reporting or recordkeeping requirements for students that participate in such programs. In addition, the amendment will not require regulated parties to acquire professional services.

3. COSTS:

The proposed amendment will not impose any capital costs on the colleges and universities located in rural areas. It will only impose minimal costs on them to update informational brochures concerning the Higher Education Opportunity Program and the income guidelines.

4. MINIMIZING ADVERSE IMPACT:

The proposed amendment updates economic criteria for student eligibility to participate in the Higher Education Opportunity Program. The amendment does not make any differentiation in eligibility based upon the geographic location of the student. In the interests of equity, uniform economic criteria are established for all students across the State.

5. RURAL AREA PARTICIPATION:

A copy of the proposed amendment was shared with each of the nonpublic colleges and universities that operated Higher Education Opportunity Programs in 2005-2006, including the 12 located in rural areas. These institutions were asked to comment on the amendment.

In addition, comments on the proposed amendment were solicited from the Rural Education Advisory Committee, whose membership includes, among others, representatives of school districts, BOCES, business interests, and government entities located in rural areas.

Job Impact Statement

The proposed amendment concerns income criteria for determining student eligibility to participate in the Higher Education Opportunity Program, a program of student assistance administered by nonpublic colleges and universities. The amendment will not affect jobs and employment opportunities in New York State. Because it is evident from the nature of this amendment that it will not affect job and employment opportunities, no affirmative steps were needed to ascertain that fact and none were taken. Accordingly, a job impact statement is not required, and one has not been prepared.

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

Certification in the Classroom Teaching Service Through Individual Evaluation

I.D. No. EDU-26-11-00004-P

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

Proposed Action: Amendment of section 80-3.7 of Title 8 NYCRR.

Statutory authority: Education Law, sections 207(not subdivided), 305(1), 3001(2), 3004(1), 3006(1)(b) and (2)

Subject: Certification in the classroom teaching service through individual evaluation.

Purpose: Extend expiration date for applicants seeking certification through individual evaluation pathway.

Text of proposed rule: Section 80-3.7 of the Regulations of the Commissioner of Education is amended, effective October 5, 2011, as follows:

§ 80-3.7 Satisfaction of education requirements for certification in the classroom teaching service through individual evaluation.

This section prescribes requirements for meeting the education requirements for classroom teaching certificates through individual evaluation. Except as otherwise provided in this section, this option for meeting education requirements shall only be available for candidates who apply for a certificate in childhood education by February 1, 2007 and for candidates who apply for any other certificate in the classroom teaching service by [February 1, 2012] *September 1, 2013*, and who upon application qualify for such certificate. Candidates with a graduate degree in science, technology, engineering or mathematics who apply for an initial teaching certificate under 80-3.7 (a)(3)(ii)(3) may continue to meet the education requirements for classroom teaching certificates through individual evaluation after [February 1, 2012] *September 1, 2013*. The candidate must have achieved a 2.5 cumulative grade point average or its equivalent in the program or programs leading to any degree used to meet the requirements for a certificate under this section. In addition, a candidate must have achieved at least a C or its equivalent in any undergraduate level course and at least a B- or its equivalent in any graduate level course in order for the semester hours associated with that course to be credited toward meeting the content core or pedagogical core semester hour requirements for a certificate under this section. All other requirements for the certificate, including but not limited to, examination and/or experience requirements, as prescribed in this Part, must also be met.

- (a) . . .
- (b) . . .
- (c) . . .

Text of proposed rule and any required statements and analyses may be obtained from: Christine Moore, NYS Education Department, 89 Washington Avenue, Office of Counsel, Room 112, Albany, NY 12234, (518) 473-8296, email: cmoore@mail.nysed.gov

Data, views or arguments may be submitted to: Peg Rivers, New York State Education Department, 89 Washington Avenue, Albany, New York, (518) 408-1189, email: privers@mail.nysed.gov

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

Regulatory Impact Statement

1. STATUTORY AUTHORITY:

Section 207 of the Education Law grants general rule making authority to the Board of Regents to carry into effect the laws and policies of the State relating to education.

Subdivision (1) of section 305 of the Education Law empowers the Commissioner of Education to be the chief executive officer of the state system of education and authorizes the Commissioner to execute educational policies determined by the Regents.

Subdivision (2) of section 3001 establishes certification by the State Education Department as a qualification to teach in the State's public schools.

Subdivision (1) of section 3004 of the Education Law authorizes the Commissioner of Education to prescribe, subject to the approval of the Regents, regulations governing the examination and certification of teachers employed in all public schools in the State.

Paragraph (b) of subdivision (1) of section 3006 of the Education Law provides that the Commissioner of Education may issue such teacher certificates as the Regents Rules prescribe.

Subdivision (2) of Section 3006 authorizes the Commissioner of Education to endorse a certificate issued by another state.

2. LEGISLATIVE OBJECTIVES:

The proposed amendment to the Regulations of the Commissioner of Education carries out the objectives of the above-referenced statutes by establishing requirements for teacher certification, including requirements for the individual evaluation of candidates who have not completed registered teacher education programs.

3. NEEDS AND BENEFITS:

The proposed amendment extends the expiration date for applicants seeking certification through the individual evaluation pathway in all classroom titles except childhood education from February 1, 2012 to September 1, 2013, thus extending the time that the individual evaluation pathway remains available for these applicants. The proposed amendment is therefore critical to facilitate the Department's continuing ability to certify a sufficient number of properly qualified candidates to fill vacant teaching positions in the State's public schools.

In 2003, the Board of Regents established requirements for teacher certification though the individual evaluation of candidates who have not completed registered teacher education programs. Under the individual evaluation pathway, candidates are required to submit evidence of course work and field experience to the State Education Department for evaluation and issuance of the certificate.

The provision regarding individual evaluation included a sunset date for individual evaluation of February 1, 2007 for certificates in childhood education and February 1, 2009 for all other certificates in the classroom teaching service. The purpose in establishing these sunset dates was to allow the Department time to assess the continued need for the individual evaluation pathway, based on how many candidates use this pathway to become certified, particularly in subject areas where there are teacher shortages.

In 2008, the Regents extended the sunset date for individual evaluation from February 1, 2009 to February 1, 2012 to address shortages in these areas.

In November 2009 the Regents adopted several key policy changes to dramatically change the way teachers are prepared, assessed for certification, and evaluated while employed in a P-12 school. One of these initiatives involves changing the certification examinations for an Initial certificate, which will take effect in May 2013. In combination with more rigorous content exams, the performance-based assessment would require demonstration of the knowledge and skills research has demonstrated are linked to classroom effectiveness. These portfolio style assessments will be completed while the teacher is doing his or her field work/student teaching, which requires access

to a P-12 school to provide the classroom and school environment for the candidate to practice and demonstrate the required skills. Examples of portfolio tasks under consideration for the teacher assessment and currently being field tested include: creating a lesson plan, video-recording the lesson, and reflecting on the outcomes, developing or selecting an assessment, administer it, analyzing the results, and planning instruction based on the results. Students in an approved teacher preparation program can work with their college faculty during their student teaching to prepare this type of portfolio. For “career changers” who are attempting to qualify for a teaching certificate through Individual Evaluation, the access to a P-12 classroom and the supports of a college program will not be readily available.

These changes in certification assessments will drive changes in teacher education preparation programs. In 2013, the Regents will be in a better position to evaluate the effect of these reform measures and to assess the continued need for and viability of the Individual Evaluation pathway.

With the scheduled sunset of the Individual Evaluation pathway for new teachers (including career changers) in 2012; and the new reforms effective in May 2013; staff recommends that the Individual Evaluation pathway be extended until September 1, 2013. This would allow:

- 1) the Regents to have time to evaluate the implementation of the reforms to teaching and the impact such changes may have on an Individual Evaluation pathway to certification;
- 2) SED staff to prepare policy options and research on the effectiveness of the Individual Evaluation pathway in addressing subject shortage areas especially in high needs schools;
- 3) candidates with applications pending through the Individual Evaluation pathway to have more certainty in making plans for college study in the next several semesters in order to complete requirements for a teaching certificate.

4. COSTS:

(a) Costs to State government: The amendment will not impose any additional costs on State government, including the State Education Department. The amendment continues the current processing of applications for initial certificates through individual evaluation.

(b) Costs to local governments: There are no costs to local governments, including school districts and BOCES.

(c) Costs to regulating agency for implementing and continued administration of the rule: As stated above in “Costs to State Government,” the amendment will impose no additional costs on the State Education Department.

5. LOCAL GOVERNMENT MANDATES:

The proposed amendment does not impose any mandatory program, service, duty, or responsibility upon local government, including school districts or BOCES.

6. PAPERWORK:

The amendment does not entail any additional paperwork requirements. Applicants seeking certification through individual evaluation will continue to apply online.

7. DUPLICATION:

The amendment does not duplicate any existing State or Federal requirements.

8. ALTERNATIVES:

The Department has not considered any alternatives.

9. FEDERAL STANDARDS:

There are no related Federal standards.

10. COMPLIANCE SCHEDULE:

It is anticipated that regulated parties will be able to achieve compliance with this amendment by its stated effective date.

Regulatory Flexibility Analysis

The proposed amendment extends the expiration date for applicants seeking certification through the individual evaluation pathway in all classroom titles except childhood education from February 1, 2012 to September 1, 2013, thus extending the time that the individual evaluation pathway remains available for these applicants. It does not establish any requirements for small businesses or local governments, including school districts or BOCES.

The amendment will not impose any adverse economic impact, recordkeeping, reporting, or other compliance requirements on small businesses or local governments. Because it is evident from the nature of the rule that it does not affect small businesses or local governments, no further steps were needed to ascertain that fact and none were taken.

Rural Area Flexibility Analysis

1. TYPES AND ESTIMATE OF NUMBER OF RURAL AREAS:

The proposed amendment will affect applicants seeking certification through the individual evaluation pathway in all classroom teaching titles except childhood education including applicants in the 44 rural counties with fewer than 200,000 inhabitants and the 71 towns and urban counties with a population density of 150 square miles or less.

2. REPORTING, RECORDKEEPING AND OTHER COMPLIANCE REQUIREMENTS AND PROFESSIONAL SERVICES:

The proposed amendment extends the expiration date for applicants seeking certification through the individual evaluation pathway in all classroom teaching titles except childhood education from February 1, 2012 through September 1, 2013. The amendment does not impose additional recordkeeping requirements and it does not require regulated parties to secure professional services to comply.

3. COSTS:

The proposed amendment extends the expiration date for applicants seeking certification through the individual evaluation pathway in all classroom teaching titles except childhood education. The proposed amendment does not impose any additional fees beyond the \$100 application fee currently charged to applicants seeking certification through individual evaluation.

4. MINIMIZING ADVERSE IMPACT:

The amendment is permissive in nature as it extends the period during which the individual evaluation pathway to certification remains available for applicants in certain classroom teaching titles. The State Education Department does not believe that establishing different standards for candidates who live or work in rural areas is warranted. A uniform standard ensures the quality of the State’s teaching workforce.

5. RURAL AREA PARTICIPATION:

The State Education Department solicited comments on the proposed amendment from the State Professional Standards and Practices Board for Teaching. The Standards Board is an advisory group to the Board of Regents and the Commissioner of Education on matters pertaining to teacher education, certification, and practice. The Board has representatives who live and/or work in rural areas, including individuals who are employed as educators in rural school districts and BOCES.

Job Impact Statement

The proposed amendment extends the expiration date for applicants seeking certification through the individual evaluation pathway in all classroom titles except childhood education from February 1, 2012 to September 1, 2013, thus extending the time that the individual evaluation pathway remains available for these applicants.

Because it is evident from the nature of the amendment that it could only have a positive impact or no impact on jobs and employment opportunities, no affirmative steps were needed to ascertain that fact and none were taken. Accordingly, a job impact statement is not required, and one has not been prepared.

PROPOSED RULE MAKING NO HEARING(S) SCHEDULED

Conforming the Practice of Midwifery to Current Law

I.D. No. EDU-26-11-00013-P

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

Proposed Action: Addition of section 29.19; amendment of sections 52.20, 79-5.2, 79-5.3, 79-5.6; and repeal of sections 79-5.5 and 79-5.7 of Title 8 NYCRR.

Statutory authority: Education Law, sections 207 (not subdivided), 6504 (not subdivided), 6507(2)(a), 6508(1) and 6509(9)

Subject: Conforming the practice of midwifery to current law.

Purpose: Removes unnecessary provisions and conforms the practice of midwifery to current law.

Text of proposed rule: 1. The Rules of the Board of Regents are amended, effective October 5, 2011, by the addition of a new section 29.19 to read as follows:

§ 29.19 *Special provisions for the profession of midwifery.*

Unprofessional conduct in the practice of midwifery shall include all conduct prohibited by sections 29.1 and 29.2 of this Part, except as provided in this section, and shall also include:

(a) *failure to have collaborative relationships that provide for consultation, collaborative management and referral to address the health status and risks of his or her patients and that include plans for emergency medical gynecological and/or obstetrical coverage with:*

(1) *a licensed physician who is board certified as an obstetrician-gynecologist by a national certifying body;*

(2) *a licensed physician who practices obstetrics and has obstetric privileges at a general hospital licensed under Article 28 of the Public Health Law; or*

(3) *a hospital, licensed under Article 28 of the Public Health Law, that provides obstetrics through a licensed physician having obstetrical privileges at such institution; or*

(b) *failure to maintain documentation of such collaborative relationships, to make information about such collaborative relationships available to his or her patients, or to provide such documentation to the Department upon request.*

2. Section 52.20 of the Regulations of the Commissioner of Education is amended, effective October 5, 2011, as follows:

§ 52.20, Midwifery.

(a) Definitions. As used in this section:

(1) [Educational preparation for the practice of nursing shall mean didactic courses accompanied by supervised clinical experiences which include, but are not limited to, the following curricular areas:

(i) technical health care skills;

(ii) maternity, pediatric, medical, surgical, psychiatric, and mental health care;

(iii) nutrition;

(iv) pharmacology;

(v) ethics; and

(vi) biological, physical, and social sciences supportive to health care.] *Educational content in the biological, physical and social sciences supportive to health care shall mean coursework which includes, but is not limited to, the following curricular areas:*

(i) *biology;*

(ii) *embryology, human development and genetics;*

(iii) *chemistry;*

(iv) *microbiology;*

(v) *human anatomy and physiology, including pathophysiology;*

(vi) *psychology; and*

(vii) *sociology or cultural anthropology.*

(2) Educational preparation for the practice of midwifery shall mean didactic courses accompanied by supervised clinical experiences which include, but are not limited to, the following curricular areas:

(i) *technical health care skills;*

(ii) *preconceptional, antepartum, intrapartum, and postpartum care;*

[(ii)] (iii) *physical assessment, diagnosis, [and] treatment, [of actual or potential] and management of health problems of women;*

[(iii)] *well-woman] (iv) primary care of women, including preventive care;*

[(iv)] (v) *neonatal care;*

[(v)] (vi) *family planning and gynecological care of prepubescent through postmenopausal women;*

[(vi)] (vii) *professional, legal, and ethical aspects of midwifery practice;*

[(vii)] *areas of] (viii) nutrition related to the practice of midwifery; and*

[(vii)] a (ix) *pharmacology [that includes instruction in drug management of midwifery clients] as described in section 79-5.5 of this Title.*

(3) Equivalent shall mean substantially the same, as determined by the department.

(b) Curriculum. In addition to meeting all applicable provisions of this Part, the following requirements shall be met:

(1) To be registered as a program recognized as a program leading to licensure in midwifery which meets the requirements in section [79-5.2(a)(2)(i)] 79-5.2 of this Title, it shall be a program in midwifery leading

to a [baccalaureate] Masters degree or higher academic credential, *or the equivalent*, and shall include educational preparation for the practice of midwifery [and additional courses in appropriate related basic sciences and clinical sciences. Admission requirements to such a program shall be the successful completion of a degree or diploma program in registered professional nursing, registered pursuant to section 52.12(a)(1) and (3) of this Part, which contains the educational preparation for the practice of nursing as defined in paragraph (a)(1) of this section, or an equivalent program as determined by the department.

(2) To be registered as a program recognized as a program leading to licensure in midwifery which meets the requirements in section 79-5.2(a)(2)(ii) of this Title, it shall be a program in midwifery leading to a baccalaureate degree or higher academic credential and shall include educational preparation for the practice of nursing and educational preparation for the practice of midwifery and additional courses in appropriate related basic sciences and clinical sciences.] *as defined in paragraph (2) of subdivision (a) of this section. Admission requirements to such a program shall include successful completion of a baccalaureate degree, or the equivalent, and successful completion of the educational content in the biological, physical and social sciences supportive to health care as defined in paragraph (1) of subdivision (a) of this section, provided that such admission requirements may be integrated as part of the Master's degree program.*

(c) Clinical facilities. A written contract or agreement shall be executed between the educational institution conducting the midwifery program and the clinical facilities or agencies which are designated to cooperate in providing the clinical experience, which shall set forth the responsibilities of each party, and shall be signed by the responsible officer of each party.

3. Subdivision (a) of section 79-5.2 of the Regulations of the Commissioner of Education is amended, effective October 5, 2011, as follows:

(a) To meet the professional education requirement for licensure as a midwife in this state, the applicant shall present satisfactory evidence of *completion of a Master's or higher degree program in midwifery or a related field acceptable to the Department which is registered by the Department pursuant to section 52.20 of this Title, accredited by an acceptable accrediting agency, or equivalent to such a registered or accredited program.*

[(1) graduation from high school, or the equivalent; and

(2) either:

(i) completion of a degree or diploma program in registered professional nursing, registered pursuant to paragraphs (1) and (3) of subdivision (a) of section 52.12 of this Title, which contains the educational preparation for the practice of nursing as defined in paragraph (1) of subdivision (a) of section 52.20 of this Title, or an equivalent program as determined by the department and completion of a program in midwifery, registered pursuant to paragraph (1) of subdivision (b) of section 52.20 of this Title, or its equivalent as determined by the department; or

(ii) completion of a program in midwifery which is either:

(a) registered by the department pursuant to paragraph (2) of subdivision (b) of section 52.20 of this Title; or

(b) determined by the department to be the equivalent of such a registered program.]

(b) For a curriculum that is offered by a post-secondary institution outside of New York State to be determined by the department to be the equivalent of a registered program in midwifery the curriculum shall be:

(1) recognized by the appropriate civil authorities of the jurisdiction in which the school is located as an acceptable education program for licensure as a midwife in that jurisdiction; and

(2) equivalent in scope, content, and level of study to a program registered by the department pursuant to subdivision (b) of section 52.20 of this Title.

4. Subdivision (b) of section 79-5.3 of the Regulations of the Commissioner of Education is amended, effective October 5, 2011, as follows:

(b) [Education requirements for admission. Notwithstanding the provisions of section 59.2 of this Title, an] *An applicant for licensure shall [not] be required to satisfy [education] the professional study of midwifery requirements set forth in section 79-5.1 of this Part before being admitted to a professional licensing examination in midwifery. [Such education requirements shall be completed prior to licensure.]*

5. Sections 79-5.5 and 79-5.7 of the Regulations of the Commissioner of Education are repealed, and section 79-5.6 of the Regulations of the Commissioner of Education is renumbered section 79-5.5 and amended, effective October 5, 2011, as follows:

[§ 79-5.6] § 79-5.5 Prescriptive privilege.

Pursuant to section 6951(2) of the Education Law, the department shall issue a certificate which authorizes a licensed midwife to prescribe and administer drugs, immunizing agents, diagnostic tests and devices, and to order laboratory tests, limited to the practice of midwifery [and subject to limitations of the practice agreement as set forth in section 79-5.7 of this Subpart]. Such a [certifications] *certification* shall be issued to a licensed

midwife who submits satisfactory evidence to the department of completion of a three-credit course in pharmacology [that includes instruction in drug management of midwifery clients and on] related to the scope of practice of midwifery, including New York State and Federal laws and regulations relating to prescriptions and record keeping, or the satisfactory completion of equivalent course work as determined by the department.

Text of proposed rule and any required statements and analyses may be obtained from: Chris Moore, State Education Department, Office of Counsel, State Education Building, Room 148, 89 Washington Avenue, Albany, NY 12234, (518) 474-3862, email: legal@mail.nysed.gov

Data, views or arguments may be submitted to: Office of the Professions, Office of the Deputy Commissioner, State Education Department, 89 Washington Avenue, 2M, Albany, NY 12234, (518) 474-1941, email: opdepcom@mail.nysed.gov

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

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

Regulatory Impact Statement

1. STATUTORY AUTHORITY:

Section 207 of the Education Law grants general rule-making authority to the Board of Regents to carry into effect the laws and policies of the State relating to education.

Section 6504 of the Education Law authorizes the Board of Regents to supervise the admission to and regulation of the practice of the professions.

Subparagraph (a) of subdivision (2) of section 6507 of the Education Law authorizes the Commissioner to promulgate regulations in administering the admission to the practice of the professions.

Subdivision (1) of section 6508 of the Education Law provides that state boards for the professions shall assist the Board of Regents and Department on matters of professional licensing.

Subdivision (9) of section 6509 of the Education Law authorizes the Board of Regents to define unprofessional conduct in the professions.

2. LEGISLATIVE OBJECTIVES:

The proposed amendments carry out the intent of the aforementioned statutes that the Department shall supervise the regulation of the practice of the professions for the benefit of the public. The proposed repeal of section 79-5.7 of the Regulations of the Commissioner of Education is necessary to implement chapter 238 of the Laws of 2010, which amended section 6951 of the Education Law to eliminate the requirement that midwives practice only under a written practice agreement with a physician or a hospital. In lieu of a written practice agreement, the law now requires midwives to have collaborative relationships with physicians or hospitals that provide for consultation, collaborative management, and referral to address the health status and risks of the midwife's patients and that include plans for emergency medical gynecological and/or obstetrical coverage. Under the proposed addition of section 29.19 of the Rules of the Board of Regents, the failure to have such a collaborative relationship would constitute unprofessional conduct.

The proposed amendment to section 79-5.3(b) of the Regulations of the Commissioner would require applicants for licensure to have completed the educational requirements for licensure in order to be admitted to the licensing examination. The contemporary licensing examination for midwives is a competency-based test predicated on completion of the entire curriculum. Accordingly, applicants should complete that curriculum prior to taking the exam. Additionally, this change would be consistent with the pre-exam requirements for most other professions.

It is proposed that section 79-5.5 of the Regulations of the Commissioner be repealed. That section provided a grandparenting option for licensure for which applicants were required to apply prior to June 1, 1996. This provision is no longer required as no such applications are still pending.

Current section 79-5.6 of the Regulations of the Commissioner would be renumbered section 79-5.5 and revised to delete a reference to the written practice agreement which is no longer required, as noted above. Additional nonsubstantive changes are proposed in the wording of the section regarding the prescriptive privilege for midwives.

3. NEEDS AND BENEFITS:

The need of the proposed amendments is to conform regulations with current statute, and to update educational requirements for licensure as a midwife, in response to increasingly independent practice by licensed midwives.

4. COSTS:

- (a) There are no additional costs to state government.
- (b) There are no additional costs to local government.
- (c) Cost to private regulated parties. The proposed amendments will not increase costs.
- (d) There are no additional costs to the regulating agency.

5. LOCAL GOVERNMENT MANDATES:

The proposed amendment relates solely to the requirement for licensees engaged in the practice of pharmacy and does not impose any programs, service, duty, or responsibility upon local governments.

6. PAPERWORK:

The proposed amendment requires licensed midwives to maintain documentation of their collaborative relationships with physicians and/or hospitals, to make information about such collaborative relationships available to their patients, and to provide such documentation to the State Education Department upon request.

7. DUPLICATION:

The proposed amendment does not duplicate other existing state or federal requirements.

8. ALTERNATIVES:

There are no viable alternatives to the proposed amendment and none were considered.

9. FEDERAL STANDARDS:

Federal standards do not apply, nor does the proposal exceed federal standards.

10. COMPLIANCE SCHEDULE:

Licensees must comply immediately with the proposed amendments.

Regulatory Flexibility Analysis

The proposed amendments to the Rules of the Board of Regents and Regulations of the Commissioner of Education relate to the practice of midwifery. They will not impose any reporting, recordkeeping, or other compliance requirements beyond those required by statute, or any adverse economic impact, on small businesses or local governments. Because it is evident from the nature of the proposed amendments that they will not affect small businesses or local governments, no affirmative steps were needed to ascertain that fact and none were taken. Accordingly, a regulatory flexibility analysis for small businesses and local governments is not required, and one has not been prepared.

Rural Area Flexibility Analysis

1. TYPES AND ESTIMATED NUMBER OF RURAL AREAS:

The regulations will apply to the 44 rural counties with less than 200,000 inhabitants and the 71 towns in urban counties with a population density of 150 per square mile or less. Of the 1,034 midwives registered by the State Education Department, 160 report their permanent address of record is in a rural county.

2. REPORTING, RECORDKEEPING AND OTHER COMPLIANCE REQUIREMENTS; AND PROFESSIONAL SERVICES:

The proposed amendment requires licensed midwives to maintain documentation of their collaborative relationships with physicians and/or hospitals, to make information about such collaborative relationships available to their patients, and to provide such documentation to the State Education Department upon request. The proposed rules do not require midwives to obtain professional services.

3. COSTS:

The proposed amendments do not impose any additional costs on regulated parties.

4. MINIMIZING ADVERSE IMPACT:

Following extensive discussion, including obtaining input from practicing professionals, the State Board of Midwifery has considered the terms of the proposed amendments to Rules of the Board of Regents and Regulations of the Commissioner of Education and has recommended the changes. Additionally, the measures have been shared with educational institutions, professional associations, and practitioners representing the profession of midwifery. The amendment is supported by representatives of these organizations. The rules make no exception for individuals who live in rural areas. The Department has determined that such requirements should apply to all midwives, no matter their geographic location, to ensure a standard of practice across the State. Because of the nature of the proposed rule, alternative approaches for rural areas were not considered.

5. RURAL AREA PARTICIPATION:

Comments on the proposed rule were solicited from statewide organizations representing all parties having an interest in the practice of midwifery. Included in this group were members of the State Board of Midwifery, educational institutions, and professional associations representing midwives, such as the New York State Association of Licensed Midwives. These groups, which have representation in rural areas, have been provided notice of the proposed rule making and opportunity to comment on the regulations.

Job Impact Statement

The proposed amendments relate to the practice of midwifery and to the educational preparation for such practice. They will not have a substantial adverse impact on jobs and employment opportunities for licensed midwives. Because it is evident from the nature of the proposed amendments that they will not affect job and employment opportunities, no affirmative steps were needed to ascertain that fact and none were taken. Ac-

cordingly, a job impact statement is not required, and one has not been prepared.

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

Massage Therapy Continuing Education

I.D. No. EDU-26-11-00014-P

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

Proposed Action: Addition of section 78.5 to Title 8 NYCRR.

Statutory authority: Education Law, sections 207(not subdivided), 6504(not subdivided), 6507(2)(a) and 7807(2); L. 2010, ch. 463, section 2

Subject: Massage therapy continuing education.

Purpose: To implement recently enacted statutory authority requiring continuing education for licensed massage therapists.

Substance of proposed rule: The Commissioner of Education proposes to promulgate regulations, relating to continuing education requirements for the practice of licensed massage therapy. The following is a summary of the substance of the regulations.

Continuing education for the practice of licensed massage therapy

A new section 78.5 is added to the Regulations of the Commissioner of Education to implement continuing education requirements to practice licensed massage therapy, as prescribed pursuant to Education Law § 7807, which was recently enacted pursuant to Chapter 463 of the Laws of 2010 and which will take effect on January 1, 2012. Under new section 78.5 of the Commissioner's regulations, a licensee would be required to complete 36 hours of continuing education per each triennial registration period, excluding the initial registration period, 12 hours of which may be completed through self-instruction. The proposed rule would also provide that a maximum of six hours of 12 hours of self-instruction would be permitted to be completed online if approved by another jurisdiction for formal education in massage therapy.

The proposed rule would describe acceptable formal continuing education and would identify types of learning activities that would be acceptable as continuing education. The proposed rule would also set forth requirements for approval as a sponsor of such continuing education. The proposed rule would also provide limited grounds for a licensee's exemption to these requirements and would provide for a conditional registration, not to exceed a one-year period, in which a licensee may complete the requirements. Additionally, the rule would provide for the pro-ration of the continuing education requirements for individuals whose next registration date will occur after January 1, 2012 but less than three years from such date.

New section 78.5 of the Commissioner's regulations would also provide that massage therapists must maintain adequate documentation verifying that they have met these continuing education requirements. This proposed rule would also require a licensed massage therapist to pay an additional continuing education fee of \$45.00. A fee would also be established for entities seeking approval as a sponsor of such continuing education.

Text of proposed rule and any required statements and analyses may be obtained from: Chris Moore, State Education Department, Office of Counsel, State Education Bldg., Room 148, 89 Washington Avenue, Albany, New York 12234, (518) 474-3862, email: legal@mail.nysed.gov

Data, views or arguments may be submitted to: Seth Rockmuller, Esq., State Education Department, Office of Professions, State Education Building, 2M, 89 Washington Ave., Albany, New York 12234, (518) 474-1941, email: opdepcom@mail.nysed.gov

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

Regulatory Impact Statement

1. STATUTORY AUTHORITY:

Section 207 of the Education Law grants general rule-making authority to the Board of Regents to carry into effect the laws and policies of the State relating to education.

Section 6504 of the Education Law authorizes the Board of Regents to supervise the admission to and regulation of the practice of the professions.

Paragraph (a) of subdivision (2) of section 6507 of the Education Law authorizes the Commissioner of Education to promulgate regulations in administering the admission to and the practice of the professions.

Subdivision 2 of section 7807 of the Education Law requires massage therapists to complete continuing education during each registration period.

Section 2 of chapter 463 of the Laws of 2010 authorizes the Commissioner of Education to promulgate regulations to implement the mandatory continuing education requirement for massage therapists.

2. LEGISLATIVE OBJECTIVES:

The proposed rule carries out the intent of the aforementioned statutes by establishing standards and procedures for acceptable formal continuing education requirements in the profession of massage therapy.

3. NEEDS AND BENEFITS:

The proposed rule implements section 7807 of the Education Law, recently enacted by Chapter 463 of the Laws of 2010, which prescribes mandatory continuing education requirements for individuals licensed in the practice of massage therapy. The proposed rule is necessary to implement these statutorily mandated continuing education requirements. The proposed rule implements the recently enacted mandatory continuing education requirements for those individuals who are engaged in the practice of massage therapy. The proposed adoption of section 78.5 of the Regulations of the Commissioner of Education is necessary to implement these statutory requirements by their effective date, which is January 1, 2012.

In accordance with this statutory authority, this proposed rule requires that within each three-year registration period, excluding the initial registration period, a licensed massage therapist must earn 36 hours of formal continuing education, no more than 12 of which may be earned through self-instruction. The proposed rule would identify acceptable coursework and activities through which a licensee may meet the mandatory continuing education requirements. The rule would also include provisions relating to the applicability of the continuing education requirements, including the grounds for granting an exemption or adjustment to the requirements; the formal continuing education required of a licensee returning to the practice of massage therapy after a lapse in practice in this State; and the requirements to obtain a conditional registration to enable those who, for good cause, were unable to complete the requirements within the triennial registration period, but who may complete such requirements within one year from issuance of such registration. The rule would also provide the requirements for approval of sponsors of the continuing education by the Department.

4. COSTS:

(a) Costs to State government: The amendment will impose the cost of reviewing and approving sponsors of continuing education, the cost of auditing the applications for the renewal of registration for massage therapists and the cost of implementing and administering this process. Additionally, the rule will impose costs on the Department to investigate and enforce, including prosecute, the willful refusal of a licensee to comply with the requirements and to practice massage therapy unlawfully, without registration. Some of this cost will be offset by the application fee paid by an entity seeking approval as a sponsor of the continuing education and by the additional continuing education fee of \$45 paid by a licensee upon each registration. It is anticipated that existing staff and resources will be utilized to complete these tasks.

(b) Costs to local government: None.

(c) Costs to private regulated parties: None. The proposed rule will not impose any additional cost on private regulated parties beyond those inherent in the statute.

(d) Cost to the regulatory agency: As stated above in Costs to State Government, the proposed rule will impose costs on the State Education Department.

5. LOCAL GOVERNMENT MANDATES:

The proposed rule does not impose any program, service, duty or responsibility upon local governments.

6. PAPERWORK:

Each licensee would be required to maintain, or ensure access by the Department to, a record of completed continuing education, which includes: the title of the course if a course, the type of educational activity if an educational activity, the subject of the continuing education, the number of hours of continuing education completed, the sponsor's name and any identifying number (if applicable), attendance verification if a course, participation verification if another educational activity, a copy of any article or book for which continuing education credit is claimed with proof of publication, and the date and location of the continuing education. Such records must be retained for at least six years from the date of completion of the continuing education and must be made available for review by the Department in the administration of the requirements of this section.

Continuing education sponsors would also be required to maintain records for at least six years from the date of completion of coursework. Those records would include the name and curriculum vitae of the faculty, a record of attendance of licensed massage therapists in the course if a course, a record of participation of licensed massage therapists in the self-instructional coursework if self-instructional coursework, an outline of the course, date and location of the course, and the number of hours for completion of the course. In the event an approved sponsor discontinues operation, the governing body of such sponsor would be required to notify the department and to transfer all records as directed by the Department.

7. DUPLICATION:

The proposed rule does not duplicate other existing State or Federal requirements.

8. ALTERNATIVES:

There are no viable alternatives to the proposed rule, and none were considered.

9. FEDERAL STANDARDS:

There are no Federal standards in the subject matter of the proposed rule.

10. COMPLIANCE SCHEDULE:

The proposed rule must be complied with by its effective date. No additional period of time is necessary to enable regulated parties to comply.

Regulatory Flexibility Analysis

The proposed rule sets forth the mandatory continuing education requirements applicable to individuals engaged in the practice of massage therapy.

The proposed rule does not regulate small businesses or local governments. They establish requirements applicable to individuals who are licensed professionals.

Because it is evident from the nature of the proposed rule that it does not affect small businesses or local governments, no further steps were needed to ascertain that fact and none were taken. Accordingly, a regulatory flexibility analysis is not required and one has not been prepared.

Rural Area Flexibility Analysis

1. TYPES AND ESTIMATED NUMBER OF RURAL AREAS:

The proposed rule will apply to the 44 rural counties with fewer than 200,000 inhabitants and the 71 towns in urban counties with a population density of 150 per square mile or less. All 16,983 licensed massage therapists who are registered to practice in New York State will be subject to the requirements of the proposed rule. Of these individuals, 3,354 massage therapists reported that their permanent address of record is in a rural county.

2. REPORTING, RECORDKEEPING AND OTHER COMPLIANCE REQUIREMENTS; AND PROFESSIONAL SERVICES:

The proposed rule will implement a recent statutory amendment requiring licensed massage therapists to complete 36 hours of formal continuing education, 12 hours of which may be self-instructional, during each triennial registration period, excluding the initial registration period. This rule identifies the subject matter of the course content and the types of learning activities and other educational activities that will meet the formal continuing education requirement. The proposed rule provides means for residents located in all counties of the State to complete the continuing education requirements by including various distance learning formats, as well as the opportunity for approved sponsors to offer such activities in a wide range of settings, including workshops, conferences, colleges, and licensure-qualifying massage therapy programs, among others.

The proposed rule does not impose a need for professional services but does impose certain minimal recordkeeping requirements on individual licensees and sponsors of the continuing education. Specifically, each licensee would be required to maintain, or ensure access by the Department to, a record of completed continuing education, which would be required to include: the title of the course if a course, the type of educational activity if an educational activity, the subject of the continuing education, the number of hours of continuing education completed, the sponsor's name and any identifying number (if applicable), attendance verification if a course, participation verification if another educational activity, a copy of any article or book for which continuing education credit is claimed with proof of publication, and the date and location of the continuing education. A licensee would be required to retain his or her records for at least six years from the date of completion of the continuing education and must make such records available for review by the Department.

Continuing education sponsors would also be required to maintain records for at least six years from the date of completion of coursework. These records would be required to include the name and curriculum vitae of the faculty, a record of attendance of licensed massage therapists in the course if a course, a record of participation of licensed massage therapists in the self-instructional coursework if self-instructional coursework, an outline of the course, date and location of the course, and the number of hours for completion of the course. In the event an approved sponsor discontinues operation, the governing body of such sponsor would be required to notify the department and to transfer all records as directed by the department.

3. COSTS:

Beyond the costs inherent in the statute, the proposed regulations do not impose additional costs on licensees or continuing education sponsors, including those located in rural areas of New York State.

4. MINIMIZING ADVERSE IMPACT:

The proposed rule implements section 7807 of the Education Law, recently enacted by Chapter 463 of the Laws of 2010, which prescribes

mandatory continuing education requirements for individuals licensed in the practice of massage therapy. This proposed rule is necessary to implement these statutorily mandated continuing education requirements. The proposed rule will provide broad flexibility in the types of activities in which such professionals may engage in order to satisfy their continuing education requirements. Because the proposed rule establishes requirements designed to ensure the competent practice of massage therapy in New York State, the Department has determined that these requirements should apply to all licensed massage therapists regardless of their geographic location. Because of the nature of the proposed rule, alternative approaches for rural areas were not considered.

5. RURAL AREA PARTICIPATION:

Comments on the proposed amendment were solicited from statewide organizations representing all parties having an interest in the practice of massage therapy. Included in this group were the State Board for Massage Therapy and professional associations representing the massage therapy profession. These groups have members who live or work in rural areas.

Job Impact Statement

The proposed rule sets forth the mandatory continuing education requirements applicable to individuals engaged in the practice of massage therapy. It establishes continuing education standards in accordance with statutory directives, specifying acceptable continuing education that would meet the statutorily prescribed mandatory continuing education requirements. The proposed amendments will have no effect on the number of jobs and employment opportunities in massage therapy or any other field.

Because it is evident from the nature of the proposed rule that it will have no impact on jobs and employment opportunities, no further steps were needed to ascertain that fact and none were taken. Accordingly, a job impact statement is not required and one has not been prepared.

Department of Environmental Conservation

NOTICE OF ADOPTION

Transportation of Uncertified Bait Fish by Anglers, Sale of Bait Fish, Use of Bait Fish and Fish Health Inspection Requirements

I.D. No. ENV-14-11-00011-A

Filing No. 517

Filing Date: 2011-06-14

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 Parts 10, 19, 35 and 188 of Title 6 NYCRR.

Statutory authority: Environmental Conservation Law, sections 3-0301, 11-0303, 11-0305 and 11-0325

Subject: Transportation of uncertified bait fish by anglers, sale of bait fish, use of bait fish and fish health inspection requirements.

Purpose: Provide some allowances for the transportation of uncertified bait fish by anglers, and adjust bait fish "green" list.

Text of final rule: Part 10 of Title 6 of NYCRR is amended as follows:

A new subparagraph 10.1(f)(3)(iii) is added to Title 6 NYCRR Part 10 to read as follows:

(iii) bait fish taken for personal use from the defined water body adjacent to or a water body within the following overland transportation corridors may be transported overland only within that designated overland transportation corridor. Such bait fish must be used in the same water body, as defined in 10.1(f)(6) and 10.1(f)(7), from which the bait fish were taken.

(a) Upper Niagara River/Lake Erie Overland Transportation Corridor shall mean the geographical area associated with the water body as defined in 10.1(f)(7)(ii) west of and including a line starting at I-90 at the Pennsylvania border, then continuing east to its intersection with I-290, then continuing north along I-290 to its intersection with State Route 62, then continuing west to its intersection with I-190, then north to its intersection with the Lower Niagara River.

(b) Lower Niagara River/Lake Ontario/St. Lawrence River Overland Transportation Corridor shall mean the geographical area associated with the water body as defined in 10.1(f)(7)(i) starting at the intersection of I-190 and the Lower Niagara River, then continuing eastward to its intersection with State Route 104, then continuing eastward to its intersection with State Route 3, then continuing east on State Route 3 to its intersection with State Route 104, then continuing eastward on State Route 104 to its intersection with State Route 11, then continuing north on State Route 11 to its intersection with State Route 56, then continuing north along State Route 56 to its intersection with State Route 37, then continuing east along State Route 37 to its intersection with Racquette Point Road, then continuing north on Racquette Point Road to its intersection with Ransom Road, and then continuing west on Ransom Road and terminating at the St. Lawrence River.

(c) Hudson River Overland Transportation Corridor shall mean the geographical area associated with the water body as defined in 10.1(f)(7)(x) starting at the eastern shore of the Hudson River at the Federal Dam in Troy, continuing east on W Glenn Avenue in Troy to its intersection with State Route 4, then continuing south on State Route 4 to its intersection with State Routes 9 & 20, then continuing easterly to its intersection with State Route 9, then continuing east on State Route 82, then continuing east on State Route 82 to its intersection with the Taconic State Parkway, then continuing south on the Taconic State Parkway to its intersection with the Sprain Brook Parkway, then continuing south on the Sprain Brook Parkway to its intersection with I-287, then continuing west on I-287 across the Tappan Zee Bridge to I-87 North, then continuing north on I-87 to where State Route 9W crosses I-87 in Greene County, then continuing north on State Route 9W to where State Route 9W crosses I-87 in Albany County, then continuing north on I-87 its intersection with State Route 7, and then continuing east on State Route 7 to its intersection with I-787, and then continuing north on I-787 to its intersection with Tibbets Avenue, and then continuing east on Tibbets Avenue to its intersection with Delaware Avenue, then proceeding in a straight line to the west edge of the Troy Dam.

Part 19 of Title 6 of NYCRR is amended as follows:

New paragraph 19.2(a)(16) is added and reads as follows:

(16) Eastern silvery minnow (*Hybognathus regius*)

Part 35 of Title 6 of NYCRR is amended as follows:

A new paragraph 35.3(a)(5) is added to read as follows:

(5) Overland Transportation Corridors shall mean those as defined in Part 10.1(f)

Subparagraph 35.3(f)(1)(i) is amended to read as follows:

(i) the name of the water body in which the bait fish [may] must be used; and

Subparagraph 35.3(f)(1)(ii) is amended to read as follows:

(ii) a warning to the purchaser that the fish may not be transported by car or other motorized vehicle except as specified in (iii) of this paragraph.

New subparagraph 35.3(f)(1)(iii) is added as follows:

(iii) receipts issued by sellers permitted pursuant to subdivision (c)(2) of this Part must specify the overland transportation corridor identified in their permit, and contain the warning that the bait fish may only be transported overland within that overland transportation corridor.

Part 188 of Title 6 of NYCRR is amended to read as follows:

Paragraph 188.2(a) is amended to read as follows:

(a) All fish species. (1) A fish health certification report shall certify that the fish being placed into the waters of the State are free of:

(i) Viral Hemorrhagic Septicemia (VHS);

(ii) Spring Viremia of Carp Virus (Infectious carp dropsy);

[(2) Until January 1, 2009, a fish health certification report shall also certify the presence or absence of the following pathogens:]

[(i)] *Aeromonas salmonicida* (Furunculosis);

[(ii)] *Yersinia ruckeri* (Enteric Red Mouth);

[(iii)] (v) Infectious Pancreatic Necrosis Virus (IPN);

[(3) Effective January 1, 2009, a fish health inspection report shall certify that the fish are free of the pathogens listed in paragraph (2) of this subdivision.]

Paragraph 188.2(b) is amended to read as follows:

(b) Additional fish health inspection requirements for Salmonidae.

(1) In addition to the requirements of subdivision (a) of this section, a fish health certification report for Salmonidae shall certify that the fish are free of:

(i) *Myxobolus cerebralis* (whirling disease);

(ii) Infectious Hematopoietic Necrosis Virus (IHN)[.];

(iii) *Renibacterium salmoninarum* (bacterial kidney disease).

[(2) Until January 1, 2009, a fish health certification report for Salmonidae shall also certify the presence or absence of *Renibacterium salmoninarum* (bacterial kidney disease).

(3) Effective January 1, 2009, a fish health certification report shall certify that the Salmonidae fish are free of *Renibacterium salmoninarum* (bacterial kidney disease).]

Paragraph 188.2(c) is amended to read as follows:

(c) [Effective January 1, 2009.] M[n]o fish shall be placed into the waters of the State unless a fish health certification report certifies that such fish are free of all pathogens identified in this section.

Final rule as compared with last published rule: Nonsubstantive changes were made in Part 10.

Text of rule and any required statements and analyses may be obtained from: Shaun Keeler, Department of Environmental Conservation, 625 Broadway, Albany, NY 12233, (518) 402-8928, email: sxkeeler@gw.dec.state.ny.us

Additional matter required by statute: A programmatic impact statement is on file with the Department of Environmental Conservation.

Revised Regulatory Impact Statement

A revised Regulatory Impact Statement is not needed, as the original Regulatory Impact Statement, as published in the Notice of Proposed Rule Making, remains valid. It does not need to be amended.

Revised Regulatory Flexibility Analysis

A revised Regulatory Flexibility Analysis for small businesses and local governments Statement is not needed. The original Regulatory Flexibility Analysis for small businesses and local governments Statement, as published in the Notice of Proposed Rule Making, remains valid and does not need to be amended.

Revised Rural Area Flexibility Analysis

A revised Rural Area Flexibility Analysis is not needed. The original Rural Area Flexibility Analysis Statement, as published in the Notice of Proposed Rule Making, remains valid and does not need to be amended.

Revised Job Impact Statement

A revised Job Impact Statement is not needed. The original Job Impact Statement, as published in the Notice of Proposed Rule Making, remains valid and does not need to be amended.

Assessment of Public Comment

The following is a summary of the comments were received by the department during the public comment period associated with the revised rule making, and the department's responses.

Comments: Comments were received indicating that revising the laws/regulations to allow for transportation corridors is a step backwards in protecting all New York waters from invasive species, as a result of bait fish and the waters where they are transported being vectors and facilitating the spread of aquatic invasive species (AIS) from infected to uninfected waters. Comments were received expressing concern over uncertified bait fish reaching waters outside the corridors including reaching waters of the Adirondacks.

Response: The movement of bait fish not certified as being disease free (of the pathogens currently contained in regulation) between water bodies will still be prohibited. With compliance, this should not increase the risk for spreading AIS species into uninfected water bodies in other regions of the state. The Department will utilize education and outreach tools for achieving compliance, as well as partnering with the angling community in emphasizing the dangers of moving uncertified bait fish from one water body to another.

Comments: Comments were received indicating that the current regulations are effective and should not be changed.

Response: The strict prohibition on the overland (motorized) transport of uncertified bait fish by anglers (current regulation) was put into effect

to ensure that the use of uncertified bait fish was limited to the same body of water from which it was collected. The department recognizes the personal collection of bait fish as a part of angling, which is highlighted on some specific waters where it is a very common practice. The department supports this practice on waters for which it is legally provided for and conducted in conformance with restrictions safeguarding against the spread of fish pathogens. Allowing transport within defined corridors will still contain the movement of bait fish, including retaining the requirement that uncertified bait fish only be used in the same body of water from which collected. With compliance, this should not increase the risk of the spread of Viral Hemorrhagic Septicemia (VHS) and other fish pathogens into uninfected water bodies.

Comments: Comments were received stating that the allowance for the overland transport of bait fish within the three corridors was unenforceable.

Response: The proposed modifications will still retain a strong enforceability component in that the transport of uncertified bait fish will be illegal outside of the identified transportation corridors (with the exception of the Marine District). The department's Division of Law Enforcement will monitor the use of bait fish including any abuse of the movement of uncertified bait fish outside of the defined corridors. Future regulatory action will be considered to address any problems that emerge. In addition, the department will utilize education and outreach tools for achieving compliance, as well as partnering with the angling community in emphasizing the dangers of moving uncertified bait fish from one water body to another.

Comments: Comments were received indicating that sale of uncertified bait fish should be restricted, including limited to just wholesalers who sell to bait shops only, as well as prohibiting all commercial netting of bait fish.

Response: The department does not support limiting the sale of uncertified bait fish to just wholesalers. Retailers can also be monitored. With requirements in place, at both the federal and state level, the department does not support prohibiting the collection of bait fish for commercial sale purposes, for either in-state or out-of-state sale. Commercial collection and sale are governed by established laws and regulations.

Comments: Comments were received pertaining to the boundaries of the corridors including that they provide for possession of uncertified bait fish at home by some, but not others.

Response: The primary purpose for establishing the corridors is to provide for transport of bait fish by anglers to assist anglers in using bait fish on three principal water bodies where the use of bait fish is a prominent part of angling, and where the movement (overland transport) of uncertified bait fish for fishing those individual bodies of water is not a risk of spreading fish diseases to other waters of the state. Providing for the home possession of uncertified bait fish was not a primary intent of the regulation changes. To the fullest extent possible, major roadways were used in establishing boundaries for the transportation corridors, to both facilitate monitoring compliance and to avoid complexity. In some instances secondary roads needed to be used, particularly within some cities and villages. While home possession of uncertified bait fish in the rest of the state is largely prohibited (as is overland transport) possession is being allowed for within the corridors, as part of providing for the use of uncertified bait fish in these defined areas (use restricted to the same body from which collected). Regardless of where the boundaries are drawn, there will always be anglers outside of the corridor. This is unavoidable and boundaries were finalized from the combination of factors described above. One modification has been made to the western boundary of the Hudson River Overland Transportation Corridor, where another major road (i.e. State Route 9W) is available and can be used to provide more travel flexibility and travel options for anglers fishing the Hudson River. As a result of this, some additional residents in the communities of Ravena and Selkirk will be included inside the corridor.

Comments: Suggestions were made for other corridors, many of which are larger in scope than the single "water bodies" as currently defined in the regulation, such as combining the Great Lakes and using a watershed approach.

Response: While the proposed modifications provide for some overland (motorized) transport of uncertified bait fish, anglers are still required to use bait fish only on the same water body from which they were collected. As part of establishing this requirement earlier, some larger combination "water bodies" that are obvious as far as being a shared water (e.g. Upper Niagara River and Lake Erie) were defined. Natural and manmade restrictions to fish passage are used to define individual water bodies, and individual water bodies include all tributaries upstream to the first impassable barrier. Natural and manmade restrictions to fish passage were also used in defining the larger combination water bodies (e.g. Niagara Falls was used). Using the previously defined "water body", including defining the larger combination water bodies, continues to be important as a basis for restricting the use of uncertified bait fish to the same water body from which collected. The combination suggested could increase the risk of VHS and other pathogens moving between the two water bodies.

Comments: Providing overland transport on the other waters of the State (conditioned by that the personally collected bait fish are only used on the same body of water from which they were collected) was suggested, including for the Ausable River and Lake Champlain. Providing for more overland transport in St. Lawrence County was suggested, as well as dropping the overland transport prohibition all together (i.e. statewide).

Response: The Department continues to acknowledge the need to safeguard against the spread of fish diseases into uninfected waters and to limit the allowance of overland transport of bait fish to a few select areas. The transportation corridors are intended to help serve angler needs in using bait fish on three principal water bodies where the use of bait fish is a prominent part of angling, and where the movement (overland transport) of uncertified bait fish for fishing those individual bodies of water is not a risk of spreading fish diseases to other waters of the state. The department will monitor activity and conduct further evaluation for determining if a broader application (of removing the overland transport requirement) is reasonable or if it needs to be reestablished for the three defined corridors.

Comments: Comments were received stating that it makes more sense to implement these regulations where fish kills have been located, not in areas where no issues have been identified, and that transportation of bait fish should be allowed in areas that don't have disease (e.g. Susquehanna River, Delaware watershed). It was also suggested that the State be divided up into certified and non-certified areas.

Response: Regardless of location and where fish kills have evolved and not evolved, the use of bait fish (uncertified) is restricted to being used only on the same body of water from which collected. As far as areas of the state where fish kills have not occurred, if the fish have not been tested then the disease status for a particular water is unknown. Introducing fish into the waters of the State with an unknown disease status presents an unacceptable risk.

Comments: A comment was received suggesting a change to the northern section of the proposed Upper Niagara River/Lake Erie Overland Transportation Corridor (i.e. where it meets the Lower Niagara River), and that the proposed location does not make sense since there is no access to the Lower River there, and that the corridor should be extended to the Lewiston Town Boat launch since this is the first location in the Lower Niagara River where a boat can be launched. This would also allow shore anglers to use bait caught in the Upper River at the fishing access locations at Artpark.

Response: It is important to safeguard against the movement of uncertified bait fish between water bodies including between the Upper Niagara River and the Lower Niagara River (note that the Lake Erie -Upper Niagara River is currently defined as one water body in regulation and the Lower Niagara River-Lake Ontario-St. Lawrence River is defined as a separate water body). Since use of bait fish from the Upper Niagara River is prohibited in the Lower Niagara River, accommodating access onto the Lower Niagara River in defining a transportation corridor for the purpose of accommodating the use of bait fish for only within the Lake Erie-Upper Niagara River Corridor is not wise from a disease prevention standpoint. Secondly, using major roadways provides well recognized boundaries facilitating an understanding of the corridor by anglers. Thirdly, it is evident from the public input received by anglers, which overwhelmingly endorses the proposed boundary for the Lake Erie-Upper Niagara River Corridor, that the corridor, as proposed, accommodates angling activity within the Lake Erie-Upper Niagara River, as intended.

Comments: Comments were received requesting more clarification of the description of the corridors.

Response: The previous definitions of the corridors have been modified to make them clearer.

Comment: Modifying the regulation to allow anglers to purchase smelt at a bait shop in the Adirondacks for fishing Adirondack lakes was requested.

Response: Because the use of bait fish is a common pathway for the spread of fish pathogens to uninfected waters, the use of uncertified bait fish on a body of water other than from which collected remains prohibited.

Comments: Comment was received stating that the movement of fish diseases through bait fish transportation is a concern for commercial fish growers, whose own populations can become infected if diseases are introduced to new waterways.

Response: The movement of bait fish (not certified as being disease free of the pathogens currently defined in regulation) between water bodies will still be prohibited. Bait fish used only on the same body of water from which they were collected should not increase the risk of introduction of fish diseases into uninfected waterways. Education and outreach will be used to seek compliance, as well as partnering with the angling community in emphasizing the dangers of moving uncertified bait fish from one water body to another. The department will monitor activity to ensure that the establishment of these corridors does not increase the risk of the spread of fish diseases into uninfected waters. Further evaluation will help determine if a broader application (of removing the overland

transport requirement) is feasible, or if it needs to be reestablished in the three areas currently defined.

Department of Health

EMERGENCY RULE MAKING

NYS Newborn Screening Panel

I.D. No. HLT-26-11-00005-E

Filing No. 518

Filing Date: 2011-06-14

Effective Date: 2011-06-14

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

Action taken: Amendment of section 69-1.2 of Title 10 NYCRR.

Statutory authority: Public Health Law, section 2500-a

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

Specific reasons underlying the finding of necessity: Advancing technology, and emerging and rising public expectations for this critical public health program demand that the panel of screening conditions be expanded through this amendment of 10 NYCRR Section 69-1.2, which would add one inherited disorder of the immune system to the scope of newborn screening services already provided by the Department's Wadsworth Center. This regulatory amendment adds one condition – severe combined immunodeficiency (SCID) – to the 44 genetic/congenital disorders and one infectious disease that comprise New York State's newborn screening test panel. The Department of Health finds that immediate adoption of this rule is necessary to preserve the public health, safety and general welfare, and that compliance with State Administrative Procedure Act (SAPA) Section 202(1) requirements for this rulemaking would be contrary to the public interest.

Immediate implementation of the proposed screening for SCID is both feasible and obligatory at this time. A laboratory test method using a dried blood spot specimen was recently validated by the Department's Newborn Screening Program. The Program has determined that a scaled-up version of the recently developed test method reproducibly generates reliable results for the large number of newborns' specimens accepted by the Program. The required instrumentation (i.e., robots to prepare DNA and thermal cyclers to detect TRECs) is already in operation at the Department's Wadsworth Center laboratory and dedicated to newborn screening. A system for follow-up and ensuring access to necessary treatment for identified infants is fully established and adequately staffed.

Early detection through screening is critical to successful treatment of SCID. A survey of more than 150 patients commissioned by the Immune Deficiency Foundation found that SCID patients who were diagnosed early and treated by 3.5 months showed a 91-percent survival rate; those treated after 3.5 months had a 76-percent survival rate. Average costs for a bone marrow transplant also increase significantly after the infant reaches 3.5 months of age, exceeding \$300,000 because of additional complications and the need for more supportive care. Now that the Program is technically proficient in DNA technology, data collection and interpretation, and has demonstrated proficiency in triage and referral procedures, failure to include SCID screening immediately would mean infants would go undetected, undetected, and may suffer serious systemic infections and even succumb to an early death. Accordingly, the Department is obligated to avoid further delays in implementing screening for SCID.

Subject: NYS Newborn Screening Panel.

Purpose: Adds Severe Combined Immunodeficiency (SCID) to NYS Newborn Screening Panel.

Text of emergency rule: Pursuant to the authority vested in the Commissioner of Health by Section 2500-a of the Public Health Law, existing Section 69-1.2 of Subpart 69-1 of Title 10 (Health) of the Official Compilation of Codes, Rules and Regulations of the State of New York (NYCRR) is amended, to be effective upon filing of a Notice of Emergency Adoption with the Secretary of State, as follows:

SUBPART 69-1
TESTING FOR PHENYLKETONURIA
AND OTHER DISEASES AND CONDITIONS
(Statutory authority: Public Health Law, sections 2500-a and 2500-f)
Section 69-1.2(b) is amended as follows:
(b) Diseases and conditions to be tested for shall include:
argininemia (ARG);

* * * *

propionic acidemia (PA);
severe combined immunodeficiency and other inherited T-cell deficiencies (SCID)
short-chain acyl-CoA dehydrogenase deficiency (SCADD);
tyrosinemia (TYR); and
very long-chain acyl-CoA dehydrogenase deficiency (VLCADD).

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 11, 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: regsna@health.state.ny.us

Summary of Regulatory Impact Statement

Statutory Authority:

Public Health Law (PHL) Section 2500-a (a) provides statutory authority for the Commissioner of Health to designate in regulation diseases or conditions for newborn testing in accordance to the Department's mandate to prevent infant and child mortality, morbidity, and diseases and disorders of childhood.

Legislative Objectives:

In enacting PHL Section 2500-a, the Legislature intended to promote public health through mandatory screening of New York State newborns to detect those with serious but treatable neonatal conditions and to ensure their referral for medical intervention. Emerging medical treatments and the complexity of genetic testing require periodic reassessments of the benefits of newborn screening. These reassessments ensure that the New York State's Newborn Screening Program (the NYS Program) meets the legislative intent of preventing childhood diseases and disorders by early detection. This proposal, which would modify the newborn screening panel currently in regulation by adding severe combined immunodeficiency (SCID), is in keeping with the legislature's public health aims of early identification and timely medical intervention for all the State's youngest citizens.

Needs and Benefits:

Severe Combined Immunodeficiency (SCID) is a primary immune deficiency, which results in the infant's failure to develop a normal immune system. The defining characteristic for SCID is a severe defect in the production and function of T-cells and/or B-cells. Affected infants are susceptible to a wide range of infections that are typically controlled by a normal immune system. If undetected and untreated, SCID typically leads to death in the first year of life. It is noteworthy that, in May of 2010, the U.S. Department of Health and Human Services (DHHS) Secretary Kathleen Sebelius added SCID to the core newborn screening panel that represents a national standard 30-test panel that states are encouraged to adopt.

The pediatric immunology community now recognizes this once-fatal disease is a disorder that can be treated and most likely cured at a reasonable cost. Early detection through screening is critical to successful treatment. Current estimates suggest that one in every 50,000 to 100,000 newborns may be affected; however, since many infants may succumb to infection before being diagnosed, the true incidence of SCID and related forms of T-cell immune deficiency may be higher. A DNA-based test for immune deficiency has been recently modified for accurate, high-throughput analyses, making possible its use for newborn screening. This test detects T-cell Receptor Gene Excision Circles or TRECs, which are produced during normal T-cell maturation but are absent or severely reduced in infants with SCID.

Immediately after confirming a SCID diagnosis, infants are started on intravenous immunoglobulins (IVIG) and antibiotics, and a donor

search is initiated to perform stem cell transplant from donor bone marrow or cord blood. SCID infants and children require IVIG for as long as they lack the ability to produce antibodies - before and often for some time after a transplant. If the transplant proves not totally corrective, IVIG may be needed for life. Alternatively, enzyme replacement therapy with bovine pegademase (PEG-ADA), an injectable medication, can be used to treat the approximately 40-percent of SCID patients with a form of the disorder characterized by a deficiency of the enzyme adenosine deaminase. This treatment is typically used only when the patient is not a candidate for the more conventional bone marrow transplant treatment.

General health care costs attributable to treatment of SCID-confirmed infants, including those related to a stem cell transplant (i.e., use of a surgical suite, stays in the neonatal intensive care unit) cannot be assessed due to large variations in charges for the professional component of specialists' and ancillary providers' services, and the scope of potentially required donor-matching services. However, overall health care costs would be reduced since early diagnosis of SCID provides the opportunity for less expensive treatments, and avoids medical complications, thereby reducing the number and average length of hospital stays, and emergency and intensive care services necessary due to recurrent infections in affected children.

If a matched, related donor cannot be found or a transplant fails, infants diagnosed with SCID typically are initially treated using IVIG as an outpatient procedure. Since IVIG only replaces the missing end product, but does not correct the deficiency in antibody production, the replacement therapy usually becomes necessary for the patient's entire lifespan. The cost of lifetime IVIG replacement therapy is estimated to be approximately \$600,000. Costs for enzyme replacement therapy for one form of SCID with PEG-ADA, which is designated as an orphan drug, are estimated at \$3,800 per injection. PEG-ADA is administered by intramuscular injection twice weekly and once weekly after stabilization is reached, usually in one to three weeks. Costs for a transplant including a 1 year follow-up period are \$300,000, while costs for an unscreened and undiagnosed child who does not receive early treatment can exceed \$600,000.

Costs:

Costs to Private Regulated Parties:

Birthing facilities would incur no new costs related to collection and submission of blood specimens to the NYS Program, since the dried blood spot specimens now collected would also be tested for SCID.

The NYS Program estimates that following implementation of this proposal, 125 newborns would screen positive for SCID annually statewide, with SCID being confirmed in seven of those infants.

Birthing facilities would likely incur minimal additional costs related to fulfilling their responsibilities for referral of screen-positive infants; such costs would be limited to human resources costs for less than 0.5 person-hour. Any birthing facility can calculate its specific cost impact based on its annual number of births and related expenses, and a referral rate of one infant per 2,100 births. The Department estimates that on average specialized care facilities would receive referrals of fewer than two infants per month for clinical assessment and additional testing to confirm or refute screening results.

Annual cost for arranging for SCID-related referrals for a facility at which 2,000 babies are delivered each year would range from 1/2 of \$40 to 1/2 of \$100, depending on whether clerical staff or nursing staff arranged for the referral, or specifically \$20-50 a year. Larger birthing facilities (i.e., those with the resources to perform transplants) would not incur even these minimal costs for referral to another facility.

Costs for Implementation and Administration of the Rule:

Costs to State Government:

State-operated facilities providing birthing services and infant follow-up and medical care would incur costs and savings as described above for private regulated parties.

State Medicaid costs will not increase with regard to referral costs, as such costs are included in rates for delivery-related services, and are not separately reimbursed. Costs associated with treatment for SCIDS for Medicaid-eligible infants would generally be borne by the

State, as most counties have already reached their cap for Medicaid liability. However, there would likely be a net savings to Medicaid since early diagnosis provides the opportunity for less expensive treatment, (on the order of \$300,000) and avoids medical complications, thereby reducing the number and average length of hospital stays, and emergency and intensive care services necessary due to recurrent infections (which can exceed \$600,000).

Costs to the Department:

Costs incurred by the Department's Wadsworth Center for performing SCID screening tests, providing short- and long-term follow-up, and supporting continuing research in neonatal and genetic diseases will be covered by State budget appropriations. The Program expects minimal to no additional laboratory instrumentation costs related to this proposal, since the necessary technology has already been purchased.

The Department will incur minimal administrative costs for notifying all New York State-licensed physicians, hospital chief executive officers (CEOs) and their designees, and other affected parties, by letter informing them of a newborn screening panel expansion or, on an ongoing basis, of information regarding positive SCID screening results.

Costs to Local Government:

Local government-operated facilities providing birthing services and medical care to affected infants would incur the costs and savings described above for private regulated parties.

Local Government Mandates:

The proposed regulations impose no new mandates on any county, city, town or village government; or school, fire or other special district, unless a county, city, town or village government; or school, fire or other special district operates a facility, such as a hospital, caring for infants 28 days of age or under and, therefore, is subject to these regulations to the same extent as a private regulated party.

Paperwork:

No increase in paperwork would be attributable to activities related to specimen collection, and reporting and filing of test results. Facilities that submit newborn specimens will sustain minimal to no increases in paperwork, specifically, only that necessary to conduct and document follow-up and/or referral of infants with abnormal screening results. Educational materials for parents and health care professionals and forms will be updated to include information on SCID at minimal costs at the next printing.

Duplication:

These rules do not duplicate any other law, rule or regulation.

Alternative Approaches:

Potential delays in detection of SCID until onset of clinical symptoms would result in increased infant morbidity and mortality, and are therefore unacceptable. Given the recent recommendation by DHHS, which takes into account that treatment is available to ameliorate adverse clinical outcomes in affected infants, the Department has determined that there are no alternatives to requiring newborn screening for this condition.

Federal Standards:

The DHHS has recommended a core newborn screening panel that represents a national standard 30-test panel that states are encouraged to adopt. A DHHS-commissioned Advisory Committee on Heritable Disorders of Newborns and Children recently recommended that states' newborn screening programs amend their test panels to include SCID. With the addition of SCID to its panel, the NYS Program would include all the DHHS-recommended tests.

Compliance Schedule:

The Commissioner of Health is expected to notify all New York State-licensed physicians by letter informing them of this newborn screening panel expansion. The letter will also be distributed to hospital CEOs and their designees responsible for newborn screening, as well as to other affected parties.

The infrastructure and mechanisms for making the necessary referrals is already in place in birthing facilities. Consequently, regulated parties should be able to comply with these regulations as of their effective date.

Regulatory Flexibility Analysis**Effect on Small Businesses and Local Governments:**

This proposed amendment to add one new condition - an immunodeficiency disorder known as severe combined immunodeficiency (SCID) to the list of 44 genetic/congenital disorders and one infectious disease, for which every newborn in New York State must be tested, will affect hospitals, alternative birthing centers, and physician and midwifery practices operating as small businesses, or operated by local government, provided such facilities care for infants 28 days of age or under, or are required to register the birth of a child. The Department estimates that ten hospitals and one birthing center in the State meet the definition of a small business. No facility recognized as having medical expertise in clinical assessment and treatment of SCID is operated as a small business. Local governments, including the New York City Health and Hospitals Corporation, operate 21 hospitals. New York State licenses 67,790 physicians and certifies 350 licensed midwives, some of whom, specifically those in private practice, operate as small businesses. It is not possible, however, to estimate the number of these medical professionals operating an affected small business, primarily because the number of physicians involved in delivering infants cannot be ascertained.

Compliance Requirements:

The Department expects that affected facilities, and medical practices operated as small businesses or by local governments, will experience minimal additional regulatory burdens in complying with the amendment's requirements, as functions related to mandatory newborn screening are already embedded in established policies and practices of affected institutions and individuals. Activities related to collection and submission of blood specimens to the State's Newborn Screening Program will not change, since newborn dried blood spot specimens now collected and mailed to the Program for other currently performed testing would also be used for the additional test proposed by this amendment.

Birthing facilities and at-home birth attendants (i.e., licensed midwives) would be required to follow up infants screening positive for SCID, and assume some responsibility for referral for medical evaluation and additional testing as they do for other conditions. The anticipated increased burden is expected to have a minimal effect on the ability of small businesses or local government-operated facilities to comply, as no such facility would experience an increase of more than one to two per month in the number of infants requiring referral.

On average, each birthing facility can expect to refer no more than one additional infant per year for clinical assessment and confirmatory testing as a result of this amendment's proposal to add SCID screening to the existing newborn screening panel. This increase is expected to have minimal effect on a birthing facility's workload since at present approximately 30 infants, on average, are referred by birthing facilities statewide; with the addition of SCID this number would increase by an average of one infant. Therefore, no additional staff would be required for these institutions to comply with this proposal.

The Department anticipates that more than 95 percent of approximately 125 referred infants will ultimately be found not to be afflicted with SCID, based on clinical assessment and laboratory tests.

The Department expects that regulated parties will be able to comply with these regulations as of their effective date, upon filing with the Secretary of State.

Professional Services:

No need for additional professional services is anticipated. Birthing facilities' existing professional staff are expected to be able to assume any increase in workload resulting from the Program's newborn screening for SCID and identification of screen-positive infants. Infants with positive screening tests for SCID would be referred to a facility employing a physician and other medical professionals with expertise in SCID.

Compliance Costs:

Birthing facilities operated as small businesses and by local governments, and practitioners who are small business owners (e.g., private practicing licensed midwives who assist with at-home births) will incur no new costs related to collection and submission of blood

specimens to the State Newborn Screening Program, since the dried blood spot specimens now collected and mailed to the Program for other currently available testing would also be used for the additional test proposed by this amendment. However, such facilities, and, to a lesser extent, at-home birth attendants, would likely incur minimal costs related to following up infants screening positive for SCID, primarily because the testing proposed under this regulation is expected to result in, on average, fewer than one referral per year at each of the 11 birthing facilities that are small businesses.

The NYS Program estimates that following implementation of this proposal, 125 newborns would screen positive for SCID annually statewide. Since timing is crucial, i.e., treatment must commence early to be effective, newborns who screen positive will require immediate referral to a facility with the requisite expertise for clinical assessment and laboratory testing. The Department estimates that on average such a facility would receive referrals of fewer than one infant per month for clinical assessment and additional testing to confirm or refute screening results. Cost figures that follow are based on 125 as a high-end estimate for the maximum number of infants statewide needing immediate referral.

Communicating the need for and/or arranging referral for medical evaluation of an identified infant would require less than 0.5 person-hour; no additional staff would be required. Annual cost for arranging for SCID-related referrals for a facility at which 2,000 babies are delivered each year would range from 1/2 of \$40 to 1/2 of \$100, depending on whether clerical staff or nursing staff arranged for the referral, or specifically \$20-50 a year. Larger birthing facilities (i.e., those with the resources to perform transplants) would not incur even these minimal costs for referral to another facility.

Economic and Technological Feasibility:

The proposed regulation would present no economic or technological difficulties to any small businesses and local governments affected by this amendment. The infrastructure for specimen collection and referrals of affected infants are already in place.

Minimizing Adverse Impact:

The Department did not consider alternate, less stringent compliance requirements, or regulatory exceptions for facilities operated as small businesses or by local government, because of the importance of the proposed testing to statewide public health. The addition of SCID to the newborn screening panel will not impose a unique burden on facilities and practitioners that are operated by a local government or as a small business. These amendments will not have an adverse impact on the ability of small businesses or local governments to comply with Department requirements for mandatory newborn screening, as full compliance would require minimal enhancements to present specimen collection, reporting, follow-up and recordkeeping practices.

Small Business and Local Government Participation:

The Program will notify all New York State-licensed physicians by letter informing them of this newborn screening panel expansion. An informational letter will also be distributed to hospital chief executive officers (CEOs) and their designees responsible for newborn screening, as well as to other affected parties. Regulated parties that are small businesses and local governments are expected to be prepared to participate in screening and follow-up for SCID on the effective date of this amendment because the staff and infrastructure needed for specimen collection and referrals of affected infants are already in place.

Rural Area Flexibility Analysis**Types of Estimated Numbers of Rural Areas:**

Rural areas are defined as counties with a population of fewer than 200,000 residents; and, for counties with a population larger than 200,000, rural areas are defined as towns with population densities of 150 or fewer persons per square mile. Forty-four counties in New York State with a population under 200,000 are classified as rural, and nine other counties include certain townships with population densities characteristic of rural areas.

This proposed amendment to add one new condition - severe combined immunodeficiency (SCID) - to the list of 44 genetic/congenital disorders and one infectious disease, for which every

newborn in the State must be tested, would affect hospitals, alternative birthing centers, and physician and midwifery practices located in rural areas, provided such facilities care for infants 28 days of age or under, or are required to register the birth of a child. The Department estimates that 54 hospitals and birthing centers operate in rural areas, and another 30 birthing facilities are located in counties with low-population density townships. No facility recognized as having medical expertise in clinical assessment and treatment of SCID operates in a rural area. New York State licenses 67,790 physicians and certifies 350 licensed midwives, some of whom are engaged in private practice in areas designated as rural; however, the number of professionals practicing in rural areas cannot be estimated because licensing agencies do not maintain records of licensees' employment addresses.

Reporting, Recordkeeping and Other Compliance Requirements:

The Department expects that birthing facilities and medical practices affected by this amendment and operating in rural areas will experience minimal additional regulatory burdens in complying with the amendment's requirements, as activities related to mandatory newborn screening are already part of established policies and practices of affected institutions and individuals. Collection and submission of blood specimens to the State's Newborn Screening Program will not be altered by this amendment; the dried blood spot specimens now collected and mailed to the Program for other currently available newborn testing would also be used for the additional test proposed by this amendment. However, birthing facilities and at-home birth attendants (i.e., licensed midwives) would be required to follow up infants screening positive for SCID, and assume referral responsibility for medical evaluation and additional testing. This requirement is expected to affect minimally the ability of rural facilities to comply, as no such facility would experience an increase of more than one to two per month in infants requiring referral. Therefore, the Department anticipates that regulated parties in rural areas will be able to comply with these regulations as of their effective date, upon filing with the Secretary of State.

Professional Services:

No need for additional professional services is anticipated. Birthing facilities' existing professional staff are expected to be able to assume any increase in workload resulting from the Program's newborn screening for SCID and identification of screen-positive infants. Infants with a positive screening test for SCID will be referred to a facility employing a physician and other medical professionals with expertise in SCID.

Compliance Costs:

Birthing facilities operating in rural areas and practitioners in private practice in rural areas (i.e., licensed midwives who assist with at-home births) will incur no new costs related to collection and submission of blood specimens to the State's Newborn Screening Program, since the dried blood spot specimens now collected and mailed to the Program for other currently available testing would also be used for the additional test proposed by this amendment. However, such facilities and, to a lesser extent, at-home birth attendants would likely incur minimal costs related to follow-up of infants screening positive, since the proposed added testing is expected to result in no more than one additional referral per month. Communicating the need and/or arranging referral for medical evaluation of one additional identified infant would require less than 0.5 person-hour, and these tasks are expected to be able to be accomplished with existing staff. Annual cost for arranging for SCID-related referrals for a facility at which 2,000 babies are delivered each year would range from 1/2 of \$40 to 1/2 of \$100, depending on whether clerical staff or nursing staff arranged for the referral, or specifically \$20-50 a year. Larger birthing facilities (i.e., those with the resources to perform transplants) would not incur even these minimal costs for referral to another facility. The Department estimates that more than 95 percent of infants will be ultimately found not to be afflicted with the target condition, based on clinical assessment and additional testing.

Minimizing Adverse Impact:

The Department did not consider less stringent compliance requirements or regulatory exceptions for facilities located in rural areas because of the importance of expanded infant testing to statewide

public health and welfare. The addition of SCID to the newborn screening panel will not impose a unique burden on facilities and practitioners operating in rural areas. These amendments will not have an adverse impact on the ability of regulated parties in rural areas to comply with Department requirements for mandatory newborn screening, as full compliance would entail minimal changes to present collection, reporting, follow-up and recordkeeping practices.

Rural Area Participation:

The Program will notify all New York State-licensed physicians by letter informing them of this newborn screening panel expansion. An informational letter will also be distributed to hospital chief executive officers (CEOs) and their designees responsible for newborn screening, as well as to other affected parties. Regulated parties in rural areas are expected to be able to participate in screening and follow-up for SCID on the effective date of this amendment.

Job Impact Statement

A Job Impact Statement is not required because it is apparent, from the nature and purpose of the proposed rule, that it will not have a substantial adverse impact on jobs and employment opportunities. The amendment proposes the addition of an immune system disorder, severe combined immunodeficiency (SCID), to the scope of newborn screening services provided by the Department. It is expected that no regulated parties will experience other than minimal impact on their workload, and therefore none will need to hire new personnel. Therefore, this proposed amendment carries no adverse implications for job opportunities.

Insurance Department

EMERGENCY RULE MAKING

Workers' Compensation Insurance

I.D. No. INS-26-11-00002-E

Filing No. 514

Filing Date: 2011-06-13

Effective Date: 2011-06-13

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

Action taken: Addition of Subpart 151-6 (Regulation 119) to Title 11 NYCRR.

Statutory authority: Insurance Law, sections 201 and 301; and Workers' Compensation Law, sections 15(8)(h)(4) and 151(2)(b)

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

Specific reasons underlying the finding of necessity: Workers' Compensation Law sections 15(8)(h)(4), 25-A(3), and 151(2)(b) require the Workers' Compensation Board ("WCB") to assess insurers and the State Insurance Fund, for the Special Disability Fund, the Fund for Reopened Cases, and the operations of the Workers' WCB, respectively. The assessments are allocated to insurers, self-insurers, group self-insurers, and the State Insurance Fund based upon the total compensation payments made by all such entities. In the case of an insurer, once the assessment amount is determined, the insurer pays the percentage of the allocation based on the total premiums it wrote during the preceding calendar year.

Prior to January 1, 2010, the Workers' Compensation Law required the Workers' Compensation Board to assess insurers on the total "direct premiums" they wrote in the preceding calendar year, whereas the insurers were collecting the assessments from their insureds on the basis of "standard premium," which took into account high deductible policies. As high deductible policies increased in the marketplace, a discrepancy developed between the assessment an insurer collected, and the assessment the insured was required to remit to the Workers' Compensation Board.

Part QQ of Chapter 56 of the Laws of 2009 ("Part QQ") amended Workers' Compensation Law sections 15(8)(h)(4) and 151(2)(b) to change the basis upon which the WCB collects the portion of the allocation from each insurer from "direct premiums" to "standard premium" in order to ensure that insurers are not overcharged or under-charged for the assessment, and to ensure that insureds with high deductible policies are charged the appropriate assessment. Effective January 1, 2010, therefore, each

insurer pays a percentage of the allocation based on the total standard premium it wrote during the preceding calendar year. Part QQ requires the Superintendent of Insurance to define "standard premium," for the purposes of setting the assessments, and to set rules, in consultation with the WCB, and New York Compensation Rating Board, for collecting the assessment from insureds.

This regulation was previously promulgated on an emergency basis on December 29, 2009, March 25, 2010, June 24, 2010, September 20, 2010, December 18, 2010, and March 18, 2011. The proposal was sent to the Governor's Office of Regulatory Reform on January 14, 2010 and the Department is awaiting approval to publish the regulation, however because the effective date of the relevant provision of the law is January 1, 2010, and the need that the assessments be calculated and collected in a timely manner, it is essential that this regulation, which establishes procedures that implement provisions of the law, be continued on an emergency basis.

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

Subject: Workers' Compensation Insurance.

Purpose: This regulation is necessary to standardize the basis upon which the workers' compensation assessments are calculated.

Text of emergency rule: A new subpart 151-6 entitled Workers' Compensation Insurance Assessments is added to read as follows:

Section 151-6.0 Preamble

(a) *Workers' Compensation Law sections 15(8)(h)(4), 25-A(3), and 151(2)(b) require the workers compensation board to assess insurers, and the state insurance fund for the special disability fund, the fund for reopened cases, and the operations of the Board, respectively. First, the assessments are allocated to insurers, self-insurers, group self-insurers, and SIF based upon the total compensation payments made by all such entities. In the case of an insurer, once the assessment amount is determined, each pays the percentage of the allocation based on the total premiums it wrote during the preceding calendar year.*

(b) *Prior to January 1, 2010, each insurer paid a percentage of the allocation based on the total direct written premiums it wrote in the preceding calendar year. However, Part QQ of Chapter 56 of the Laws of 2009 ("Part QQ") amended Workers' Compensation Law sections 15(8)(h)(4), and 151(2)(b) to change the basis upon which the board collects the portion of the allocation from each insurer. Thus, effective January 1, 2010, each insurer pays a percentage of the allocation based on the total standard premium it wrote during the preceding calendar year. Part QQ requires the superintendent of insurance (the "superintendent") to define "standard premium," for the purposes of the assessments, and to set rules, in consultation with the board, and NYCIRB for collecting the assessment from insureds.*

Section 151-6.1 Definitions

As used in this Part:

- (a) *Board means the New York workers' compensation board.*
- (b) *Insurer means an insurer authorized to write workers' compensation insurance in this state, except for the SIF.*
- (c) *NYCIRB means the New York workers' compensation rating board.*
- (d) *SIF means the state insurance fund.*
- (e) *Standard Premium means*
 - (i) *the premium determined on the basis of the insurer's approved rates; as modified by:*
 - (a) *any experience modification or merit rating factor;*
 - (b) *any applicable territory differential premium;*
 - (c) *the minimum premium;*
 - (d) *any Construction Classification Premium Adjustment Program credits;*
 - (e) *any credit from return to work and / or drug and alcohol prevention programs;*
 - (f) *any surcharge or credit from a workplace safety program;*
 - (g) *any credit from independently-filed insurer specialty programs (for example, alternative dispute resolution, drug-free workplace, managed care or preferred provider organization programs);*
 - (h) *any charge for the waiver of subrogation;*
 - (i) *any charge for foreign voluntary coverage; and*
 - (j) *the additional charge for terrorism, and the charge for natural disasters and catastrophic industrial accidents.*
 - (ii) *For purposes of determining standard premium, the insurer's expense constant, including the expense constant in the minimum premium, the insurer's premium discount, and premium credits for participation in any deductible program shall be excluded from the premium base.*
 - (iii) *The insurer shall use the definition of standard premium set forth in this Part to report standard premium to the Board.*

Section 151-6.2 Collection of assessments

Any assessments required by Workers' Compensation Law sections 15(8)(h)(4), 25-A(3) and 151(2)(b) that are collected by an insurer or SIF

from policyholders shall be collected through a surcharge based on standard premium in a percentage to be determined by the superintendent in consultation with NYCIRB and the Board.

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 10, 2011.

Text of rule and any required statements and analyses may be obtained from: David Neustadt, New York State Insurance Department, 25 Beaver Street, New York, NY 10004, (212) 480-5265, email: dneustad@ins.state.ny.us

Regulatory Impact Statement

1. **Statutory authority:** The authority of the Superintendent of Insurance for the promulgation of Part 151-6 of Title 11 of the Official Compilation of Codes, Rules and Regulations of the State of New York (Fifth Amendment to Regulation No. 119) derives from Sections 201 and 301 of the Insurance Law, and Sections 15, 25-A, and 151 of the Workers' Compensation Law.

Sections 201 and 301 of the Insurance Law authorize the Superintendent to effectuate any power accorded to him by the Insurance Law, and to prescribe regulations interpreting the Insurance Law.

Sections 15, 25-A, and 151 of the Workers' Compensation Law, as amended by Part QQ of Chapter 56 of the Laws of 2009 require the Superintendent to define the "standard premium" upon which assessments are made for the Special Disability Fund, the Fund for Reopened Cases, and the operations of the Workers' Compensation Board ("WCB"). Section 15 of the Workers' Compensation Law further requires workers' compensation insurers to collect the assessments from their policyholders through a surcharge based on premiums in accordance with the rules set forth by the Superintendent, in consultation with the New York Workers' Compensation Insurance Rating Board ("NYCIRB"), and the chair of the WCB.

2. **Legislative objectives:** (a) Workers' Compensation Law sections 15(8)(h)(4), 25-A(3), and 151(2)(b) require the WCB to assess insurers writing workers' compensation insurance and the State Insurance Fund, for the Special Disability Fund, the Fund for Reopened Cases, and the operations of the WCB, respectively. The assessments are allocated to insurers, self-insurers, group self-insurers, and the State Insurance Fund based upon the total compensation payments made by all such entities. In the case of an insurer, once the assessment amount is determined, the insurer pays the percentage of the allocation based on the total premiums it wrote during the preceding calendar year.

Prior to January 1, 2010, the Workers' Compensation Law required the WCB to assess insurers based on the total "direct premiums" they wrote in the preceding calendar year, whereas the insurers collected assessments from their insureds based on the "standard premium," which took into account high deductible policies. As high deductible policies increased in the marketplace, a discrepancy developed between the assessment an insurer collected and the assessment the insurer was required to remit to the WCB.

Therefore, Part QQ of Chapter 56 of the Laws of 2009 ("Part QQ") amended Workers' Compensation Law sections 15(8)(h)(4) and 151(2)(b) to change the basis upon which the Board collects the portion of the allocation from each insurer from "direct premiums" to "standard premium" to ensure that insurers are not overcharged or under-charged for the assessment, and to make certain that insureds with high deductible policies are charged the appropriate assessment. Thus, effective January 1, 2010, each insurer pays a percentage of the allocation based on the total standard premium it wrote during the preceding calendar year. Part QQ requires the Superintendent to define "standard premium," for the purposes of the assessments, and to set rules, in consultation with the WCB and NYCIRB, for collecting assessments from insureds.

3. **Needs and benefits:** This amendment is necessary, and mandated by the Workers' Compensation Law, to standardize the basis upon which the workers' compensation assessments are calculated to eliminate any discrepancy between the amount that an insurer collects from employers and the amount that an insurer remits to the WCB.

The discrepancy in the assessment calculation and remittance became evident as a result of the proliferation of large deductible policies. In many instances, the "direct premium" paid on a large deductible policy is less than the "standard premium" would be for that policy. Insurers that offered high-deductible policies collected assessments based on the "standard premium," but the Workers' Compensation Law required the WCB to use "direct premiums" to bill insurers. Thus, in some instances, workers' compensation insurers collected from employers more money than they remitted to the WCB.

4. **Costs:** This amendment standardizes the basis upon which the workers' compensation assessments are calculated to ensure that there is no discrepancy between the amount that an insurer collects from employers, and the amount that an insurer remits to the WCB. Although the amend-

ment itself does not impose new costs, the impact of changing the basis for workers' compensation assessments may increase costs for some insurers, but reduce costs for others. Taken together, the amendment aims to level the playing field for insurers that offer large deductible policies and those that do not.

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

6. Paperwork: This amendment requires no new paperwork. Insurers and the State Insurance Fund already collect and remit assessments to the WCB. This regulation only standardizes the basis upon which the assessments are calculated, as required by the Workers' Compensation Law.

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

8. Alternatives: No alternatives were considered, because Part QQ requires the Superintendent to define "standard premium" for the purpose of the assessments, and to set rules, in consultation with the WCB and NYCIRB, for collecting the assessment from insureds. Based on discussions with NYCIRB and the WCB, the Superintendent determined that the term "standard premium" should conform to the definition currently used by insurers, and should ensure that the definition accounts for high deductible policies.

NYCIRB has been collecting premium data on a "standard" basis since its inception nearly 100 years ago. The "standard premium" is the premium without regard to credits, deviations, or deductibles. As new credits and types of policies (such as large deductible policies) develop, NYCIRB adjusts the definition to account for the changes. The Insurance Department is merely adopting NYCIRB's current definition.

9. Federal standards: There are no applicable federal standards.

10. Compliance schedule: The effective date of the relevant provision of the law is January 1, 2010. The assessments must be calculated and collected as of January 1, 2010.

Regulatory Flexibility Analysis

1. Small businesses:

The Insurance Department finds that this rule will not impose any adverse economic impact on small businesses and will not impose any reporting, recordkeeping or other compliance requirements on small businesses.

This amendment applies to all workers' compensation insurers authorized to do business in New York State, as well as to the State Insurance Fund ("SIF"). It standardizes the basis upon which the workers' compensation assessments are calculated to ensure that there is no discrepancy between the amount that an insurer collects from employers, and the amount that an insurer remits to the Workers' Compensation Board.

The basis for this finding is that this rule is directed at workers' compensation insurers authorized to do business in New York State, none of which falls within the definition of "small business" pursuant to section 102(8) of the State Administrative Procedure Act. The Insurance Department has monitored Annual Statements and Reports on Examination of authorized workers' compensation insurers subject to this rule, and believes that none of the insurers falls within the definition of "small business," because there are none that are both independently owned and have fewer than one hundred employees. Nor does SIF come within the definition of "small business" pursuant to section 102(8) of the State Administrative Procedure Act, because SIF is neither independently owned nor operated, and does not employ one hundred or fewer individuals.

2. Local governments:

The amendment does not impose any impacts, including any adverse impacts, or reporting, recordkeeping, or other compliance requirements on any local governments. This amendment does not affect self-insured local governments, because it applies only to insurers.

Rural Area Flexibility Analysis

1. Types and estimated numbers of rural areas: This amendment applies to all workers' compensation insurers authorized to do business in New York State, as well as the State Insurance Fund ("SIF"). These entities do business throughout New York State, including rural areas as defined in section 102(10) of the State Administrative Procedure Act ("SAPA").

2. Reporting, recordkeeping and other compliance requirements, and professional services: This regulation is not expected to impose any reporting, recordkeeping or other compliance requirements on public or private entities in rural areas. Insurers and SIF already collect and remit assessments to the Workers' Compensation Board ("WCB"). This amendment simply standardizes the basis upon which the assessments are calculated.

3. Costs: This amendment standardizes the basis upon which the workers' compensation assessments are calculated to ensure that there is no discrepancy between the amount that an insurer collects from employers, and the amount that an insurer remits to the WCB. Although the amendment itself does not impose new costs, the impact of changing the basis

for workers' compensation assessments may increase costs for some insurers, but reduce costs for others. Taken together, the amendment aims to level the playing field for insurers that offer large deductible policies and those that do not.

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

5. Rural area participation: This amendment is required by statute. The entities covered by this amendment - workers' compensation insurers authorized to do business in New York State and the State Insurance Fund - do business in every county in this state, including rural areas as defined in section 102(10) of SAPA. This amendment standardizes the basis upon which the workers' compensation assessments are calculated.

Job Impact Statement

This rule will not adversely impact job or employment opportunities in New York. The rule merely standardizes the basis upon which workers' compensation assessments are calculated to ensure that there is no discrepancy between the amount that an insurer collects from employers, and the amount that an insurer remits to the Workers' Compensation Board. An insurer's existing personnel should be able to perform this task. There should be no region in New York that would experience an adverse impact on jobs and employment opportunities. This rule should not have a measurable impact on self-employment opportunities.

Office for People with Developmental Disabilities

NOTICE OF ADOPTION

Changes in Methodology for Appeals

I.D. No. PDD-15-11-00022-A

Filing No. 526

Filing Date: 2011-06-14

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 686.13 of Title 14 NYCRR.

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

Subject: Changes in methodology for appeals.

Purpose: To increase appeal thresholds and to limit grounds for appeals.

Text or summary was published in the April 13, 2011 issue of the Register, I.D. No. PDD-15-11-00022-P.

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

Text of rule and any required statements and analyses may be obtained from: Barbara Brundage, Director, Regulatory Affairs Unit, OPWDD, 44 Holland Avenue, Albany, NY 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.

Assessment of Public Comment

OPWDD received one comment from a voluntary provider as follows.

Comment: An agency urged that the amendments (this one among others) be withdrawn because the proposed changes depart from the "core principles" that define the relationship between the State and voluntary providers. It asserted that providers need a safety net in the form of the appeal mechanism to address "unforeseen operating losses."

Response: OPWDD will not be withdrawing the regulations. The appeals process was amended to be better synchronized with OPWDD's prospective reimbursement methodologies. OPWDD has a long established tradition of reaching out to stakeholders for their input before instituting systemic changes to programs and payments. Providers through provider associations participated in numerous discussions during the development stage of these amendments.

NOTICE OF ADOPTION

Efficiency Adjustment for HCBS Waiver Respite Services

I.D. No. PDD-15-11-00023-A

Filing No. 522

Filing Date: 2011-06-14

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 635-10.5 of Title 14 NYCRR.

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

Subject: Efficiency adjustment for HCBS waiver respite services.

Purpose: To implement an efficiency adjustment by modifying the price methodology for HCBS waiver respite services.

Text of final rule: Subparagraph 635-10.5(h)(3)(iii) is amended as follows:

(iii) For operating prices:

(a) The unit of service shall be one hour equaling 60 minutes.

(b) The provider may claim reimbursement in 15-minute increments, as the service is documented.

(c) [OMRDD] OPWDD shall determine the price by dividing the [OMRDD] OPWDD approved total annual budgeted costs by the corresponding projected hours of utilization. [OMRDD] OPWDD shall approve budgeted costs if they are reasonable, related to respite services and consistent with efficiency, economy and quality of care. *The approved total annual budgeted costs established for newly certified sites after June 30, 2011, shall reflect a 2 percent reduction in operating costs as was implemented for providers on July 1, 2011 pursuant to clause (d) of this subparagraph.*

(d) Effective July 1, 2011, prices shall be revised to reflect a 2 percent reduction to the price in effect on June 30, 2011.

Final rule as compared with last published rule: Nonsubstantive changes were made in section 635-10.5(h)(3).

Text of rule and any required statements and analyses may be obtained from: Barbara Brundage, Director, Regulatory Affairs Unit, OPWDD, 44 Holland Avenue, Albany, NY 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.

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

A minor change was made to the proposed regulation to remove an extraneous comma.

This change does not necessitate revisions to the previously published Regulatory Impact Statement, Regulatory Flexibility Analysis for Small Business and Local Governments, Rural Area Flexibility Analysis or Job Impact Statement.

Assessment of Public Comment

OPWDD received one comment from a voluntary provider as follows.

Comment: An agency urged that the amendments (this one among others) be withdrawn because the proposed changes depart from the three "core principles" that define the relationship between the State and voluntary providers. It asserted that efficient providers reserve funds to accommodate special needs as they arise; that providers need a safety net in the form of the appeal mechanism to address "unforeseen operating losses;" and that interchange allows providers to reallocate funds between cost centers and programs to meet changing needs and compensates for a reimbursement system that is "neither scientific nor accurate." It contended that "these three principles have been violated by the proposed regulations."

Response: OPWDD will not be withdrawing the regulations. The amendments were designed to encourage operating efficiencies. Aspects of the regulations were formulated to reduce surplus funding by more closely aligning reimbursement with actual costs. The appeals process was amended to be better synchronized with OPWDD's prospective reimbursement methodologies. OPWDD has a long established tradition of reaching out to stakeholders for their input before instituting systemic changes to programs and payments. Providers through provider associations participated in numerous discussions during the development stage of these amendments.

NOTICE OF ADOPTION

Efficiency Adjustment for Residential Habilitation Services in Supportive IRAs and Supportive CRs

I.D. No. PDD-15-11-00024-A

Filing No. 529

Filing Date: 2011-06-14

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(b) and 671.7(a) of Title 14 NYCRR.

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

Subject: Efficiency adjustment for residential habilitation services in supportive IRAs and supportive CRs.

Purpose: To implement an efficiency adjustment by modifying the supportive IRA price methodology.

Text or summary was published in the April 13, 2011 issue of the Register, I.D. No. PDD-15-11-00024-P.

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

Text of rule and any required statements and analyses may be obtained from: Barbara Brundage, Director, Regulatory Affairs Unit, OPWDD, 44 Holland Avenue, Albany, NY 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.

Assessment of Public Comment

OPWDD received one comment from a voluntary provider as follows.

Comment: An agency urged that the amendments (this one among others) be withdrawn because the proposed changes depart from the three "core principles" that define the relationship between the State and voluntary providers. It asserted that efficient providers reserve funds to accommodate special needs as they arise; that providers need a safety net in the form of the appeal mechanism to address "unforeseen operating losses;" and that interchange allows providers to reallocate funds between cost centers and programs to meet changing needs and compensates for a reimbursement system that is "neither scientific nor accurate." It contended that "these three principles have been violated by the proposed regulations."

Response: OPWDD will not be withdrawing the regulations. The amendments were designed to encourage operating efficiencies. Aspects of the regulations were formulated to reduce surplus funding by more closely aligning reimbursement with actual costs. The appeals process was amended to be better synchronized with OPWDD's prospective reimbursement methodologies. OPWDD has a long established tradition of reaching out to stakeholders for their input before instituting systemic changes to programs and payments. Providers through provider associations participated in numerous discussions during the development stage of these amendments.

NOTICE OF ADOPTION

Reimbursement Methodology for Residential Habilitation Services Delivered in Supervised IRAs and Supervised CRs

I.D. No. PDD-15-11-00025-A

Filing No. 530

Filing Date: 2011-06-14

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 and 671.7 of Title 14 NYCRR.

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

Subject: Reimbursement methodology for residential habilitation services delivered in supervised IRAs and supervised CRs.

Purpose: To modify reimbursement for prices in supervised IRAs and supervised CRs effective July 1, 2011.

Text of final rule: A new subparagraph 635-10.5(b)(18)(iv) is added as follows:

(iv) Effective July 1, 2011, supervised IRA prices shall be reduced according to the measures outlined in this subparagraph. There are two distinct actions to the price reductions. The personal services action addresses provider surpluses in funding for direct care, clinical and support staff and the associated fringe benefits. The administrative action addresses reimbursable administrative costs and holds reimbursement to a level of efficiency. Providers may be subject to only one action or to both actions or they may be exempt from both.

(a) Applicability. The price reductions will apply to all providers except for those which meet the criteria for exemption.

The first criterion, in order for any provider to be exempt from the impact of the reduction on any basis, is a cost report requirement. Region I providers must have filed a 2008-2009 cost report and Regions II and III providers must have filed a 2008 cost report on or before December 23, 2010, except that a provider may submit the cost report after December 23, 2010 if the cost report represents an original submission or a resubmission specifically requested by OPWDD due to identified inaccuracies or insufficiencies. Cost reports submitted after December 23, 2010 must be submitted by May 1, 2011 unless the Commissioner exercises or has exercised his or her discretion to extend the May 1, 2011 deadline. Providers with cost reports submitted in accordance with the deadlines in this clause (a) may qualify for exemption from the personal services surpluses action pursuant to subclause (1) of clause (b) of this subparagraph. Providers with cost reports submitted in accordance with the deadlines in this clause (a) may qualify for exemption from the administrative action pursuant to subclause (1) of clause (c) of this subparagraph. Providers which did not submit cost reports in accordance with the deadlines in this clause (a) shall be subject to price reductions pursuant to clause (d) of this subparagraph.

OPWDD shall employ data extracted from the most recent 2008/2008-2009 cost report submitted by a provider on or before December 23, 2010, except that data from a 2008/2008-2009 cost report submitted after December 23, 2010 representing an original submission or a resubmission specifically requested by OPWDD due to identified inaccuracies or insufficiencies and submitted by May 1, 2011 or a later deadline extended by the Commissioner shall also be utilized. For providers of supervised residential habilitation services which did not operate group day habilitation or supplemental group day habilitation programs for the cost reporting year 2008/2008-2009, the components subjected to analysis relate to the provider's supervised IRAs. For providers which did operate group day habilitation and/or supplemental group day habilitation programs for the cost reporting year 2008/2008-2009, the components subjected to analysis relate to the combination of the provider's supervised IRAs, group day habilitation and/or supplemental group day habilitation services. Additionally, for providers which converted a residential program to a supervised IRA or a day program to a group or supplemental group day habilitation program subsequent to the 2008/2008-2009 cost report period, OPWDD incorporated the data included in the 2008/2008-2009 cost report(s) for the converted program(s) prior to conversion into its analyses.

(b) Personal Services Surpluses Action.

(1) Exemptions.

(i) Providers with FTE personal services losses and actual personal services fringe benefit percentages greater than the reimbursable percentages are exempt. To qualify for this exemption, a provider must meet each of the two criteria which follow.

(A) FTE personal services loss. OPWDD compared each provider's actual FTEs for direct care, clinical care and support as reported in its 2008/2008-2009 cost report to the maximum reimbursable FTEs designated for direct care, clinical care and support as reflected in the corresponding price(s). This analysis included the FTE equivalents for contracted services. OPWDD identified a subset of providers which demonstrated an excess of actual FTEs over reimbursable FTEs. They meet the first criterion for this exemption.

(B) Fringe benefit percentage. The fringe benefit percentage equals the total fringe benefits costs for direct care, clinical and support staff divided by the salary costs for direct care, clinical and support staff expressed as a percentage. For the providers which meet the criterion in subitem (A) of this item, OPWDD compared each provider's actual direct care, clinical and support services associated fringe benefit percentage as evidenced by its 2008/2008-2009 cost report data to the reimbursable direct care, clinical and support services associated fringe benefit percentage as reflected in the corresponding price(s). OPWDD identified a subset of providers with actual fringe benefit percentages that were higher than the fringe benefit percentage in the price(s). They are exempt.

(ii) Providers with a loss in personal services and associated fringe benefits combined are exempt. OPWDD examined 2008/2008-2009 cost reports for those providers not exempted by virtue of item (i) of this subclause. OPWDD compared each provider's actual expenses for

direct care, clinical care and support and the associated fringe benefits to the total reimbursable costs reflected in the corresponding price(s) and designated for direct care, clinical care and support and the associated fringe benefits cost categories. This analysis included contracted services. OPWDD identified a subset of providers which demonstrated an excess of actual expenses for direct care, clinical care and support and the associated fringe benefits over reimbursable costs reflected in the corresponding price(s) and designated for direct care, clinical care and support and the associated fringe benefits. They are exempt.

(iii) Providers with aggregate unmodified surpluses. Providers not exempted by virtue of items (i) or (ii) of this subclause were identified as having aggregate unmodified surpluses equal to the amount by which the aggregated reimbursable costs as reflected in the prices and designated for direct care, clinical care and support and the associated fringe benefits exceeded the corresponding aggregated actual expenses for direct care, clinical care and support and the associated fringe benefits as reported in those providers' cost reports for reporting year 2008/2008-2009.

(iv) To/from transportation modification. For all providers with aggregate unmodified surpluses as defined in item (iii) of this subclause, OPWDD examined their 2008/2008-2009 cost reports. OPWDD compared the provider's aggregated actual expenses for to/from transportation to the aggregated total reimbursable costs reflected in the corresponding price(s) and designated for to/from transportation. If the aggregated total reimbursable costs exceeded aggregated actual expenses for to/from transportation, OPWDD added the amount of this excess to the aggregate unmodified surplus amount calculated pursuant to item (iii) of this subclause to yield the aggregate surplus. Conversely, if the aggregated actual expenses for to/from transportation exceeded the aggregated total reimbursable costs reflected in the corresponding price(s) for to/from transportation, OPWDD offset the unmodified surplus amount calculated pursuant to item (iii) of this subclause by this difference to derive the aggregate surplus. If, however, this calculation yielded a negative number for any provider, it is not considered a surplus and such provider is exempt.

(2) Providers subject to the personal services surpluses action are those providers which are not specifically exempted pursuant to subclause (1) of this clause.

(3) Untrended tentative aggregate gross reduction. A provider identified as having an aggregate surplus after the to/from transportation modification pursuant to the analysis conducted by OPWDD as described in item (iv) of subclause (1) of this clause shall be subject to a price reduction. This aggregate surplus is referred to as the untrended tentative aggregate gross reduction.

(4) Tentative aggregate gross reduction. The tentative aggregate gross reduction equals the untrended tentative aggregate gross reduction pursuant to subclause (3) of this clause trended to June 30, 2011 dollars.

(c) Administrative action.

(1) Exemptions.

(i) Total agency revenue exemption. Providers with total agency gross revenues less than \$1.5 million dollars as reflected in the agency fiscal summaries of their 2008/2008-2009 cost reports are exempt.

(ii) Compensation exemption. For each provider not exempted by virtue of item (i) of this subclause, OPWDD extracted from the governing board and compensation summaries in its 2008/2008-2009 cost report the total annualized compensation of all employees with agency administrative titles. Using this dollar value, OPWDD compared the total annualized compensation to the total agency revenue as described in item (i) of this subclause to establish a value that expressed the total annualized compensation as a percentage of total agency revenue. OPWDD identified a subset of providers with percentages equal to or less than one half of one percent. They are exempt.

(iii) Administrative expenses as a percent of operating expenses exemption. For providers not exempted by virtue of items (i) or (ii) of this subclause, total reimbursable administration (agency and program including fringe benefits) costs as reflected in the price(s) corresponding to the provider's 2008/2008-2009 reporting year were expressed as a percentage of the total reimbursable operating costs in that price (those prices). As a prerequisite to this calculation, when appropriate, respective amounts were adjusted for capacity changes that occurred throughout the year. OPWDD identified a subset of providers with percentages of less than 10 percent. They are exempt.

(2) Providers subject to the administrative action are those providers which are not specifically exempted pursuant to subclause (1) of this clause.

(3) Tentative aggregate gross reduction. For providers subject to the administrative action, OPWDD used the compensation data also used in item (ii) of subclause (1) of this clause and the reported number of FTEs corresponding to those administrative titles as reported

in providers' 2008/2008-2009 cost reports. OPWDD computed a provider-specific average compensation per FTE for the administrative titles. Similarly, OPWDD computed a provider-specific average compensation per FTE for direct care, clinical and support staff using data from providers' 2008/2008-2009 cost reports. (Direct care, clinical and support staff collectively are referred to as direct support staff.) The compensation data for both administrative titles and direct support titles included fringe benefits. A ratio of average administrative compensation to average direct support compensation was determined for each provider. Providers' ratios were then ranked and separated into 5 graduated levels. A reduction percentage was established to correspond to each level of compensation ratios. The reduction percentage for a provider is dependent on a provider's positioning in the five levels. The following chart gives the explicit ranges for the compensation ratios and the applicable reduction percentage.

Compensation Ratios Administration to Direct Support	Reimbursable Administrative Costs Reduction Percentage
Equal to or greater than 10.0:1	9.0%
Equal to or greater than 6.0:1 but less than 10.0:1	7.5%
Equal to or greater than 4.0:1 but less than 6.0:1	6.0%
Equal to or greater than 3.0:1 but less than 4.0:1	4.0%
Less than 3.0:1	2.0%

The tentative aggregate gross reduction equals the reduction percentage determined by a provider's ranking in the compensation ratio comparisons applied to that provider's aggregate reimbursable administrative costs as reflected in the corresponding price(s) at June 30, 2011.

(d) Total impact limitation. Before OPWDD revises a provider's supervised IRA price, it shall assess the total impact on a provider of all the tentative gross reductions and tentative aggregate gross reductions pursuant to this subparagraph 635-10.5(b)(18)(iv) and sections 635-10.5(c)(16), 635-10.5(e)(6) and 671.7(a)(13) of this Title, combined with the final price and fee reductions pursuant to sections 635-10.5(b)(18)(iii), 635-10.5(d)(6), 635-10.5(h)(3)(iii)(d), 635-10.5(ab)(12)(iii)(b) and 671.7(a)(12) of this Title. The total impact to an individual provider shall be limited to an amount not to exceed 6.5 percent of the aggregated total gross reimbursable operating costs as reflected in a provider's June 30, 2011 prices and the aggregated total gross allowable reimbursement reflected in a provider's June 30, 2011 fees for the provider's programs and/or services subject to the price and fee revisions. The lesser of the amount of the total impact or the amount of the total impact as limited by the 6.5 percent provision represents the final impact. For providers for which no 2008/2008-2009 cost reports were available because the conditions established in clause (a) of this subparagraph were not met, the total impact is calculated as follows: The aggregated total gross reimbursable operating costs as reflected in a provider's June 30, 2011 prices and the aggregated total gross allowable reimbursement as reflected in a provider's June 30, 2011 fees for the provider's programs and/or services subject to the price and fee revisions are summed. The total is multiplied by 6.5 percent. The product is the final impact for these providers.

(e) Allocation of final impact. Before allocation, the final impact on a provider shall be reduced by the final price and fee reductions pursuant to sections 635-10.5(b)(18)(iii), 635-10.5(d)(6), 635-10.5(h)(3)(iii)(d), 635-10.5(ab)(12)(iii)(b) and 671.7(a)(12) of this Title because those reductions are not subject to any further revisions. The remainder of the final impact on a provider shall be distributed equitably across the reimbursable operating costs in that provider's supervised residential habilitation, group day habilitation, supplemental group day habilitation and prevocational services in proportion to the amount of reduction each of these programs would have incurred had the reductions been calculated separately. OPWDD shall make an internal allocation within the price for providers subject to both the personal services surplus action and the administrative action pursuant to this subparagraph 635-10.5(b)(18)(iv).

(f) Final supervised IRA price reduction percentage. The allocation of the final impact to a provider's supervised residential habilitation services shall be expressed as a percentage of the total gross reimbursable operating costs reflected in the price in effect on June 30, 2011.

(g) The final supervised IRA price shall be the supervised IRA price in effect on June 30, 2011 reduced by the final supervised IRA price reduction percentage pursuant to clause (f) of this subparagraph applied to that price.

(h) For the purposes of requesting a price adjustment, the ef-

fects of this price reduction shall not be construed as a basis for loss. In processing a price adjustment, any revised price will be offset by the monetary impact, prorated as appropriate, of the price reduction as calculated pursuant to this clause.

(i) The commissioner, at his or her discretion, may waive all or a portion of this adjustment for a provider upon the provider demonstrating that the imposition of the reduction would jeopardize the continued operation of the residential habilitation services.

A new paragraph 635-10.5(b)(22) is added as follows:

(22) 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.

Subdivision 671.7(a) is amended by the addition of new paragraphs (13) and (14) as follows:

(13) Effective July 1, 2011, pursuant to subparagraph (b)(18)(iv) of section 635-10.5, providers shall be subject to the supervised IRA price reductions except for those providers specifically excluded by the exemptions described in that subparagraph.

(14) 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.

Final rule as compared with last published rule: Nonsubstantive changes were made in section 635-10.5(b).

Text of rule and any required statements and analyses may be obtained from: Barbara Brundage, Director, Regulatory Affairs Unit, OPWDD, 44 Holland Avenue, Albany, NY 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.

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

Minor changes were made to the proposed regulation to correct punctuation and to insert conforming language for consistency.

These changes do not necessitate revisions to the previously published Regulatory Impact Statement, Regulatory Flexibility Analysis for Small Business and Local Governments, Rural Area Flexibility Analysis or Job Impact Statement.

Assessment of Public Comment

OPWDD received three comments from voluntary providers. The comments and OPWDD's responses follow.

Comment: A voluntary agency wrote that the regulations should "incorporate two basic items: Adjusting for vacancies reported on the CFR" and "Adjusting for IRAs opened during the year." The writer proposed new language for insertion into the regulations to address these concerns.

Response: OPWDD will not be making the changes that were recommended. OPWDD reasoned that no adjustment for utilization was necessary because statewide utilization in IRAs is already at a high level (96 percent). With respect to sites opened for partial years, the data extracted from price sheets factored in the capacity changes for those sites that either opened or closed during the year.

Comment: Another agency urged that the amendments (this one among others) be withdrawn because the proposed changes depart from the three "core principles" that define the relationship between the State and voluntary providers. It asserted that efficient providers reserve funds to accommodate special needs as they arise; that providers need a safety net in the form of the appeal mechanism to address "unforeseen operating losses;" and that interchange allows providers to reallocate funds between cost centers and programs to meet changing needs and compensates for a reimbursement system that is "neither scientific nor accurate." It contended that "these three principles have been violated by the proposed regulations."

Response: OPWDD will not be withdrawing the regulations. The amendments were designed to encourage operating efficiencies. Aspects of the regulations were formulated to reduce surplus funding by more closely aligning reimbursement with actual costs. The appeals process was amended to be better synchronized with OPWDD's prospective reimbursement methodologies. OPWDD has a long established tradition of reaching out to stakeholders for their input before instituting systemic changes to programs and payments. Providers through provider associations participated in numerous discussions during the development stage of these amendments. With respect to the interchange restriction, OPWDD is responding to providers by repealing this aspect of the amendments in order to avoid negative consequences to those providers already demonstrating the greatest levels of efficiency. This will occur through a separate emergency rule making action that is timed to coincide with the adoption of these regulations.

Comment: A third provider expressed its view that the methodology employed to effect the price reductions should not include exemptions for any providers. It insisted that every provider should “shoulder” the burden and “contribute its fair share to the budget cut.” It opined that non-exempt providers will be forced to discharge individuals in order to downsize and that those individuals will migrate to exempt providers for services. It projected that a consequent “revenue transfer” from non-exempt to exempt providers will ensue with agency survival paralleling the monetary movement. It objected to the focus of the exemption criteria on personal services and expounded that by cutting personal services reimbursement without regard to provider status in terms of Other Than Personal Services (OTPS), providers which have experienced losses in OTPS are precluded from using interchange to fund those legitimate expenses. The provider also opposed the inclusion of program administrative expenses in the equation for determination of the administrative efficiency adjustment because it discerns a distinction between agency and program administration that skews the results. In its view, program administrative staff who provide clinic oversight command higher compensation than agency administrative staff, and therefore only agency administrative expenses should be utilized for the purposes of the administrative reduction. Finally, this provider states that the methodology fails to take into account an efficiency adjustment that is already in place. Because that efficiency adjustment is not distributed to the cost categories on the price sheets, identified surpluses are overstated in the calculations.

Response: In designing the methodology, OPWDD attempted to be sensitive to those providers which operated without surplus reimbursement or at exceptionally efficient levels. For such providers, reductions could cause severe hardships and OPWDD elected not to impose reductions on providers with the least ability to sustain them. OPWDD selected personal services as the object of the efficiency adjustments because its statistical analysis indicated this and the associated cost categories were being overfunded. OPWDD purposely did not target OTPS because, as a component of Non-personal Services (NPS), it was subject to an efficiency adjustment in May, 2010 in Group and Supplemental Group Day Habilitation and in October, 2010 in supervised IRAs and supervised CRs. OPWDD considers that the prospect of agency downsizing to accommodate to these funding reductions is improbable because the reductions targeted surpluses. Further, OPWDD notes that regulatory safeguards are in place to protect individuals in the event that an agency seeks to discharge them. These safeguards can be found in 14 NYCRR Section 633.12.

The provider is incorrect in classifying clinical oversight as program administration. Both agency and program administration categories are intended to represent purely administrative functions and clinic oversight is a clinical function and belongs in the clinical cost category.

Finally, the writer identifies an earlier efficiency adjustment that if taken into account could potentially reduce the surplus derived by OPWDD’s calculations for the personal services efficiency adjustment. OPWDD observes that the earlier efficiency adjustment was intended to be permanent. Introducing it into the equation concerning the present amendments would diminish its effect. Moreover, OPWDD has no means to determine how an individual provider might have absorbed and distributed the effects of that efficiency adjustment.

NOTICE OF ADOPTION

Reimbursement Methodology for Group Day Habilitation Services and Supplemental Group Day Habilitation Services

I.D. No. PDD-16-11-00012-A

Filing No. 523

Filing Date: 2011-06-14

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 635-10.5(c) of Title 14 NYCRR.

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

Subject: Reimbursement methodology for group day habilitation services and supplemental group day habilitation services.

Purpose: To modify the reimbursement methodology for group day habilitation services effective July 1, 2011.

Text or summary was published in the April 20, 2011 issue of the Register, I.D. No. PDD-16-11-00012-P.

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

Text of rule and any required statements and analyses may be obtained from: Barbara Brundage, Director, Regulatory Affairs Unit, OPWDD, 44 Holland Avenue, Albany, NY 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.

Assessment of Public Comment

OPWDD received two comments from voluntary providers. The comments and OPWDD’s responses follow.

Comment: An agency urged that the amendments (this one among others) be withdrawn because the proposed changes depart from the three “core principles” that define the relationship between the State and voluntary providers. It asserted that efficient providers reserve funds to accommodate special needs as they arise; that providers need a safety net in the form of the appeal mechanism to address “unforeseen operating losses;” and that interchange allows providers to reallocate funds between cost centers and programs to meet changing needs and compensates for a reimbursement system that is “neither scientific nor accurate.” It contended that “these three principles have been violated by the proposed regulations.”

Response: OPWDD will not be withdrawing the regulations. The amendments were designed to encourage operating efficiencies. Aspects of the regulations were formulated to reduce surplus funding by more closely aligning reimbursement with actual costs. The appeals process was amended to be better synchronized with OPWDD’s prospective reimbursement methodologies. OPWDD has a long established tradition of reaching out to stakeholders for their input before instituting systemic changes to programs and payments. Providers through provider associations participated in numerous discussions during the development stage of these amendments. With respect to the interchange restriction, OPWDD is responding to providers by repealing this aspect of the amendments in order to avoid negative consequences to those providers already demonstrating the greatest levels of efficiency. This will occur through a separate emergency rule making action that is timed to coincide with the adoption of these regulations.

Comment: A second provider expressed its view that the methodology employed to effect the price reductions should not include exemptions for any providers. It insisted that every provider should “shoulder” the burden and “contribute its fair share to the budget cut.” It opined that non-exempt providers will be forced to discharge individuals in order to downsize and that those individuals will migrate to exempt providers for services. It projected that a consequent “revenue transfer” from non-exempt to exempt providers will ensue with agency survival paralleling the monetary movement. It objected to the focus of the exemption criteria on personal services and expounded that by cutting personal services reimbursement without regard to provider status in terms of Other Than Personal Services (OTPS), providers which have experienced losses in OTPS are precluded from using interchange to fund those legitimate expenses. The provider also opposed the inclusion of program administrative expenses in the equation for determination of the administrative efficiency adjustment because it discerns a distinction between agency and program administration that skews the results. In its view, program administrative staff who provide clinic oversight command higher compensation than agency administrative staff, and therefore only agency administrative expenses should be utilized for the purposes of the administrative reduction. Finally, this provider states that the methodology fails to take into account an efficiency adjustment that is already in place. Because that efficiency adjustment is not distributed to the cost categories on the price sheets, identified surpluses are overstated in the calculations.

Response: In designing the methodology, OPWDD attempted to be sensitive to those providers which operated without surplus reimbursement or at exceptionally efficient levels. For such providers, reductions could cause severe hardships and OPWDD elected not to impose reductions on providers with the least ability to sustain them. OPWDD selected personal services as the object of the efficiency adjustments because its statistical analysis indicated this and the associated cost categories were being overfunded. OPWDD purposely did not target OTPS because, as a component of Non-personal Services (NPS), it was subject to an efficiency adjustment in May, 2010 in Group and Supplemental Group Day Habilitation and in October, 2010 in supervised IRAs and supervised CRs. OPWDD considers that the prospect of agency downsizing to accommodate to these funding reductions is improbable because the reductions targeted surpluses. Further, OPWDD notes that regulatory safeguards are in place to protect individuals in the event that an agency seeks to discharge them. These safeguards can be found in 14 NYCRR Section 633.12.

The provider is incorrect in classifying clinical oversight as program administration. Both agency and program administration categories are intended to represent purely administrative functions and clinic oversight is a clinical function and belongs in the clinical cost category.

Finally, the writer identifies an earlier efficiency adjustment that if

taken into account could potentially reduce the surplus derived by OPWDD's calculations for the personal services efficiency adjustment. OPWDD observes that the earlier efficiency adjustment was intended to be permanent. Introducing it into the equation concerning the present amendments would diminish its effect. Moreover, OPWDD has no means to determine how an individual provider might have absorbed and distributed the effects of that efficiency adjustment.

NOTICE OF ADOPTION

Efficiency Adjustment for HCBS Waiver Community Habilitation Services

I.D. No. PDD-16-11-00013-A

Filing No. 527

Filing Date: 2011-06-14

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 635-10.5(ab) of Title 14 NYCRR.

Statutory authority: Mental Hygiene Law, section 13.09(b)

Subject: Efficiency adjustment for HCBS waiver community habilitation services.

Purpose: To implement an efficiency adjustment by modifying the fee schedule for HCBS waiver community habilitation.

Text or summary was published in the April 20, 2011 issue of the Register, I.D. No. PDD-16-11-00013-P.

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

Text of rule and any required statements and analyses may be obtained from: Barbara Brundage, Director, Regulatory Affairs Unit, OPWDD, 44 Holland Avenue, Albany, NY 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.

Assessment of Public Comment

OPWDD received one comment from a voluntary provider as follows.

Comment: An agency urged that the amendments (this one among others) be withdrawn because the proposed changes depart from the three "core principles" that define the relationship between the State and voluntary providers. It asserted that efficient providers reserve funds to accommodate special needs as they arise; that providers need a safety net in the form of the appeal mechanism to address "unforeseen operating losses;" and that interchange allows providers to reallocate funds between cost centers and programs to meet changing needs and compensates for a reimbursement system that is "neither scientific nor accurate." It contended that "these three principles have been violated by the proposed regulations."

Response: OPWDD will not be withdrawing the regulations. The amendments were designed to encourage operating efficiencies. Aspects of the regulations were formulated to reduce surplus funding by more closely aligning reimbursement with actual costs. The appeals process was amended to be better synchronized with OPWDD's prospective reimbursement methodologies. OPWDD has a long established tradition of reaching out to stakeholders for their input before instituting systemic changes to programs and payments. Providers through provider associations participated in numerous discussions during the development stage of these amendments.

NOTICE OF ADOPTION

Reimbursement of Clinic Treatment Facilities ("Article 16 Clinics")

I.D. No. PDD-16-11-00014-A

Filing No. 525

Filing Date: 2011-06-14

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 679 of Title 14 NYCRR.

Statutory authority: Mental Hygiene Law, sections 13.07, 13.09 and

43.02; L. 2009, ch. 58, section 21; and Public Health Law, section 2807(2-a)(e)

Subject: Reimbursement of clinic treatment facilities ("Article 16 clinics").

Purpose: To effect a new reimbursement methodology for clinic treatment facilities and to achieve consistency with other State agencies.

Substance of final rule:

The regulations change the reimbursement methodology for clinics certified or operated by OPWDD. The unit of service is a clinic visit. A clinic visit must include face-to-face service. However, associated observation is considered a face-to-face service. A clinic visit is all the clinical services provided for a person on a common date of service, except that a diagnostic and evaluation service conducted over more than one day is treated as one visit, and on-site and off-site clinic visits provided on the same day are treated as two separate visits.

Clinics assign ICD diagnostic codes and CPT/HCPCS procedure codes to all services and submit this information with claims for reimbursement. The methodology groups these codes to Ambulatory Patient Groups (APGs) based upon the intensity of the services provided, procedures performed, diagnoses, and resource utilization. Each APG is associated with a relative weight, and there are procedure-specific weights and associated weights. APGs, APG relative weights and procedure-specific and associated weights are listed in Department of Health regulations. APGs may package with a same-day medical visit. When multiple procedures group to the same APG, payment may be discounted.

Each clinic is assigned to a peer group. Peer Group A includes clinics that have the main clinic site in New York City or Long Island. Peer Group B includes clinics that have the main clinic site in any other county in the State. Peer Group C includes clinics that are affiliated with and serving two major hospital systems and that, as of July 1, 2011, are designated by the United States Department of Health and Human Services' Administration on Developmental Disabilities as a University Center for Excellence in Developmental Disabilities; are designated by the National Institutes for Health's Eunice Kennedy Shriver National Institute of Child Health and Human Development as an Intellectual and Developmental Disability Research Center, and are designated by the United States Public Health Service Health Resources and Services Administration Maternal and Child Health Bureau as a Leadership Education in Neurodevelopmental and Related Disabilities training program.

There is a base rate for each peer group. The operating component of the rate is the product of the base rate and the procedure's allowed relative APG weight or the final APG weight for each APG on a claim.

If a visit includes a service which maps to an APG which allows a capital add-on, there will be a capital add-on to the operating component of the APG payment for the visit. The capital component will equal the capital cost component of the clinic's regular visit fee in effect on June 30, 2011.

OPWDD will review the capital cost component beginning July 1, 2012 for clinics that were licensed by the Department of Health as diagnostic and treatment centers, transferred long term therapeutic and clinical habilitative services on or after April 1, 2009 to an OPWDD licensed clinic, and received capital funding equal to the diagnostic and treatment center property component. OPWDD will compare the capital cost reimbursement to the clinic's actual capital expenditures from the financial report for the period two years prior. The capital cost component will then be changed to the lesser of (1) the most recent reimbursement; or (2) the greater of actual capital expenditures or the amount reimbursed to OPWDD licensed clinics that are not having their capital component reviewed.

APG reimbursement is phased in using a blended payment. The blended payment is comprised of the clinic's provider specific average legacy fee, plus payment under the APG methodology, plus a capital cost component, if any. For the period beginning on July 1, 2011 and ending on June 30, 2012, the payment will be 75% of the provider specific average legacy fee and 25% of the APG fee; for the twelve months beginning July 1, 2012, the payment will be 50% of the provider specific average legacy fee and 50% of the APG fee; for the six months beginning July 1, 2013, the blend will be 25% of the provider specific average legacy fee and 75% of the APG fee. On and after January 1, 2014, fees will be entirely APG based.

OPWDD will determine the average legacy fee as follows. OPWDD will determine counts of paid visits for each clinic and visit type under the previous reimbursement methodology for service dates between April 1, 2009 and March 31, 2010. OPWDD may adjust this look-back period to accommodate instances where a clinic was not certified by OPWDD for the entire year. OPWDD will also determine each clinic's total operating payment by visit type by multiplying the count of paid visits for the visit type by the operating component of the fee in effect on June 30, 2011 for the same visit type. OPWDD may adjust these results to prevent a clinic from incurring a decrease or increase in Medicaid reimbursement

disproportionate to that of the clinics within its peer group. OPWDD will then sum the total operating payments by visit type and then divide this amount by the clinic's total paid visits across all visit types. The result will be the average legacy fee for the provider.

Clinics that begin operation on or after July 1, 2011 will be reimbursed in accordance with the phase-in except that the average of the legacy fees for all clinics will be used in the payment calculation, instead of the clinic-specific average legacy fee.

Department of Health regulations list the clinic services that will not be paid using the APG classification and reimbursement system.

Final rule as compared with last published rule: Nonsubstantial changes were made in sections 679.2(a)(3), 679.3(j), (p), 679.8(b), (c), (d), 679.9(a), (b), (c) and (e).

Text of rule and any required statements and analyses may be obtained from: Barbara Brundage, Director, Regulatory Affairs Unit, OPWDD, 44 Holland Avenue, Albany, NY 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.

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

Minor changes were made to the proposed regulation to correct grammar, italicize "i.e.," to move a misplaced bracket and to remove an extraneous "the." Also, language was updated to replace references to "the effective date" or dates pegged to the effective date with the actual calendar dates.

These changes do not necessitate revisions to the previously published Regulatory Impact Statement, Regulatory Flexibility Analysis for Small Business and Local Governments, Rural Area Flexibility Analysis or Job Impact Statement.

Assessment of Public Comment

The agency received no public comment.

NOTICE OF ADOPTION

Personal Services Surpluses Adjustment for Prevocational Services

I.D. No. PDD-16-11-00015-A

Filing No. 524

Filing Date: 2011-06-14

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 635-10.5(e) of Title 14 NYCRR.

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

Subject: Personal services surpluses adjustment for Prevocational Services.

Purpose: To modify reimbursement methodology for Prevocational Services effective July 1, 2011.

Text of final rule: Subdivision 635-10.5(e) is amended by the addition of a new paragraph (6) as follows and existing paragraphs (6)-(10) are renumbered to be (7)-(11):

(6) Effective July 1, 2011, prevocational services prices shall be reduced according to the measures outlined in this paragraph. This personal services action addresses provider surpluses in funding for direct care, clinical and support staff and the associated fringe benefits.

(i) *Applicability.* The price reduction shall apply to all providers except for those which meet the criteria for exemption.

The first criterion, in order for any provider to be exempt from the impact of the reduction on any basis, is a cost report requirement. Region I providers must have filed a 2008-2009 cost report and Regions II and III providers must have filed a 2008 cost report on or before December 23, 2010, except that a provider may submit the cost report after December 23, 2010 if the cost report represents an original submission or a resubmission specifically requested by OPWDD due to identified inaccuracies or insufficiencies. Cost reports submitted after December 23, 2010 must be submitted by May 1, 2011 unless the Commissioner exercises or has exercised his or her discretion to extend the May 1, 2011 deadline. Providers with cost reports submitted in accordance with the deadlines in this subparagraph (i) may qualify for exemption pursuant to subparagraph (ii) of this paragraph. Providers which did not submit cost reports in ac-

cordance with the deadlines in this subparagraph (i) shall be subject to price reductions pursuant to subparagraph (vii) of this paragraph. OPWDD shall employ data extracted from the most recent 2008/2008-2009 cost report submitted by a provider on or before December 23, 2010, except that data from a 2008/2008-2009 cost report submitted after December 23, 2010 representing an original submission or a resubmission specifically requested by OPWDD due to identified inaccuracies or insufficiencies and submitted by May 1, 2011 or a later deadline extended by the Commissioner shall also be utilized.

(ii) *Exemptions.*

(a) *FTE personal services loss.* OPWDD compared each provider's actual FTEs for direct care, clinical care and support as reported in its 2008/2008-2009 cost report to the maximum reimbursable FTEs designated for direct care, clinical care and support as reflected in the corresponding price. This analysis included the FTE equivalents for contracted services. OPWDD identified a subset of providers which demonstrated an excess of actual FTEs over reimbursable FTEs. They are exempt.

(b) *Providers with a loss in personal services and associated fringe benefits combined are exempt.* OPWDD examined 2008/2008-2009 cost reports for those providers not exempted by virtue of clause (a) of this subparagraph. OPWDD compared each provider's actual expenses for direct care, clinical care and support and the associated fringe benefits to the total reimbursable costs reflected in the corresponding price and designated for direct care, clinical care and support and the associated fringe benefits cost categories. This analysis included contracted services. OPWDD identified a subset of providers which demonstrated an excess of actual expenses for direct care, clinical care and support and the associated fringe benefits over reimbursable costs reflected in the corresponding price and designated for direct care, clinical care and support and the associated fringe benefits. They are exempt.

(iii) *Providers subject to prevocational services price reduction are those providers which are not specifically exempted pursuant to subparagraph (ii) of this paragraph.*

(iv) *Untrended gross surplus.* A provider is identified as having an untrended gross surplus when the analysis as conducted and described in clause (b) of subparagraph (ii) demonstrated an excess of reimbursable costs as reflected in the price for the respective reporting period and designated for direct care, clinical care and support and the associated fringe benefits over actual expenses for direct care, clinical care and support and the associated fringe benefits as reported in the provider's 2008/2008-2009 cost report. The amount of this excess is the untrended gross surplus.

(v) *Untrended tentative gross reduction.* The untrended gross surplus multiplied by 40 percent is referred to as the untrended tentative gross reduction.

(vi) *Tentative gross reduction.* The tentative gross reduction equals the untrended tentative gross reduction pursuant to subparagraph (v) of this paragraph trended to June 30, 2011 dollars.

(vii) *Total impact limitation.* Before OPWDD revises a provider's prevocational services price, it shall assess the total impact on a provider of all the tentative gross reductions and tentative aggregate gross reductions pursuant to this paragraph 635-10.5(e)(6) and sections 635-10.5(b)(18)(iv), 635-10.5(c)(16), and 671.7(a)(13) of this Title, combined with the final price and fee reductions pursuant to sections 635-10.5(b)(18)(iii), 635-10.5(d)(6), 635-10.5(h)(3)(iii)(d), 635-10.5(ab)(12)(iii)(b) and 671.7(a)(12) of this Title. The total impact to an individual provider shall be limited to an amount not to exceed 6.5 percent of the aggregated total gross reimbursable operating costs as reflected in a provider's June 30, 2011 prices and the aggregated total gross allowable reimbursement reflected in a provider's June 30, 2011 fees for the provider's programs and/or services subject to the price and fee revisions. The lesser of the amount of the total impact or the amount of the total impact as limited by the 6.5 percent provision represents the final impact. For providers for which no 2008/2008-2009 cost reports were available because the conditions established in subparagraph (i) of this paragraph were not met, the total impact is calculated as follows: The aggregated total gross reimbursable operating costs as reflected in a provider's June 30, 2011 prices and the aggregated total gross allowable reimbursement as reflected in a provider's June 30, 2011 fees for the provider's programs and/or services subject to the price and fee revisions are summed. The total is multiplied by 6.5 percent. The product is the final impact for these providers.

(viii) *Allocation of final impact.* Before allocation, the final impact on a provider shall be reduced by the final price and fee reductions pursuant to sections 635-10.5(b)(18)(iii), 635-10.5(d)(6), 635-10.5(h)(3)(iii)(d), 635-10.5(ab)(12)(iii)(b) and 671.7(a)(12) of this Title because those reductions are not subject to any further revisions. The remainder of the final impact on a provider shall be distributed equitably across the reimbursable operating costs in that provider's prevocational, supervised

residential habilitation, group day habilitation, and supplemental group day habilitation services in proportion to the amount of reduction each of these programs would have incurred had the reductions been calculated separately.

(ix) Final prevocational services price reduction percentage. The allocation of the final impact to a provider's prevocational services shall be expressed as a percentage of the total gross reimbursable operating costs reflected in the price in effect on June 30, 2011.

(x) The final prevocational services price shall be the prevocational services price in effect on June 30, 2011 reduced by the final prevocational services price reduction percentage pursuant to subparagraph (ix) of this paragraph applied to that price.

(xi) For the purposes of requesting a price adjustment, the effects of this price reduction shall not be construed as a basis for loss. In processing a price adjustment, any revised price will be offset by the monetary impact, prorated as appropriate, of the adjustment as calculated pursuant to this paragraph.

(xii) The commissioner, at his or her discretion, may waive all or a portion of this adjustment for a provider upon the provider demonstrating that the imposition of the reduction would jeopardize the continued operation of the prevocational services.

Subdivision 635-10.5(e) is amended by the addition of new paragraphs (12) and (13) as follows and existing paragraph (12) is renumbered to be (14).

(12) 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.

(13) The price determined through the application of this subdivision may be appealed. Such appeal shall be pursuant to section 686.13(i) of this Title, except that the determination following such first level appeal process shall be the commissioner's final decision. At the conclusion of the first level appeal process, OPWDD shall notify the provider of any revised price or denial of the request. Once OPWDD has informed the provider of the appeal outcome, a provider which submits a revised cost report for the period reviewed shall not be entitled to an increase in the award determination based on that resubmission.

Final rule as compared with last published rule: Nonsubstantial changes were made in section 635-10.5(e)(6).

Text of rule and any required statements and analyses may be obtained from: Barbara Brundage, Director, Regulatory Affairs Unit, OPWDD, 44 Holland Avenue, Albany, NY 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.

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

Minor changes were made to the proposed regulation to remove extraneous commas and to correct underlining.

These changes do not necessitate revisions to the previously published Regulatory Impact Statement, Regulatory Flexibility Analysis for Small Business and Local Governments, Rural Area Flexibility Analysis or Job Impact Statement.

Assessment of Public Comment

OPWDD received one comment from a voluntary provider as follows.

Comment: An agency urged that the amendments (this one among others) be withdrawn because the proposed changes depart from the three "core principles" that define the relationship between the State and voluntary providers. It asserted that efficient providers reserve funds to accommodate special needs as they arise; that providers need a safety net in the form of the appeal mechanism to address "unforeseen operating losses;" and that interchange allows providers to reallocate funds between cost centers and programs to meet changing needs and compensates for a reimbursement system that is "neither scientific nor accurate." It contended that "these three principles have been violated by the proposed regulations."

Response: OPWDD will not be withdrawing the regulations. The amendments were designed to encourage operating efficiencies. Aspects of the regulations were formulated to reduce surplus funding by more closely aligning reimbursement with actual costs. The appeals process was amended to be better synchronized with OPWDD's prospective reimbursement methodologies. OPWDD has a long established tradition of reaching out to stakeholders for their input before instituting systemic changes to programs and payments. Providers through provider associations participated in numerous discussions during the development stage of these amendments. With respect to the interchange restriction, OPWDD is responding to providers by repealing this aspect of the amendments in order to avoid negative consequences to those providers already demon-

strating the greatest levels of efficiency. This will occur through a separate emergency rule making action that is timed to coincide with the adoption of these regulations.

NOTICE OF ADOPTION

Limits on Reimbursement of Group Day Habilitation, Supplemental Group Day Habilitation, and Prevocational Services

I.D. No. PDD-16-11-00016-A

Filing No. 521

Filing Date: 2011-06-14

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 635-10.5(c)(7) and (e)(8) of Title 14 NYCRR.

Statutory authority: Mental Hygiene Law, section 13.09(b)

Subject: Limits on reimbursement of Group Day Habilitation, Supplemental Group Day Habilitation, and Prevocational Services.

Purpose: To impose stricter limits on reimbursement of services per person per day.

Text of final rule: Paragraph 635-10.5(c)(7) is amended as follows:

(7) Billing limits for group day habilitation and supplemental group day habilitation.

(i) [On a given day, a maximum of one and a half units per consumer, either one full unit and one half unit, or three half units, may be reimbursed for:]

[(a) group day habilitation only; or]

[(b) any combination of group day habilitation or prevocational services (see subdivision (e) of this section).]

On a given day, for an individual who does not receive supplemental group day habilitation on that day, a maximum of the following may be reimbursed:

(a) one full unit of group day habilitation; or

(b) one full unit of a blended service which includes group day habilitation (a blended service is a combination of day habilitation, prevocational services (see subdivision (e) of this section) and/or supported employment services); or

(c) any combination of two half units of: group day habilitation, prevocational services or blended services.

(ii) On a given day, for an individual who receives supplemental group day habilitation on that day, a maximum of one and a half units (either one full unit and one half unit, or three half units) may be reimbursed for any combination of group day habilitation, supplemental group day habilitation, prevocational services or blended services.

(iii) On a given day, a maximum of one full unit per [consumer] individual, either one full unit or two half units, may be reimbursed for supplemental group day habilitation.

(iv) Where more than one agency delivers services on a given day to the same individual, the total number of units billed for that day by all agencies may not exceed the maximum allowed daily units described in subparagraphs (i), (ii) and (iii) of this paragraph.

(v) Exceptions.

(a) An agency providing, or proposing to provide, services to an individual who is eligible to receive supplemental group day habilitation may request a waiver from the limits established in subparagraph (ii) of this paragraph.

(b) The billing limits established in subparagraph (ii) of this paragraph may be waived on an individual basis by the commissioner if the commissioner finds, based on the request submitted by the agency:

(1) that services in excess of the limit are necessary to preserve the health or safety of the individual; and

(2) that alternative services which are not subject to the limit have been considered to meet the health or safety needs of the individual, but that the alternative services are either inappropriate and/or unavailable.

(c) Any waiver by the commissioner shall specify the maximum number of units of service that may be reimbursed for services to the individual on a given day and shall specify the duration of the waiver. In no case shall the waiver period exceed six months. The approval may be extended (or re-extended) by the commissioner at the end of the specified period for an additional specified period which cannot exceed six months.

Paragraph 635-10.5(e)(9) is amended as follows:

(9) Billing limits for prevocational services.

(i) [On a given day, a maximum of one and a half units per consumer, either one full unit and one half unit, or three half units, may be reimbursed for:]

[(a) prevocational services; or]

[(b) any combination of prevocational services or group day habilitation.]

On a given day, for an individual who does not receive supplemental group day habilitation (see subdivision (c) of this section) on that day, a maximum of the following may be reimbursed:

(a) one full unit of prevocational services; or

(b) one full unit of a blended service which includes prevocational services (a blended service is a combination of day habilitation, prevocational services and/or supported employment services); or

(c) any combination of two half units of: group day habilitation, prevocational services or blended services.

(ii) On a given day, for an individual who receives supplemental group day habilitation on that day, a maximum of one and a half units (either one full unit and one half unit, or three half units) may be reimbursed for any combination of group day habilitation, supplemental group day habilitation, prevocational services or blended services.

[(ii)] (iii) Where more than one agency delivers services on a given day to the same [consumer] individual, the total number of units billed for that day by all agencies may not exceed the maximum allowed daily units described in [subparagraph] subparagraphs (i) and (ii) of this paragraph.

(iv) *Exceptions.*

(a) An agency providing, or proposing to provide, services to an individual who is eligible to receive supplemental group day habilitation may request a waiver from the limits established in subparagraph (ii) of this paragraph.

(b) The billing limits established in subparagraph (ii) of this paragraph may be waived on an individual basis by the commissioner if the commissioner finds, based on the request submitted by the agency:

(1) that services in excess of the limit are necessary to preserve the health or safety of the individual; and

(2) that alternative services which are not subject to the limit have been considered to meet the health or safety needs of the individual, but that the alternative services are either inappropriate and/or unavailable.

(c) Any waiver by the commissioner shall specify the maximum number of units of service that may be reimbursed for the individual on a given day and shall specify the duration of the waiver. In no case shall the waiver period exceed six months. The approval may be extended (or re-extended) by the commissioner at the end of the specified period for an additional specified period which cannot exceed six months.

Final rule as compared with last published rule: Nonsubstantive changes were made in section 635-10.5(e)(9).

Text of rule and any required statements and analyses may be obtained from: Barbara Brundage, Director, Regulatory Affairs Unit, OPWDD, 44 Holland Avenue, Albany, NY 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.

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

One minor change was made to the proposed regulation to enhance clarity and consistency. The word "full" was inserted before the word "unit" as one unit is described elsewhere in the regulations as a "full unit."

This change does not necessitate revisions to the previously published Regulatory Impact Statement, Regulatory Flexibility Analysis for Small Business and Local Governments, Rural Area Flexibility Analysis or Job Impact Statement.

Assessment of Public Comment

Comment:

One voluntary provider agency testified at a public hearing regarding the proposed regulations. The provider objected to the limit of one and a half units placed on the receipt of day services for individuals who receive supplemental day habilitation services. The provider currently serves individuals in excess of that limit on a routine basis, providing a full unit of day habilitation and a full unit of supplemental day habilitation for many individuals on weekdays. The provider described the individuals served as follows: some from large families of 8 children on average who live in small homes; some have aging parents, sick parents, a deceased parent, or a single Mother. None of these individuals live in certified residences. The provider stated that the extensive day services provided by her agency are necessary in order for the individuals to live with their families and that without the extensive services many of the individuals

would need to live in residential facilities. The provider was concerned that the alternate services that might be available, such as community habilitation or respite, might not be as beneficial for the individuals. Further, the provider stated that the services would cost about the same amount as supplemental day habilitation. The provider requested that if the regulations are unchanged that OPWDD grant a waiver for the individuals it serves that need services in excess of the limit.

Response:

OPWDD is adopting the regulations as proposed, including the limit on day services for individuals who receive supplemental day habilitation. OPWDD considers that providers will almost always be able to meet individuals' needs for the habilitation services within the new limit. OPWDD recognizes that in rare circumstances providers newly subject to the limits may need to provide other types of services or provide services over the limits in order to meet the individual's needs for health and safety. In recognition of this possibility, the regulations establish procedures for providers to request a waiver of this limit in rare circumstances when services in excess of the limit are necessary to preserve the health or safety of the individual. OPWDD will consider the application of this provider (or any other provider) for the limits to be waived for services provided to specific individuals. In addition, OPWDD will explore whether these individuals need services in excess of the limit and whether it would be appropriate to meet those needs through the provision of alternative services such as community habilitation or respite. OPWDD will also explore whether it is appropriate to authorize this particular agency to provide alternative services if such services are determined to be warranted.

Since the provider does not currently provide respite services, it is difficult to ascertain whether the provision of respite services in lieu of supplemental day habilitation would be more costly as the price established for respite services is specific to each provider and a price has not been determined in the event that this particular provider is approved to provide respite services. However, OPWDD would expect that the reimbursement for respite would most likely be less costly than the provision of supplemental day habilitation even if an equivalent number of hours are provided. The provision of community habilitation (except for individual community habilitation) would be less expensive hour for hour. It is also feasible that not all individuals affected by the limit would receive respite or community habilitation. Regardless of whether alternative services are more or less costly, OPWDD considers that it is unlikely that the need for day habilitation services is in excess of one and a half units in a given day for any individual and that the more appropriate service would likely be respite.

NOTICE OF ADOPTION

Reimbursement of ICF/DDs

I.D. No. PDD-16-11-00017-A

Filing No. 519

Filing Date: 2011-06-14

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 681.14 of Title 14 NYCRR.

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

Subject: Reimbursement of ICF/DDs.

Purpose: To modify reimbursement methodology and make associated changes.

Substance of final rule: With this regulation, OPWDD changes its methodology for reimbursing ICF/DD facilities that have a certified capacity of under 31 beds. Traditionally, reimbursement has taken the form of site-specific prospective rates. The operating components of those rates have been based on actual costs from providers' annual cost reports in a chosen year to which inflationary multipliers are periodically applied—usually annually. Absent cost year data, approved budgets are utilized in creating the rate. The rates cannot exceed statistically derived screens that represent maximum reimbursement ceilings for each of the operating cost categories reflected in the rate.

These regulations change the methodology for under 31-bed sites to hold rates to the lower of 2008/ 2008-2009 costs (depending on whether the provider reports on a calendar or fiscal year basis) or screen values. For sites that opened after the beginning of the cost reporting period, budgeted costs will be compared to the screens. For the purposes of the rate calculations, OPWDD assumed that providers allocated all expenses matched to their HCE I-III revenues to the fringe benefit costs category in the 2008/ 2008-2009 cost reports. Administrative, clinical and fringe benefit screens are modified to make them compatible with the new

methodology. Once the site-specific rates are recalculated, the regulations consolidate the site-specific rates for each provider resulting in a single weighted average ICF/DD rate for each provider applicable to all its sites. The methodology ensures that the operating funding level reflected in the consolidated rate for each provider will range between an amount equal to the June 30, 2011 operating funding level and an amount equal to the June 30, 2011 operating funding level reduced by 10 percent.

The regulations also add the option for OPWDD to set new site rates for under 31-bed facilities opening after July 1, 2011, using either the current agency rate, agency submitted budgeted costs, or historical data for similar facilities. New site specific rates shall be incorporated into the single weighted average rate for the provider.

In conjunction with these changes for under 31-bed facilities, OPWDD adopts other measures in its amendments. The additional provisions with respect to appeals apply to all ICF/DDs regardless of capacity (both under 31-bed and over 30-bed ICF/DDs). Appeals which have been previously allowed for cost overruns occurring due to a variety of circumstances will be limited to bed vacancies. The loss threshold criterion for providers who submit applications due to bed vacancies increases from \$1000 to \$5000. Once OPWDD notifies a provider of an appeal outcome, a provider which resubmits its annual cost report corresponding to that rate appeal year, is not entitled to an increase in that award based on that resubmission. In addition to the vacancy appeals, OPWDD will continue to make corrections to rates in the event of material errors in computations and cost data upon which the rate is predicated as well as adjustments for capacity changes, capital cost changes and audit findings.

A final provision applicable to the under 31-bed facilities prohibits providers from using revenues realized from reimbursement attributable to components of the rate other than the administrative component to fund administrative expenses.

The regulations are effective July 1, 2011. The new methodology applies to services delivered on or after that date. Changes to the appeals methodology apply to rates calculated for rate periods beginning July 1, 2011 and thereafter.

Final rule as compared with last published rule: Nonsubstantive changes were made in section 681.14(d), (4), (8) and (i)(11).

Text of rule and any required statements and analyses may be obtained from: Barbara Brundage, Director, Regulatory Affairs Unit, OPWDD, 44 Holland Avenue, Albany, NY 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.

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

Minor changes were made to the proposed regulation to correct grammar, spelling, underlining, and to change a number from text to Arabic numeral.

These changes do not necessitate revisions to the previously published Regulatory Impact Statement, Regulatory Flexibility Analysis for Small Business and Local Governments, Rural Area Flexibility Analysis or Job Impact Statement.

Assessment of Public Comment

OPWDD received one comment from a voluntary provider as follows. Comment: An agency urged that the amendments (this one among others) be withdrawn because the proposed changes depart from the three "core principles" that define the relationship between the State and voluntary providers. It asserted that efficient providers reserve funds to accommodate special needs as they arise; that providers need a safety net in the form of the appeal mechanism to address "unforeseen operating losses;" and that interchange allows providers to reallocate funds between cost centers and programs to meet changing needs and compensates for a reimbursement system that is "neither scientific nor accurate." It contended that "these three principles have been violated by the proposed regulations."

Response: OPWDD will not be withdrawing the regulations. The amendments were designed to encourage operating efficiencies. Aspects of the regulations were formulated to reduce surplus funding by more closely aligning reimbursement with actual costs. The appeals process was amended to be better synchronized with OPWDD's prospective reimbursement methodologies. OPWDD has a long established tradition of reaching out to stakeholders for their input before instituting systemic changes to programs and payments. Providers through provider associations participated in numerous discussions during the development stage of these amendments. With respect to the interchange restriction, OPWDD is responding to providers by repealing this aspect of the amendments in order to avoid negative consequences to those providers already demonstrating the greatest levels of efficiency. This will occur through a separate

emergency rule making action that is timed to coincide with the adoption of these regulations.

NOTICE OF ADOPTION

Efficiency Adjustment for HCBS Waiver Supported Employment Services

I.D. No. PDD-16-11-00018-A

Filing No. 528

Filing Date: 2011-06-14

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 635-10.5(d) of Title 14 NYCRR.

Statutory authority: Mental Hygiene Law, section 13.09(b)

Subject: Efficiency adjustment for HCBS waiver supported employment services.

Purpose: To implement an efficiency adjustment by modifying the fee schedule for HCBS waiver supported employment services.

Text or summary was published in the April 20, 2011 issue of the Register, I.D. No. PDD-16-11-00018-P.

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

Text of rule and any required statements and analyses may be obtained from: Barbara Brundage, Director, Regulatory Affairs Unit, OPWDD, 44 Holland Avenue, Albany, NY 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.

Assessment of Public Comment

OPWDD received one comment from a voluntary provider as follows. Comment: An agency urged that the amendments (this one among others) be withdrawn because the proposed changes depart from the three "core principles" that define the relationship between the State and voluntary providers. It asserted that efficient providers reserve funds to accommodate special needs as they arise; that providers need a safety net in the form of the appeal mechanism to address "unforeseen operating losses;" and that interchange allows providers to reallocate funds between cost centers and programs to meet changing needs and compensates for a reimbursement system that is "neither scientific nor accurate." It contended that "these three principles have been violated by the proposed regulations."

Response: OPWDD will not be withdrawing the regulations. The amendments were designed to encourage operating efficiencies. Aspects of the regulations were formulated to reduce surplus funding by more closely aligning reimbursement with actual costs. The appeals process was amended to be better synchronized with OPWDD's prospective reimbursement methodologies. OPWDD has a long established tradition of reaching out to stakeholders for their input before instituting systemic changes to programs and payments. Providers through provider associations participated in numerous discussions during the development stage of these amendments.

NOTICE OF ADOPTION

Reimbursement of Specialty Hospitals

I.D. No. PDD-16-11-00019-A

Filing No. 520

Filing Date: 2011-06-14

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 680.12 of Title 14 NYCRR.

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

Subject: Reimbursement of Specialty Hospitals.

Purpose: To modify the reimbursement methodology for Specialty Hospitals and make associated changes.

Text of final rule: Clause 680.12(b)(3)(ii)(b) is amended as follows:

(b) NYS Office [of Mental Retardation and] for People With

Developmental Disabilities, [Division of Revenue Management, 30 Russell Road] *Office of Counsel, 44 Holland Avenue, Albany, NY [12206-1377] 12229.*

Subparagraph 680.12(b)(5)(iii) is amended as follows:

(iii) In the event the provider discovers that the financial reports it has submitted are incomplete, inaccurate or incorrect prior to receiving its new rate, the provider must notify [OMRDD] *OPWDD* that such error exists. The provider will have 30 days from the date such notification is received by [OMRDD] *OPWDD* to submit revised reports or additional data. Such data or report shall meet the certification requirements of the report being corrected. If the corrected data or report are received within a reasonable time before the issuance of the rate, [OMRDD] *OPWDD* shall incorporate the corrected data or report into its computation of the rate without the provider having to file an appeal application. *However, OPWDD will not accept the resubmission of a January 1 - December 31, 2008 cost report subsequent to January 1, 2011 for the purposes of the calculation of the rate effective July 1, 2011 as described in clause (5)(ii)(f) of subdivision (d) of this section.*

Clause 680.12(d)(5)(ii)(e) is amended as follows:

(e) For the period January 1, 1992 through December 31, 1992 and for each subsequent rate period *through June 30, 2011*, the rate shall be equal to the reimbursable operating costs and appropriate appeal adjustments contained in the Year 4 rate calculated pursuant to clause (i)(d) of this paragraph, as trended, with the addition of appropriately approved property.

Subparagraph 680.12(d)(5)(ii) is amended by the addition of a new clause (f) as follows:

(f) *For the period July 1, 2011 through December 31, 2011 and for each subsequent rate period, rates for other than newly-certified facilities for non-ACD clients and for ACD clients when the commissioner has determined that the occupancy of certified beds for the facility and the region is 80 percent or more shall be as follows. The operating component of the rate shall be equal to the allowable operating costs as reported by the provider in its 2008 annual cost report trended to the current rate period. For the period July 1, 2011 through December 31, 2011 and for each subsequent rate period, the capital component of the rate shall be equal to the allowable capital costs as reported in the provider's 2008 annual cost report. However, OPWDD shall update the capital component of the July 1, 2011 - December 31, 2011 rate based upon capital cost information reported in cost reports for years subsequent to the 2008 reporting year subject to a desk audit review by OPWDD.*

Subdivision 680.12(e) is amended as follows:

(e) [First level rate] *Rate appeals and corrections.*

(1) *Rate appeals for rate periods prior to July 1, 2011.*

(i) *First level rate appeals.*

(a) The commissioner shall consider first level rate appeals applications for revisions to the rate, if brought within 120 days of the provider's receipt of the initial rate computation sheet. However, if the appeal is to the ACD rate calculated in accordance with section 680.12(d)(4)(ii) of this Part, the appeal must be from the ACD rate for a group of individuals residing in a physically distinct wing, unit or part of the facility, receiving similar services, having similar characteristics, and for whom the provider can identify discrete costs.

[(2)] (b) For any first level appeal, the provider must demonstrate that the rate requested in the appeal is necessary to ensure efficient and economic operation of the facility. If an appeal pursuant to this section is the ACD rate, the provider must also show that the individuals to whom the appeal pertains require care for which the necessary cost of providing [client] care *to admitted individuals* exceeds the ACD rate.

[(3)] (c) First level rate revision appeal applications shall be made in writing to the commissioner.

[(i)] (1) The application shall set forth the basis for the first level appeal and the issues of fact. Appropriate documentation shall accompany the application and [OMRDD] *OPWDD* may request such additional documentation as it deems necessary.

[(ii)] (2) Actions on first level rate appeal applications will be processed without unjustifiable delay.

[(4)] (d) A rate revised pursuant to an appeal shall not be considered final unless and until approved by the State Division of the Budget. At the conclusion of the first level appeal process [OMRDD] *OPWDD* shall notify the specialty hospital of any proposed revised rate or denial of same. [OMRDD] *OPWDD* shall inform the facility that the facility may either accept the proposed revised rate or request a second level appeal in accordance with section 602.9 of this Title in the event that the proposed revised rate fails to grant some or all of the relief requested.

[(5)] (e) At no point in the first level appeal process shall the provider have a right to any form of interim report or determination made by [OMRDD] *OPWDD* or the State Division of the Budget.

[(6)] (f) If [OMRDD] *OPWDD* approves the revision to the rate and the State Division of the Budget denies the revision, the provider shall have no further right to administrative review pursuant to this section.

[(7)] (g) Any rate revised in accordance with subdivision (d) of this section shall be effective according to the dates indicated in the approval of rate appeal notification. Such notification shall be sent to the provider by certified mail, return receipt requested.

[(8)] (h) Any additional reimbursement received by the facility, pursuant to a rate revised in accordance with this subdivision or section 602.9 of this Title, shall be restricted to the specific purpose set forth in the appeal decision.

[(9)] (ii) Second level rate appeals.

[(i)] (a) [OMRDD's] *OPWDD's* denial of the first level appeal of any or all of the relief requested in the appeals provided for in [paragraph (1) of this subdivision] *subparagraph (i) of this paragraph* shall be final, unless the facility requests a second level appeal to the commissioner in writing within 30 days of notification of denial or proposed revised rate.

[(ii)] (b) Second level appeals shall be brought and determined in accordance with the applicable provision of Part 602 of this Title.

(2) *Rate corrections for rate periods beginning on or after July 1, 2011.*

(i) *The commissioner will correct rates in instances where there are material errors in the information submitted by the provider which OPWDD used to establish the rate or where there are material errors in the rate computation and only in instances which would result in an annual increase of \$5,000 or more in a specialty hospital's allowable costs.*

(ii) *In order to request a rate correction in accordance with subparagraph (i) of this paragraph, the provider must send to OPWDD its request by certified mail, return receipt requested, within 90 days of the provider receiving the rate computation or within 90 days of the first day of the rate period in question, whichever is later.*

(3) *Rate appeals for rate periods beginning on or after July 1, 2011.*

(i) *Threshold. The threshold is \$5,000.*

(ii) *The only appeals that shall be considered are vacancy appeals.*

(iii) *First level rate appeals.*

(a) *Notification of first level appeal. In order to appeal a rate, the provider must send to OPWDD within one year of the close of the rate period in question, a first level appeal application by certified mail, return receipt requested.*

(b) *First level rate appeal applications shall be made in writing to the commissioner.*

(c) *The application shall set forth the issues of fact. Appropriate documentation shall accompany the application and OPWDD may request such additional documentation as it deems necessary.*

(d) *Actions on first level rate appeal applications will be processed without unjustifiable delay.*

(e) *The burden of proof on first level appeals shall be on the provider to demonstrate that the rate requested in the first level appeal is necessary to ensure efficient and economical operation of the specialty hospital.*

(f) *A rate revised by OPWDD pursuant to an appeal shall not be considered final unless and until approved by the State Division of the Budget.*

(g) *At no point in the first level appeal process shall the provider have a right to an interim report of any determinations made by any of the parties to the appeal. At the conclusion of the first level appeal process OPWDD shall notify the provider of any proposed revised rate or denial of same. OPWDD shall inform the provider that it may either accept the proposed revised rate or request a second level appeal in accordance with the provisions of section 602.9 of this Title, in the event that the proposed revised rate fails to grant some or all of the relief requested.*

(h) *At the conclusion of the first level appeal process, OPWDD shall notify the provider of any revised rate or denial of the request. Once OPWDD has informed the provider of the appeal outcome, if the provider submits a revised cost report for the period reviewed, it shall not be entitled to an increase in the award determination based on that resubmission.*

(i) *If OPWDD approves the revision to the rate and the State Division of the Budget denies the revision, the provider shall have no further right to administrative review pursuant to this section.*

(j) *Any rate revised in accordance with this paragraph shall be effective according to the dates indicated in the approval of the rate appeal notification.*

(k) *Any additional reimbursement received by the provider pursuant to a rate revised in accordance with this paragraph shall be restricted to the specific purpose set forth in the first or second level appeal decision. If the provider does not spend such reimbursement on such specific purpose, OPWDD shall be entitled to recover such reimbursement.*

(ii) *Second level rate appeals.*

(a) *OPWDD's denial of the first level appeal of any or all of the relief requested shall be final, unless the provider requests a second level appeal to the commissioner in writing within 30 days of service of notification of denial or proposed revised rate.*

(b) Second level appeals shall be brought and determined in accordance with the applicable provisions of Part 602 of this Title.

Final rule as compared with last published rule: Nonsubstantive changes were made in section 680.12(b)(5) and (d)(5).

Text of rule and any required statements and analyses may be obtained from: Barbara Brundage, Director, Regulatory Affairs Unit, OPWDD, 44 Holland Avenue, Albany, NY 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.

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

Minor changes were made to the proposed regulation to remove extraneous commas.

These changes do not necessitate revisions to the previously published Regulatory Impact Statement, Regulatory Flexibility Analysis for Small Business and Local Governments, Rural Area Flexibility Analysis or Job Impact Statement.

Assessment of Public Comment

OPWDD received one comment from a voluntary provider as follows.

Comment: An agency urged that the amendments (this one among others) be withdrawn because the proposed changes depart from the three "core principles" that define the relationship between the State and voluntary providers. It asserted that efficient providers reserve funds to accommodate special needs as they arise; that providers need a safety net in the form of the appeal mechanism to address "unforeseen operating losses;" and that interchange allows providers to reallocate funds between cost centers and programs to meet changing needs and compensates for a reimbursement system that is "neither scientific nor accurate." It contended that "these three principles have been violated by the proposed regulations."

Response: OPWDD will not be withdrawing the regulations. The amendments were designed to encourage operating efficiencies. Aspects of the regulations were formulated to reduce surplus funding by more closely aligning reimbursement with actual costs. The appeals process was amended to be better synchronized with OPWDD's prospective reimbursement methodologies. OPWDD has a long established tradition of reaching out to stakeholders for their input before instituting systemic changes to programs and payments. Providers through provider associations participated in numerous discussions during the development stage of these amendments.

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-31-09-00007-P	August 5, 2009
PSC-37-09-00009-P	September 16, 2009
PSC-37-09-00011-P	September 16, 2009
PSC-37-09-00012-P	September 16, 2009
PSC-03-11-00015-P	January 19, 2011
PSC-14-11-00010-P	April 6, 2011
PSC-15-11-00017-P	April 13, 2011

PROPOSED RULE MAKING NO HEARING(S) SCHEDULED

Transfer of Ownership Interests in a Proposed 100 MW Generation Facility from Astoria to USPG

I.D. No. PSC-26-11-00006-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 petition requesting

the approval of the transfer of ownership interests in a proposed 100 MW generation facility from Astoria Generating Company, L.P. (Astoria) to USPG Devco Holdings LLC (USPG).

Statutory authority: Public Service Law, sections 2(11), 5(1)(b) and 70

Subject: Transfer of ownership interests in a proposed 100 MW generation facility from Astoria to USPG.

Purpose: Consideration of the transfer of ownership interest in a proposed 100 MW generation facility from Astoria to USPG.

Substance of proposed rule: The Public Service Commission is considering a petition filed on June 7, 2011 requesting approval of the transfer of ownership interests in an approximately 100 MW gas-fired generation facility to be constructed in Brooklyn, NY from Astoria Generating Company, L.P. (Astoria) to USPG DevCo Holdings LLC (USPG). All permits and authorizations needed to construct the facility would be transferred to USPG, which would lease the land where the facility would be built from Astoria. The Commission may adopt, reject or modify, in whole or in part, the relief proposed.

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

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

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

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

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

(11-E-0306SP1)

PROPOSED RULE MAKING NO HEARING(S) SCHEDULED

Water Rates and Charges

I.D. No. PSC-26-11-00007-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 filing by Grandview Waterworks Corp. requesting approval to increase its annual revenues by about \$25,266 or 50%.

Statutory authority: Public Service Law, sections 4(1), 5(1)(f), 89-c(1) and (10)

Subject: Water rates and charges.

Purpose: To approve an increase in annual revenues by about \$25,266 or 50%.

Substance of proposed rule: On June 3, 2011, Grandview Waterworks Corp. (Grandview or the company) filed to become effective October 1, 2011, Leaf No. 12, Revision 4 to its electronic tariff schedule, P.S.C. No. 2 - Water. Grandview is requesting to increase its annual operating revenues by about \$25,266 or 50%. The company provides metered water to approximately 118 customers in two real estate developments known as Grandview Country Estates and The Willows, located in the Town of Kinderhook, Columbia County. The company proposes to increase its quarterly minimum charge for the first 10,000 gallons or less from \$69.13 to \$103.69 and its usage charge from \$4.93 per thousand gallons to \$7.40. Grandview's tariff, along with its proposed changes, is available on the Commission's Home Page on the World Wide Web (www.dps.state.ny.us) located under Commission Documents). The Commission may approve or reject, in whole or in part, or modify the company's request.

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

Data, views or arguments may be submitted to: Jaclyn A. Brillling, Secretary, Public Service Commission, 3 Empire State Plaza, Albany, New York 12223-1350, (518) 474-6530, email: 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-W-0297SP1)

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

Whether to Permit the Use of RITZ Instrument Grade Current and Voltage Transformers

I.D. No. PSC-26-11-00008-P

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

Proposed Action: The Public Service Commission is considering whether to approve, deny or modify, in whole or in part, a petition filed by RITZ Instrument Transformers Inc. for the approval to use the RITZ instrument grade current and voltage transformers.

Statutory authority: Public Service Law, section 67(1)

Subject: Whether to permit the use of RITZ instrument grade current and voltage transformers.

Purpose: Pursuant to 16 NYCRR Part 93, is necessary to permit electric utilities in New York State to use the RITZ transformers.

Substance of proposed rule: The Public Service Commission is considering whether to grant, deny or modify, in whole or part, the petition filed by RITZ Instrument Transformers Incorporated, to use the DCAW, DCAB, DCBW, DCBB, DCCW, DCCB, DCDW, DCEW, DCEB current transformers, and DVE6 and DVF6 voltage transformers in substation applications.

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, Three Empire State Plaza, Albany, New York 10007, (518) 486-2655, email: leann_ayer@dps.state.ny.us

Data, views or arguments may be submitted to: Jaclyn A. Brilling, Secretary, Public Service Commission, Three Empire State Plaza, Albany, NY 10007, (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-0303SP1)

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

Petition for the Submetering of Electricity at Commercial Property

I.D. No. PSC-26-11-00009-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 Hoosick River Hardwoods, LLC to submeter electricity at 28 Taylor Avenue, commercial property, in Berlin, New York.

Statutory authority: Public Service Law, sections 2, 4(1), 65(1), 66(1) and 67(1)

Subject: Petition for the submetering of electricity at commercial property.

Purpose: To consider the request of by Hoosick River Hardwoods, LLC to submeter electricity at 28 Taylor Avenue, in Berlin, 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 Hoosick River Hardwoods, LLC to submeter electricity at 28 Taylor Ave-

nue, commercial property, in Berlin, New York, located in the territory of New York State Electric and Gas Corporation.

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. Brilling, 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-0298SP1)

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

Transfer of Water Supply Assets

I.D. No. PSC-26-11-00010-P

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

Proposed Action: The PSC is considering a Joint Petition filed by Four Corners Water Works Corporation and the Town of East Fishkill for approval to transfer all assets serving Four Corners Subdivision to the Town of East Fishkill.

Statutory authority: Public Service Law, sections 4(1), 5(1)(f), 89-c(1), (10) and 89-h

Subject: Transfer of water supply assets.

Purpose: Transfer the water supply assets of Four Corners Water Works Corporation to the Town of East Fishkill.

Substance of proposed rule: Four Corners Water Works Corporation (company) serves approximately 140 customers in the Four Corners Subdivision (a/k/a Moore Property Subdivision) and an adjacent area located in the Town of East Fishkill, Dutchess County. At full development, there will be more than 280 residential customers served. The company does not provide fire protection service. On June 14, 2011, the company and the Town of East Fishkill filed a joint petition requesting approval of the transfer of all of the water supply assets serving the Four Corners Subdivision to the Town of East Fishkill. The Commission may approve or reject, in whole or in part, or modify the company's request.

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

Data, views or arguments may be submitted to: Jaclyn A. Brilling, 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-W-0315SP1)

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

Waiver of 16 NYCRR Sections 894.1 Through 894.4 and 894.9

I.D. No. PSC-26-11-00011-P

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

Proposed Action: The Public Service Commission is considering whether to approve or reject, in whole or in part, a petition by the Town of Halcott (Greene County), for a waiver of 16 NYCRR sections 894.1 through 894.4 and 894.9 pertaining to the franchising process.

Statutory authority: Public Service Law, section 216(1)

Subject: Waiver of 16 NYCRR sections 894.1 through 894.4 and 894.9.

Purpose: To allow the Town of Halcott to waive certain preliminary franchise procedures to expedite the cable franchising process.

Substance of proposed rule: The Public Service Commission is considering whether to approve, modify or deny in whole or in part, a petition by the Town of Halcott (Greene County), for a waiver of 16 NYCRR sections 894.1 through 894.4 and section 894.9 pertaining to franchising procedures.

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-V-0314SP1)

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

Waiver of Generation Retirement Notice Requirements

I.D. No. PSC-26-11-00012-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 petition from Indeck Oswego, L.P. requesting a waiver of generation retirement notice requirements for its 55 MW generation facility.

Statutory authority: Public Service Law, sections 2(11), 5(1)(b), 65(1), (2), (3), 66(1), (2), (3), (4), (5), (8) and (10)

Subject: Waiver of generation retirement notice requirements.

Purpose: Consideration of waiver of generation retirement notice requirements.

Substance of proposed rule: The Public Service Commission is considering a petition filed on June 9, 2011 from Indeck Oswego, L.P. requesting a waiver of generation retirement notice requirements for its 55 MW generation facility located in Oswego, NY. The Commission may adopt, reject or modify, in whole or in part, the relief proposed.

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-0307SP1)

**Office of Temporary and
Disability Assistance**

NOTICE OF ADOPTION

Standard Utility Allowances for the Food Stamp Program

I.D. No. TDA-16-11-00004-A

Filing No. 532

Filing Date: 2011-06-14

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 387.12(f)(3)(v)(a), (b) and (c); and addition of section 387.12(f)(3)(v)(d) to Title 18 NYCRR.

Statutory authority: Social Services Law, sections 20(3)(d) and 95; 7 USC section 2014(e)(6)(C); and 7 CFR section 273.9(d)(6)(iii)

Subject: Standard Utility Allowances for the Food Stamp Program.

Purpose: These regulatory amendments are necessary to set forth the federally approved standard allowances as of April 1, 2011 and to clarify the Office of Temporary and Disability Assistance's process for periodically reviewing and updating the standard utility allowances.

Text or summary was published in the April 20, 2011 issue of the Register, I.D. No. TDA-16-11-00004-EP.

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

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

Assessment of Public Comment

During the public comment period on this proposed rule concerning standard utility allowances (SUAs) for the Food Stamp Program, the Office of Temporary and Disability Assistance (OTDA) received only one set of comments. The commenters identified themselves as class counsel in the matter of Cavetti v. Berlin, a hybrid Article 78 proceeding which seeks certification as a proposed class action seeking to prevent the State's implementation of the Federally-mandated and approved change in the SUAs. To the extent that the comments present legal arguments in the context of a pending litigation, they will not be addressed in this response. OTDA's assessment of public comments is strictly limited to those comments submitted with respect to the proposed rule itself and the manner of its promulgation.

To the extent that alternatives were raised to the regulation by the commenters, it is OTDA's position that no alternative methods for calculating the 2011 SUA amounts were determined appropriate as the methodology for calculating the subsequently approved SUA amounts was, in fact, recommended by the United States Department of Agriculture (USDA).

Comment: The commenters assert that OTDA has violated the State Administrative Procedures Act (SAPA) by promulgating regulations on an emergency basis on March 31, 2011 when OTDA could have begun the normal rule making process as early as mid-December 2010.

Response: OTDA does not agree that it has violated SAPA, as the emergency rule making was promulgated to supplement an existing valid regulation. OTDA could not have begun the rule making process in mid-December 2010. At that time, OTDA had not obtained approval from the USDA of its proposed SUAs for the Food Stamp Program. OTDA needed to obtain USDA approval prior to promulgating regulations.

Comment: The commenters assert that OTDA violated the State Administrative Procedures Act (SAPA) by dispensing with public participation in its rule making process.

Response: OTDA filed a Notice of Emergency and Proposed Rule Making on March 31, 2011 thereby enabling the 45-day public comment period to commence.

Comment: The commenters assert that the process by which OTDA's adjusted the SUAs suggested a "self-created" emergency which could not form the basis of the Agency's justification for initiating the emergency rule making process.

Response: OTDA did not create an emergency in order to file its Notice of Emergency and Proposed Rule Making with the Department of State. Consistent with federal rules and regulations, OTDA reviewed and adjusted the SUAs consistent with USDA recommendations reflecting changes in energy costs. The adjusted SUAs were approved from USDA.

Between February 14 and April 1, 2011, OTDA issued individual notices to each household whose food stamp benefits would be reduced due to the reduction in the SUAs amounts and advised these households that “there will be a change to the Standard Utility Allowances (SUA) used to figure the amount of food stamp benefits a household gets. These changes are required under federal regulation and reflect changes to fuel, utility and heating prices since the last change to these amounts in February 2009. These changes may DECREASE the amount of food stamp benefits you get. The changes will take place beginning with your April, 2011 Food Stamps,” and then listed the SUA amounts in the body of the notice. The notices provided each household the opportunity to seek review of the change through the administrative hearings process, and information as to how such a hearing could be requested.

On February 15, 2011, OTDA provided General Information System (GIS) releases, GIS 11 TA/DC004, to Upstate New York and New York City setting forth the required adjustments to the SUAs for the Food Stamp Program. On March 28, 2011, a Temporary Restraining Order was granted based on alleged SAPA violations directing that the federally-approved SUAs not be implemented on April 1, 2011. Faced with the TRO stripping New York State’s ability to use a SUA, on March 31, 2011, OTDA filed a Notice of Emergency and Proposed Rule Making in order to protect New York’s food stamp recipients from the alternative of using actual utility costs which would have significantly reduced their food stamp benefits. OTDA has acted responsibly and in compliance with federal and State statutes and regulations.

Comment: The commenters attempt to calculate the total monthly loss of food stamp benefits in New York State.

Response: USDA regulations required the re-calibration of the SUA to reflect current utility costs subject to USDA approval. The adjustment to the SUA was federally mandated and approved.

Comment: The commenters assert that OTDA implemented its SUAs reduction without giving the 350,000 affected food stamp households any advance notice or opportunity to comment.

Response: Federal regulations at 7 CFR 273.12(e)(1) provide that where there is a federal adjustment to eligibility, standards and deductions, a notice of adverse action “shall not be used,” although State agencies are required to publicize such changes through such devices as posters, news media, or “general notices mailed to households.” New York State regulations at 18 NYCRR 358-3.3(e)(2) also provide that there is no right to an individual adverse action notice when the Federal government initiates an adjustment to eligibility standards allotments or deductions and the State initiates adjustments to utility standards. Between February 14 and April 1, 2011, OTDA issued individual notices to each household whose food stamp benefits would be reduced due to the reduction in the SUAs amounts. These notices were mailed to the households’ addresses of record. The notices provided each household the opportunity to seek review of the change through the administrative hearings process, and information as to how such a hearing could be requested.

Comment: The commenters assert that the record is less than clear whether OTDA had until April 1, 2011 or May 1, 2011 to implement its revised SUAs.

Response: USDA clearly mandated that New York State implement the SUA change effective no later than April 1, 2011.

Comment: The commenters dispute OTDA’s claim that if households continued to receive food stamp benefits after March 31, 2011 pursuant to the prior SUAs, those households would have been required to repay the excess food stamp benefits.

Response: Both State and federal regulation require that households receiving overpayments of food stamp benefits be subject to recoupment at the rate of 10% of their monthly food stamp benefits until the resulting overpayment of food stamp benefits is recovered. This assertion is consistent with 7 USC 2022(b), 7 CFR 273.18(a) and 18 NYCRR 387.19 which require recoupment of food stamp overpayments.

Comment: The commenters claim that it was ludicrous for OTDA to assert that the State may be forced to use the actual shelter expenses of each individual food stamp household thereby requiring all 58 local social services districts in New York State to call all 1.6 million food stamp households into their respective district offices to provide verification of actual shelter expenses.

Response: Pursuant to 7 CFR 273.9(d)(6)(iii)(B), the State has the option of using SUAs in lieu of using actual utility expenses in computing food stamp benefit amounts. The State promulgated regulations at 18 NYCRR 387 authorizing the use of the SUAs and setting forth the general framework and rules for their use as a deduction from the calculation of food stamp benefit amounts. Without any federal authority to use a prior SUA amount, and without the state regulatory authority to use the SUAs, the State would be compelled to use the actual utility expenses of each individual food stamp household in calculating the excess shelter deduction which is used in computing food stamp benefit amounts.

Comment: The commenters repeatedly assert that OTDA has failed to establish a lawful basis for its resort to emergency rulemaking.

Response: OTDA clearly set forth the specific reasons underlying the finding of necessity for its emergency rule making in the notice (TDA-16-11-00004-EP) published in the State Register on April 20, 2011.

Comment: The commenters assert that OTDA’s regulatory impact statement neglected to cite and discuss the methodology used to compute the revised SUAs or the studies, reports and analyses that served as the basis for the revised SUAs.

Response: The Supplemental Nutrition Assistance Program (SNAP) [known in New York as the Food Stamp Program] is a federally administered program. For the SUAs revision in April, 2011, OTDA followed the USDA’s recommendation that State agencies could recalibrate its SUAs by applying a straight 8.1% reduction reflecting the downward change in the consumer price index for fuel and utilities between July 2008 and July 2010. OTDA applied this federally recommended 8.1% reduction to its SUAs, and thereafter obtained USDA approval of the resultant SUA dollar amounts.

Comment: The commenters assert that OTDA’s RIS failed to state that the new SUA amounts were lower than the previously used SUAs and thereby would result in a reduction of up to \$20.00 in monthly food stamp benefits.

Response: The RIS advised that if past SUAs were used in calculating ongoing food stamp benefits, thousands of food stamp households would receive food stamp overpayments each month. The RIS did not address general reductions of up to \$20.00 per month. Between February 14 and April 1, 2011, OTDA had issued individual notices to each household whose food stamp benefits would be reduced due to the reduction in the SUAs amounts, as noted above.

Comment: The commenters assert that OTDA did not discuss significant alternatives to the rule that were considered by the agency.

Response: For this federal program, OTDA followed the USDA recommendation and received USDA approval of its 2011 SUAs. In the RIS, OTDA discussed the alternative of not implementing the federally-approved adjustment to the SUAs.

Comment: The commenters assert that OTDA’s regulatory flexibility analysis for small businesses and local governments (RFASBLG) incorrectly asserted that the regulatory amendments would have no effect on small businesses.

Response: SNAP [known in New York as the Food Stamp Program] is a federally administered program. In 2011, the USDA requires annual recalibration of the SUAs to reflect current utility costs used in computing food stamp benefit amounts. USDA determined that due to the reduction in the consumer price index for fuel and utilities between July 2008 and July 2010, food stamp households would be spending less of their household income on utility expenses thus making more of their household income available to address their nutritional needs. It is not that less money would be spent on food. Rather, it is recognition that, due to reduced utility costs, additional income was available to be spent on food.

Comment: The commenters acknowledge that OTDA had adopted the methodology recommended by USDA in calculating its 2011 SUAs, but asserted that the 2011 SUAs were incorrect due to a miscalculation of 2009 SUA amounts. The commenters claim that OTDA’s failure to include water and sewage costs in its old SUA methodology rendered its pre-April 1, 2011 SUAs inadequate and in violation of the State regulatory definition of SUAs. The commenters recommended that with water and sewerage costs added to the other components of OTDA’s old SUA methodology, the 2009 SUA amounts would be upwardly revised. Next the commenters recommended that the 8.1% reduction to the SUAs be made to the recalculated 2009 SUAs in order to obtain higher 2011 SUAs.

Response: The calculations of the 2009 SUA amounts are not at issue in this rule making process. The 2009 SUA amounts, which generally resulted in increases in food stamp benefits, were not challenged from the time of their implementation through March 31, 2011, when they were replaced by the 2011 SUA amounts.

Moreover, it is the agency’s position that no alternative methods for calculating the 2011 SUA amounts are appropriate as the methodology for calculating the 2011 SUA amounts was recommended by the United States Department of Agriculture (USDA) and later the actual amounts were approved by USDA.

Comment: The commenters made recommendations for further regulatory amendments to 18 NYCRR 387.12(f)(3)(v).

Response: OTDA will review the recommendations made by the commenters, and based upon this review, will consider any further or additional regulatory amendments as may be deemed appropriate.

Workers' Compensation Board

EMERGENCY RULE MAKING

Pharmacy and Durable Medical Equipment Fee Schedules and Requirements for Designated Pharmacies

I.D. No. WCB-26-11-00001-E

Filing No. 512

Filing Date: 2011-06-10

Effective Date: 2011-06-10

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

Action taken: Addition of Parts 440 and 442 to Title 12 NYCRR.

Statutory authority: Workers' Compensation Law, sections 117, 13 and 13-o

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

Specific reasons underlying the finding of necessity: This rule provides pharmacy and durable medical equipment fee schedules, the process for payment of pharmacy bills, and rules for the use of a designated pharmacy or pharmacies. Many times claimants must pay for prescription drugs and medicines themselves. It is unduly burdensome for claimants to pay out-of-pocket for prescription medications as it reduces the amount of benefits available to them to pay for necessities such as food and shelter. Claimants also have to pay out-of-pocket many times for durable medical equipment. Adoption of this rule on an emergency basis, thereby setting pharmacy and durable medical equipment fee schedules will help to alleviate this burden to claimants, effectively maximizing the benefits available to them. Benefits will be maximized as the claimant will only have to pay the fee schedule amount and there reimbursement from the carrier will not be delayed. Further, by setting these fee schedules, pharmacies and other suppliers of durable medical equipment will be more inclined to dispense the prescription drugs or equipment without requiring claimants to pay up front, rather they will bill the carrier. Adoption of this rule further advances pharmacies directly billing by setting forth the requirements for the carrier to designate a pharmacy or network of pharmacies. Once a carrier makes such a designation, when a claimant uses a designated pharmacy he cannot be asked to pay out-of-pocket for causally related prescription medicines. This rule sets forth the payment process for pharmacy bills which along with the set price should eliminate disputes over payment and provide for faster payment to pharmacies. Finally, this rule allows claimants to fill prescriptions by the internet or mail order thus aiding claimants with mobility problems and reducing transportation costs necessary to drive to a pharmacy to fill prescriptions. Accordingly, emergency adoption of this rule is necessary.

Subject: Pharmacy and durable medical equipment fee schedules and requirements for designated pharmacies.

Purpose: To adopt pharmacy and durable medical equipment fee schedules, payment process and requirements for use of designated pharmacies.

Substance of emergency rule: Chapter 6 of the Laws of 2007 added Section 13-o to the Workers' Compensation Law ("WCL") mandating the Chair to adopt a pharmaceutical fee schedule. WCL Section 13(a) mandates that the Chair shall establish a schedule for charges and fees for medical care and treatment. Part of the treatment listed under Section 13(a) includes medical supplies and devices that are classified as durable medical equipment. The proposed rule adopts a pharmaceutical fee schedule and durable medical equipment fee schedule to comply with the mandates. This rule adds a new Part 440 which sets forth the pharmacy fee schedule and procedures and rules for utilization of the pharmacy fee schedule and a new Part 442 which sets forth the durable medical equipment fee schedule.

Section 440.1 sets forth that the pharmacy fee schedule is applicable to prescription drugs or medicines dispensed on or after the most recent effective date of § 440.5 and the reimbursement for drugs dispensed before that is the fee schedule in place on the date dispensed.

Section 440.2 provides the definitions for average wholesale price, brand name drugs, controlled substances, generic drugs, independent pharmacy, pharmacy chain, remote pharmacy, rural area and third party payor.

Section 440.3 provides that a carrier or self-insured employer may designate a pharmacy or pharmacy network which an injured worker must

use to fill prescriptions for work related injuries. This section sets forth the requirements applicable to pharmacies that are designated as part of a pharmacy network at which an injured worker must fill prescriptions. This section also sets forth the procedures applicable in circumstances under which an injured worker is not required to use a designated pharmacy or pharmacy network.

Section 440.4 sets forth the requirements for notification to the injured worker that the carrier or self-insured employer has designated a pharmacy or pharmacy network that the injured worker must use to fill prescriptions. This section provides the information that must be provided in the notice to the injured worker including time frames for notice and method of delivery as well as notifications of changes in a pharmacy network.

Section 440.5 sets forth the fee schedule for prescription drugs. The fee schedule in uncontroverted cases is average wholesale price minus twelve percent for brand name drugs and average wholesale price minus twenty percent for generic drugs plus a dispensing fee of five dollars for generic drugs and four dollars for brand name drugs, and in controverted cases is twenty-five percent above the fee schedule for uncontroverted claims plus a dispensing fee of seven dollars and fifty cents for generic drugs and six dollars for brand-name drugs. This section also addresses the fee when a drug is repackaged.

Section 440.6 provides that generic drugs shall be prescribed except as otherwise permitted by law.

Section 440.7 sets forth a transition period for injured workers to transfer prescriptions to a designated pharmacy or pharmacy network. Prescriptions for controlled substances must be transferred when all refills for the prescription are exhausted or after ninety days following notification of a designated pharmacy. Non-controlled substances must be transferred to a designated pharmacy when all refills are exhausted or after 60 days following notification.

Section 440.8 sets forth the procedure for payment of prescription bills or reimbursement. A carrier or self-insured employer is required to pay any undisputed bill or portion of a bill and notify the injured worker by certified mail within 45 days of receipt of the bill of the reasons why the bill or portion of the bill is not being paid, or request documentation to determine the self-insured employer's or carrier's liability for the bill. If objection to a bill or portion of a bill is not received within 45 days, then the self-insured employer or carrier is deemed to have waived any objection to payment of the bill and must pay the bill. This section also provides that a pharmacy shall not charge an injured worker or third party more than the pharmacy fee schedule when the injured worker pays for prescriptions out-of-pocket, and the worker or third party shall be reimbursed at that rate.

Section 440.9 provides that if an injured worker's primary language is other than English, that notices required under this part must be in the injured worker's primary language.

Section 440.10 provides penalties for failing to comply with this Part and that the Chair will enforce the rule by exercising his authority pursuant to Workers' Compensation Law § 111 to request documents.

Part 442 sets forth the fee schedule for durable medical equipment.

Section 442.1 sets forth that the fee schedule is applicable to durable medical goods and medical and surgical supplies dispensed on or after July 11, 2007.

Section 442.2 sets forth the fee schedule for durable medical equipment as indexed to the New York State Medicaid fee schedule, except the payment for bone growth stimulators shall be made in one payment. This section also provides for the rate of reimbursement when Medicaid has not established a fee payable for a specific item and for orthopedic footwear. This section also provides for adjustments to the fee schedule by the Chair as deemed appropriate in circumstances where the reimbursement amount is grossly inadequate to meet a pharmacies or providers costs and clarifies that hearing aids are not durable medical equipment for purposes of this rule.

Appendix A provides the form for notifying injured workers that the claim has been contested and that the carrier is not required to reimburse for medications while the claim is being contested.

Appendix B provides the form for notification of injured workers that the self-insured employer or carrier has designated a pharmacy that must be used to fill prescriptions.

This notice is intended to serve only as an emergency adoption, to be valid for 90 days or less. This rule expires September 7, 2011.

Text of rule and any required statements and analyses may be obtained from: Heather MacMaster, Esq., New York State Workers' Compensation Board, 20 Park Street, Office of General Counsel, Albany, New York 12207, (518) 486-9564, email: regulations@wcb.state.ny.us

Summary of Regulatory Impact Statement

Section 1 provides the statutory authority for the Chair to adopt a pharmacy fee schedule pursuant to Workers' Compensation Law Section (WCL) 13-o as added to the WCL by Chapter 6 of the Laws of 2007 which

requires the Chair to adopt a pharmaceutical fee schedule. Chapter 6 also amended WCL Section 13(a) to mandate that the Chair establish a schedule for charges and fees for medical care and treatment. Such medical care and treatment includes supplies and devices that are classified as durable medical equipment (hereinafter referred to as DME).

Section 2 sets forth the legislative objectives of the proposed regulations which provide the fee schedules to govern the cost of prescription medicines and DME. This section provides a summary of the overall purpose of the proposed regulation to reduce costs of workers' compensation and the scope of the regulation with regard to process and guidance to implement the rule.

Section 3 explains the needs and benefits of the proposed regulation. This section provides the explanation of the requirement of the Chair to adopt a pharmacy fee schedule as mandated by Chapter 6 of the Laws of 2007. The legislation authorizes carriers and self-insured employers to voluntarily decide to designate a pharmacy or pharmacy network and require claimants to obtain their prescription medicines from the designated pharmacy or network. This section explains how prescriptions were filled prior to the enactment of the legislation and the mechanisms by which prescriptions were reimbursed by carriers and self-insured employers. This section also provides the basis for savings under the proposed regulation. The cost savings realized by using the pharmacy fee schedule will be approximately 12 percent for brand name drugs and 20 percent for generic drugs from the average wholesale price. This section explains the issues with using the Medicaid fee schedule. The substantive requirements are set forth that carriers must follow to notify a claimant of a designated pharmacy or network. This includes the information that must be included in the notification as well as the time frames within which notice must be provided. This section also describes how carriers and self-insured employers will benefit from a set reimbursement fee as provided by the proposed regulation. This section provides a description of the benefits to the Board by explaining how the proposed regulation will reduce the number of hearings previously necessary to determine proper reimbursement of prescription medications by using a set fee schedule.

Section 4 provides an explanation of the costs associated with the proposed regulation. It describes how carriers are liable for the cost of medication if they do not respond to a bill within 45 days as required by statute. This section describes how carriers and self-insured employers which decide to require the use of a designated network will incur costs for sending the required notices, but also describes how the costs can be offset to a certain degree by sending the notices listed in the Appendices to the regulation with other forms. Pharmacies will have costs associated with the proposed regulation due to a lower reimbursement amount, but the costs are offset by the reduction of administrative costs associated with seeking reimbursement from carriers and self-insured employers. Pharmacies will be required to post notice that they are included in a designated network and a listing of carriers that utilize the pharmacy in the network. This section describes how the rule benefits carriers and self-insured employers by allowing them to contract with a pharmacy or network to provide drugs thus allowing them to negotiate for the lowest cost of drugs.

Section 5 describes how the rule will affect local governments. Since a municipality of governmental agency is required to comply with the rules for prescription drug reimbursement the savings afforded to carriers and self-insured employers will be substantially the same for local governments. If a local government decides to mandate the use of a designated network it will incur some costs from providing the required notice.

Section 6 describes the paperwork requirements that must be met by carriers, employers and pharmacies. Carriers will be required to provide notice to employers of a designated pharmacy or network, and employers in turn will provide such notice to employees so that employees will know to use a designated pharmacy or network for prescription drugs. Pharmacies will be required to post notice that they are part of a designated network and a listing of carriers that utilize the pharmacy within the network. This section also specifies the requirement of a carrier or self-insured employer to respond to a bill within 45 days of receipt. If a response is not given within the time frame, the carrier or self-insured employer is deemed to have waived any objection and must pay the bill. This section sets forth the requirement of carriers to certify to the Board that designated pharmacies within a network meet compliance requirements for inclusion in the network. This section sets forth that employers must post notification of a designated pharmacy or network in the workplace and the procedures for utilizing the designated pharmacy or network. This section also sets forth how the Chair will enforce compliance with the rule by seeking documents pursuant to his authority under WCL § 111 and impose penalties for non-compliance.

Section 7 states that there is no duplication of rules or regulations.

Section 8 describes the alternatives explored by the Board in creating the proposed regulation. This section lists the entities contacted in regard

to soliciting comments on the regulation and the entities that were included in the development process. The Board studied fee schedules from other states and the applicability of reimbursement rates to New York State. Alternatives included the Medicaid fee schedule, average wholesale price minus 15% for brand and generic drugs, the Medicare fee schedule and straight average wholesale price.

Section 9 states that there are no applicable Federal Standards to the proposed regulation.

Section 10 provides the compliance schedule for the proposed regulation. It states that compliance is mandatory and that the proposed regulation takes effect upon adoption.

Regulatory Flexibility Analysis

1. Effect of rule:

Approximately 2511 political subdivisions currently participate as municipal employers in self-insured programs for workers' compensation coverage in New York State. As part of the overall rule, these self-insured local governments will be required to file objections to prescription drug bills if they object to any such bills. This process is required by WCL § 13(i)(1) - (2). This rule affects members of self-insured trusts, some of which are small businesses. Typically a self-insured trust utilizes a third party administrator or group administrator to process workers' compensation claims. A third party administrator or group administrator is an entity which must comply with the new rule. These entities will be subject to the new rule in the same manner as any other carrier or employer subject to the rule. Under the rule, objections to a prescription bill must be filed within 45 days of the date of receipt of the bill or the objection is deemed waived and the carrier, third party administrator, or self-insured employer is responsible for payment of the bill. Additionally, affected entities must provide notification to the claimant if they choose to designate a pharmacy network, as well as the procedures necessary to fill prescriptions at the network pharmacy. If a network pharmacy is designated, a certification must be filed with the Board on an annual basis to certify that the all pharmacies in a network comply with the new rule. The new rule will provide savings to small businesses and local governments by reducing the cost of prescription drugs by utilization of a pharmacy fee schedule instead of retail pricing. Litigation costs associated with reimbursement rates for prescription drugs will be substantially reduced or eliminated because the rule sets the price for reimbursement. Additional savings will be realized by utilization of a network pharmacy and a negotiated fee schedule for network prices for prescription drugs.

2. Compliance requirements:

Self-insured municipal employers and self-insured non-municipal employers are required by statute to file objections to prescription drug bills within a forty five day time period if they object to bills; otherwise they will be liable to pay the bills if the objection is not timely filed. If the carrier or self-insured employer decides to require the use of a pharmacy network, notice to the injured worker must be provided outlining that a network pharmacy has been designated and the procedures necessary to fill prescriptions at the network pharmacy. Certification by carriers and self-insured employers must be filed on an annual basis with the Board that all the pharmacies in a network are in compliance with the new rule. Failure to comply with the provisions of the rule will result in requests for information pursuant to the Chair's existing statutory authority and the imposition of penalties.

3. Professional services:

It is believed that no professional services will be needed to comply with this rule.

4. Compliance costs:

This proposal will impose minimal compliance costs on small business or local governments which will be more than offset by the savings afforded by the fee schedule. There are filing and notification requirements that must be met by small business and local governments as well as any other entity that chooses to utilize a pharmacy network. Notices are required to be posted in the workplace informing workers of a designated network pharmacy. Additionally, a certification must be filed with the Board on an annual basis certifying that all pharmacies within a network are in compliance with the rule.

5. Economic and technological feasibility:

There are no additional implementation or technology costs to comply with this rule. The small businesses and local governments are already familiar with average wholesale price and regularly used that information prior to the adoption of the Medicaid fee schedule. Further, some of the reimbursement levels on the Medicaid fee schedule were determined by using the Medicaid discounts off of the average wholesale price. The Red Book is the source for average whole sale prices and it can be obtained for less than \$100.00. Since the Board stores its claim files electronically, it has provided access to case files through its eCase program to parties of interest in workers' compensation claims. Most insurance carriers, self-insured employers and third party administrators have computers and internet access in order to take advantage of the ability to review claim files from their offices.

6. Minimizing adverse impact:

This proposed rule is designed to minimize adverse impacts to all insurance carriers, employers, self-insured employers and claimants. The rule provides a process for reimbursement of prescription drugs as mandated by WCL section 13(i). Further, the notice requirements are to ensure a claimant uses a network pharmacy to maximize savings for the employer as any savings for the carrier can be passed on to the employer. The costs for compliance are minimal and are offset by the savings from the fee schedule. The rule sets the fee schedule as average wholesale price (AWP) minus twelve percent for brand name drugs and AWP minus twenty percent for generic drugs. As of July 1, 2008, the reimbursement for brand name drugs on the Medicaid Fee Schedule was reduced from AWP minus fourteen percent to AWP minus sixteen and a quarter percent. Even before the reduction in reimbursement some pharmacies, especially small ones, were refusing to fill brand name prescriptions because the reimbursement did not cover the cost to the pharmacy to purchase the medication. In addition the Medicaid fee schedule did not cover all drugs, include a number that are commonly prescribed for workers' compensation claims. This presented a problem because WCL § 13-o provides that only drugs on the fee schedule can be reimbursed unless approved by the Chair. The fee schedule adopted by this regulation eliminates this problem. Finally, some pharmacy benefit managers were no longer doing business in New York because the reimbursement level was so low they could not cover costs. Pharmacy benefit managers help to create networks, assist claimants in obtaining first fills without out of pocket costs and provide utilization review. Amending the fee schedule will ensure pharmacy benefit managers can stay in New York and help to ensure access for claimants without out of pocket cost.

7. Small business and local government participation:

The Assembly and Senate as well as the Business Council of New York State and the AFL-CIO provided input on the proposed rule.

Rural Area Flexibility Analysis

1. Types and estimated numbers of rural areas:

This rule applies to all carriers, employers, self-insured employers, third party administrators and pharmacies in rural areas. This includes all municipalities in rural areas.

2. Reporting, recordkeeping and other compliance requirements:

Regulated parties in all areas of the state, including rural areas, will be required to file objections to prescription drug bills within a forty five day time period or will be liable for payment of a bill. If regulated parties fail to comply with the provisions of Part 440 penalties will be imposed and the Chair will request documentation from them to enforce the provision regarding the pharmacy fee schedule. The new requirement is solely to expedite processing of prescription drug bills or durable medical bills under the existing obligation under Section 13 of the WCL. Notice to the injured worker must be provided outlining that a network pharmacy has been designated and the procedures necessary to fill prescriptions at the network pharmacy. Carriers and self-insured employers must file a certification on an annual basis with the Board that all the pharmacies in a network are in compliance with the new rule.

3. Costs:

This proposal will impose minimal compliance costs on carriers and employers across the State, including rural areas, which will be more than offset by the savings afforded by the fee schedule. There are filing and notification requirements that must be met by all entities subject to this rule. Notices are required to be posted and distributed in the workplace informing workers of a designated network pharmacy and objections to prescription drug bills must be filed within 45 days or the objection to the bill is deemed waived and must be paid without regard to liability for the bill. Additionally, a certification must be filed with the Board on an annual basis certifying that all pharmacies within a network are in compliance with the rule. The rule provides a reimbursement standard for an existing administrative process.

4. Minimizing adverse impact:

This proposed rule is designed to minimize adverse impact for small businesses and local government from imposition of new fee schedules and payment procedures. This rule provides a benefit to small businesses and local governments by providing a uniform pricing standard, thereby providing cost savings reducing disputes involving the proper amount of reimbursement or payment for prescription drugs or durable medical equipment. The rule mitigates the negative impact from the reduction in the Medicaid fee schedule effective July 1, 2008, by setting the fee schedule at Average Wholesale Price (AWP) minus twelve percent for brand name prescription drugs and AWP minus twenty percent for generic prescription drugs. In addition, the Medicaid fee schedule did not cover many drugs that are commonly prescribed for workers' compensation claimants. This fee schedule covers all drugs and addresses the potential issue of repackagers who might try to increase reimbursements.

5. Rural area participation:

Comments were received from the Assembly and the Senate, as well as

the Business Council of New York State and the AFL-CIO regarding the impact on rural areas.

Job Impact Statement

The proposed amendment will not have an adverse impact on jobs. This amendment is intended to provide a standard for reimbursement of pharmacy and durable medical equipment bills.