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

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

h. An agents and brokers trade organization inquired if an insurer may increase the premium on a six month policy at each policy renewal. However, article 23 of the Insurance Law requires an insurer to use the rates in effect upon renewal of each policy, regardless of the rate filing system used to make the rate filing (i.e., regardless of whether the filing was made as file and use or in accordance with prior approval). Thus, the Department made no changes to the regulation in response to this comment.

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

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

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

Regulatory Flexibility Analysis

1. Small businesses:

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

2. Local governments:

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

Rural Area Flexibility Analysis

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

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

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

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

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

Job Impact Statement

The Insurance Department finds that this rule will have no adverse impact on jobs and employment opportunities. It merely implements section 2350 of the Insurance Law, which directs the superintendent to establish standards for flexible rating systems providing nonbusiness automobile insurance policies. The number of insurance company personnel necessary to submit a flexible rating filing should be no different than submitting a rate filing under the prior law.

Office of Medicaid Inspector General

NOTICE OF ADOPTION

Compliance Programs for Medical Assistance Provider

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

Filing No. 655

Filing Date: 2009-06-09

Effective Date: 2009-07-01

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

Action taken: Addition of Part 521 to Title 18 NYCRR.

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

Subject: Compliance programs for medical assistance providers.

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

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

PART 521

PROVIDER COMPLIANCE PROGRAMS

§ 521.1 General requirements and scope.

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

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

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

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

§ 521.2 Definitions.

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

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

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

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

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

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

§ 521.3 Compliance Program Required Provider Duties.

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

(1) billings;

(2) payments;

(3) medical necessity and quality of care;

(4) governance;

(5) mandatory reporting;

(6) credentialing; and

(7) other risk areas that are or should with due diligence be identified by the provider.

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

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

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

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

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

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

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

(i) failing to report suspected problems;

(ii) participating in non-compliant behavior; or

(iii) encouraging, directing, facilitating or permitting either actively or passively non-compliant behavior;

such disciplinary policies shall be fairly and firmly enforced;

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

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

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

§ 521.4 Determination of Adequacy of Compliance Program.

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

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

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

Final rule as compared with last published rule: Nonsubstantive changes were made in sections 521.1, 521.2(b) and 521.3.

Text of rule and any required statements and analyses may be obtained from: Erin C. Morigerato, Esq., Office of the Medicaid Inspector General, 800 N. Pearl Street, Albany, New York 12204, (518) 408-0508, email: ecm03@omig.state.ny.us

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

Changes made to the last published rule do not necessitate revision to the RIS, RFA, RAFA or JIS because they were non-substantial changes made for the purposes of clarity and consistency of the text of the regulation and do not require any changes to the RIS, RFA, RAFA, or JIS.

Assessment of Public Comment

The Office of the Medicaid Inspector General (OMIG) received 11 comments from providers, state agencies, health plans, advocacy

groups and other individuals in response to the January 14, 2009 proposed rulemaking. While some commenters expressed interest in supporting and working with the OMIG to implement provider compliance requirements pursuant to N.Y. Social Service Law 363-d, generally, other commenters expressed concerns related to various aspects of the proposed regulation for a variety of reasons.

After reviewing the comments received, the OMIG determined that nonsubstantive technical revisions to the text were necessary for purposes of clarity and consistency. Nonsubstantive technical revisions were made in sections 521.1, 521.2 (b), and 521.3. There are no changes to the Regulatory Impact Statement, Regulatory Flexibility Analysis for Small Businesses and Local Governments, Rural Area Flexibility Analysis and Job Impact Statement which were previously submitted. Accordingly, the OMIG concludes that there are no issues which would impede the adoption of the regulation.

The comments have been summarized and the response to each comment appears below.

Comment:

The OMIG received comments suggesting technical changes to the text of the proposed regulation for purposes of clarity and consistency.

Response:

After considering those comments, the OMIG determined that nonsubstantive technical revisions to the text are necessary for purposes of clarity and consistency. Specifically, nonsubstantive technical changes were made in sections 521.1, 521.2 (b), and 521.3.

Comment:

Many commenters requested clarification on the applicability of the proposed regulation (i.e. which providers are required to comply).

Response:

Pursuant to N. Y. Social Services Law (SSL) § 363-d, those providers subject to this proposed regulation are: providers subject to Articles 28 and 36 of the N. Y. Public Health Law; Articles 16 and 31 of the N.Y. Mental Hygiene Law; and providers who provide care, services or supplies under the medical assistance (Medicaid) program for which the Medicaid program is a ''substantial portion'' of their business operations.

This regulation simply mirrors the statutory language and in addition, defines ''substantial portion'' by establishing a five hundred thousand dollars ($500,000.00) threshold, calculated over any consecutive twelve month period, for previous, current or reasonably anticipated Medicaid claims or orders, direct or indirect receipts of Medicaid funds, or previous or current submissions of Medicaid claims on behalf of other parties. For purposes of determining whether a provider is subject to this rulemaking under Part 521.2 (b), amounts of Medicaid funds actually claimed, ordered, submitted or received in a fiscal year or reasonably expected to be claimed, ordered, submitted or received in a fiscal year should be counted when calculating the $500,000.00 threshold.

Comment:

One commenter suggested that the proposed regulation does not apply to most Early Intervention service providers because such providers do not meet the requirements set forth in Part 521.1 even though Medicaid pays for a significant portion of the services they provide. The commenter indicated that Early Intervention service providers do not provide ''care, services or supplies under the medical assistance program.'' The commenter further indicated that Early Intervention service providers are not subject to the proposed regulation because the municipality where the child resides is deemed the provider of such services pursuant to Public Health Law s 2559(3)(a). Additionally, the commenter noted that few Early Intervention service providers reach the $500,000.00 threshold established in Part 521.2(b).

Response:

Early Intervention service providers will be subject to the proposed regulation if they meet the requirements set forth in Parts 521.1(c) and 521.2(b). The OMIG disagrees with commenter's suggestion that these providers are exempt from the proposed regulation because they do not provide care, services or supplies to enrollees; while they are not enrolled in Medicaid, they provide services under the Medicaid program.

Comment:

We received comments from a state agency requesting clarification as to whether the proposed regulation applies to providers who do not meet the requirements set forth in Part 521.1(b) but are nonetheless subject to Article 16 of the N. Y. Mental Hygiene Law pursuant to provider agreements.

Response:

SSL 363-d mandates that providers subject to Article 16 of the N. Y. Mental Hygiene Law to implement a compliance program. SSL 363-d does not provide any exceptions to this requirement. The proposed regulation simply mirrors the text of the underlying statute.

Comment:

Some commenters requested clarification on whether the proposed regulation will apply to managed care organizations. One commenter suggested that managed care organizations should be exempt from the proposed regulation because they do not provide care, services or supplies to enrollees.

Response:

Managed care organizations that meet the regulatory requirements set forth in Parts 521.1 and 521.2 will be subject to the proposed regulation. The OMIG disagrees with commenter's suggestion that managed care organizations should be exempt from the proposed regulation. Managed care organizations certified under Article 44 of the New York State Public Health Law (PHL) who provide comprehensive health services under the medical assistance program to enrollees are directly compensated through a monthly capitation payment for each enrollee and provided supplemental capitation payments as described in the NYS Medicaid Managed Care and Family Health Plus Model Contract.

Comment:

Several commenters expressed concern with the inclusion of risk areas in the proposed regulation that traditionally have not been part of a compliance program and requested clarification on why the OMIG chose to incorporate certain risk areas in the proposed language of Parts 521.3(a) and 521.3(c)(6). Another commenter suggested that if an organization has structures in place to address additional risk areas and ensures effective communication between those responsible for the compliance program and the additional risk areas, the organization would ''satisfactorily meet the OMIG's requirements and thus, the additional risk areas need not be formally moved into the compliance domain''.

Response:

The OMIG has identified special areas of concern or risk areas in addition to billings to and payments from the Medicaid program as required by SSL 363-d. These include, but are not limited to, medical necessity and quality of care, governance, mandatory reporting and credentialing. The OMIG believes that these risk areas should be incorporated into an effective compliance program based upon reviews of audits and investigations. In addition, the OMIG recommends that providers incorporate into their compliance program other risk areas that are or should with due diligence be identified within the provider's organization. The OMIG disagrees with those commenters who asserted that these additional risk areas need not be specifically identified in a compliance program. The Legislature in creating SSL 363-d found that Medicaid providers may be able to detect and correct payment and billing mistakes and fraud if required to develop and implement compliance programs. The Legislature also found that the purpose of a compliance program is to organize provider resources to resolve payment discrepancies and detect inaccurate billings, ''among other things'', as quickly and efficiently as possible, and to impose systematic checks and balances to prevent future reoccurrences. The statute further provides that a compliance program shall at a minimum be applicable to billings to and payments from the Medicaid program but ''need not be confined to such matters.''

Comment:

One commenter requested clarification regarding the OMIG's issuance of provider specific compliance guidance. Another commenter seemed to be under the misconception that managed care organizations will be subject to a ''separate and distinct'' compliance directive from the OMIG.

Response:

SSL 363-d requires the OMIG to create and make available on its website guidelines, which reflect the requirements of the statute. The OMIG will be issuing provider specific compliance program guidance that will include recommendations and guidance on how specific segments of the provider industry can implement compliance programs. This compliance program guidance will be made available on the OMIG's internet website. While this proposed regulation mirrors the statutory requirements in SSL 363-d which requires certain providers to establish a compliance program, the OMIG's compliance program guidance is intended to provide assistance to providers in developing and implementing compliance programs.

Comment:

Specific questions were posed by a number of commenters relating to the eight elements required to be incorporated into a provider's compliance program pursuant to SSL 363-d.

Response:

The OMIG declines to further regulate the eight elements required by SSL 363-d to be included into a provider's compliance program. The text of the proposed regulation mirrors the elements required by SSL 363-d with some additions. Section 521.3(a) and 521.3(c)(6) include language requiring providers to include certain risk areas into their compliance program. Section 521.3(c)(2) adds that the entity's other senior administrator shall be designated by the entity's chief executive for purposes of direct reporting by the designated employee or compliance officer. Finally, Section 521.3(c)(5)(ii) clarifies that sanctions may be imposed for active or passive non-compliant behavior.

We believe the specific questions posed by commenters relating to the eight elements required to be incorporated into a provider's compliance program pursuant to SSL 363-d are more appropriately addressed in the provider specific compliance guidance. The OMIG has been and continues to work closely with specific segments of the provider community to develop industry specific provider compliance guidance to allow flexibility for a provider to develop a program appropriate to its characteristics.

Comment:

Some commenters requested clarification on the annual certification requirement.

Response:

SSL 363-d requires that a provider shall certify that the provider satisfactorily meets the requirements of the statute upon enrollment in the Medicaid program. This language mirrors the statutory requirements and in addition further requires providers to certify that they satisfactorily meet the requirements of the statute on an annual basis every December thereafter. Participating providers currently enrolled in the Medicaid program will be required to certify that they satisfactorily meet the requirements of the statute every December after the effective date of this regulation. Providers who apply for enrollment into the Medicaid program will be required to certify that they satisfactorily meet the requirements of the statute upon enrollment and every December after the effective date of this regulation. The OMIG is currently developing a certification form that will allow providers to certify that they have a compliance program that meets the statutory and regulatory requirements in place. The certification form and accompanying directions will be made available on the OMIG's internet website.

Comment:

One commenter suggested that there may be an administrative burden associated with the annual certification process. The commenter stated that for some health care providers, annual certification may require ''extensive legal research and analysis because of the potential for complicated legal implications.'' The commenter asserts that the burden associated with annual certification is disproportionate to its utility.

Response:

The OMIG does not believe that the annual certification process will require the ''extensive, legal research and analysis'' as the commenter suggests. Annual certification will enable the OMIG to determine whether existing providers participating in the Medicaid program have met the requirements of the statute and this regulation. The goal of annual certification is to ensure that providers participating in the Medicaid program have effective compliance programs in place that satisfactorily meets the requirements of the underlying statute.

Comment:

Some commenters requested clarification on the OMIG's determination of an ''effective'' compliance program.

Response:

In creating SSL 363-d, the Legislature recognized that in order for a compliance program to be effective it must be designed to be compatible with the provider's characteristics. SSL 363-d(1) requires providers to adopt effective compliance program elements, and to implement such a program appropriate to its characteristics. In addition, SSL 363-d(3) gives the Commissioner of the Department of Health and the Medicaid Inspector General the authority to determine at any time if a provider has a compliance program that satisfactorily meets the requirements of the statute. SSL 363-d(3)(b) provides that in the event that the Commissioner of Health or the Medicaid Inspector General finds that the provider does not have a satisfactory program within ninety days after the effective date of this regulation, the provider may be subject to any sanctions or penalties permitted by federal or state laws and regulations, including revocation of the provider's agreement to participate in the medical assistance program. The proposed regulation mirrors the language in the underlying statute.

Comment:

Some commenters requested clarification regarding the OMIG's acceptance of a federal compliance program that satisfactorily meets the requirements of SSL 363-d.

Response:

The proposed regulation mirrors the statutory language in SSL 363-d which mandates that if a provider's compliance program is accepted by the Federal Department of Health and Human Services Office of the Inspector General (OIG) and remains in compliance with the standards promulgated by such office, the provider's compliance program shall be deemed in compliance with the provisions of SSL 363-d, so long as such program adequately addresses medical assistance program risk areas and compliance. At the present time the OIG does not ''accept'' provider compliance programs as a general rule unless the provider has entered into a Corporate Integrity Agreement (CIA) with the OIG. If there is no existing CIA, providers have the option of voluntarily adopting a compliance program and the OIG has issued several industry specific compliance program guidance documents to help providers to establish such programs.

Thus, the OMIG intends to collaborate with the OIG to determine whether a compliance program required by a CIA is in compliance with the provisions of SSL 363-d for the small number of New York providers who are currently subject to a CIA with the OIG. The OMIG also intends to collaborate with the OIG if the possibility of federally accepted compliance programs arise in the future. The OMIG recognizes that a compliance program may be a part of more comprehensive compliance activities so long as the minimum requirements of the statute are met.

Comment:

Some commenters requested clarification on the effective date and time frame for implementation of the proposed regulation. Some commenters suggested that 90 days from the effective date of the proposed regulation as mandated by SSL 363-d is inadequate to make meaningful changes to an effective compliance program.

Response:

SSL 363-d mandates that providers who do not have a satisfactory program within 90 days after the effective date of this regulation may be subject to sanctions or penalties permitted by federal and state laws and regulations, including revocation of the provider's agreement to participate in the medical assistance program. In response to commenters' concerns regarding the time frame for implementing a compliance program, the OMIG will establish an effective date for the proposed regulation as July 1, 2009. Thus, this proposed regulation will be effective on July 1, 2009 and providers subject to the regula-

tion will be required to have a compliance program in place within 90 days of such date.

Comment:

One commenter suggested that upon OMIG's finding that a provider does not have a satisfactory compliance program in place, the OMIG should give the provider a limited period of time to submit a satisfactory compliance program for consideration prior to the imposition of sanctions or penalties.

Response:

We believe that such concerns are matters of OMIG policy and need not be specifically provided for in the text of the proposed regulation. We appreciate commenter's suggestion and will take such suggestion under consideration when developing internal policies and procedures with regard to enforcement of the proposed regulation.

Comment:

A number of commenters raised concerns regarding the fiscal impact on providers required to implement a compliance program.

Response:

The requirement that certain medical assistance providers prepare and adopt compliance programs is established by statute in SSL 363-d (2). Any costs that may be incurred by these providers would be a direct result of that statute and not this rulemaking. In creating SSL 363-d, the Legislature recognized that there are a wide variety of provider types participating in the Medicaid program and for a compliance program to be effective it must be designed to be compatible to reflect a provider's size, complexity, resources and culture. The costs incurred by regulated parties in order to comply with the proposed regulation will vary depending upon any existing compliance measures the provider has in place at the time the regulation takes effect. For those providers who already have an operating compliance program, potentially little or no costs may be incurred in order to establish a compliance program that satisfies the proposed regulation. However, for those providers who do not have a program in place that meets the requirements set forth in this proposed regulation and the underlying governing statute, some costs will be incurred in order to establish a compliance program. The extent of those costs will depend on the size and other attributes of the provider as well as the level of effort that is necessary for the provider to establish a compliance program that satisfies each of the eight mandatory elements.

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

Thus, the OMIG tried to anticipate and address all circumstances regarding the costs and burdens associated with mandatory compliance programs. We believe we have created a set of requirements that appropriately meets the statutory provisions of SSL 363-d while at the same time provides the flexibility for providers to adopt an effective compliance program appropriate to its characteristics.

Department of Motor Vehicles

NOTICE OF ADOPTION

Traffic Violations Bureau Fines

I.D. No. MTV-16-09-00006-A
Filing No. 656
Filing Date: 2009-06-09
Effective Date: 2009-07-06

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

Action taken: Amendment of section 123.4 of Title 15 NYCRR.

Statutory authority: Vehicle and Traffic Law, sections 215(a), 225(3) and 226(1)(b)

Subject: Traffic Violations Bureau fines.

Purpose: To revise Traffic Violations Bureau fines for guilty pleas by mail.

Text of final rule: 123.4 Fine schedule for guilty plea. (a) When a motorist pleads guilty by mail or in person at a bureau hearing office, he or she is required to pay the appropriate fine as follows:

(1) $75 for a first red light violation *where such violation occurred on or after May 15, 2003, except that such fine shall be $95 where such violation occurred on or after July 6, 2009; provided, however,* such fine shall be $150 in the City of New York where such violation occurred on or after May 15, 2003[;]*, except that such fine shall be $190 in the City of New York where such violation occurred on or after July 6, 2009*;

(2) $150 for a second red light violation committed within a period of 18 months *where such violation occurred on or after May 15, 2003,* except that *such fine shall be $190 where such violation occurred on or after July 6, 2009; provided, however,* such fine shall be $300 in the City of New York where such violation occurred on or after May 15, 2003[;]*, except that such fine shall be $375 in the City of New York where such violation occurred on or after July 6, 2009*;

(3) $375 for a third red light violation committed within a period of 18 months, *where such violation occurred on or after May 15, 2003,* except that *such fine shall be $470 where such violation occurred on or after July 6, 2009; provided, however,* such fine shall be $750 in the City of New York where such violation occurred on or after May 15, 2003[;]*, except that such fine shall be $940 in the City of New York where such violation occurred on or after July 6, 2009*;

(4) [$45] *$60* for all speed offenses where the charge is driving 10 miles per hour or less above the speed limit;

(5) [$90] *$115* for all speeding offenses where the charge is driving at least 11 miles per hour but not more than 30 miles per hour above the speed limit;

(6) [$50] *$65* for operating an uninspected vehicle, unless the violation is based upon a certificate of inspection which has been expired for 60 days or less, in which case the fine shall be [$25] *$35*;

(7) [$30] *$40* for any equipment violation;

(8) [$75] *$95* for operating an unregistered vehicle, or for unlicensed operation, unless the violation is based upon a registration or license which has been expired for 60 days or less, in which case the fine shall be $40; or

(9) [$40] *$50* for any other traffic infraction, except where otherwise specified by statue.

Final rule as compared with last published rule: Nonsubstantive changes were made in section 123.4(a)(1), (2) and (3).

Text of rule and any required statements and analyses may be obtained from: Heidi A. Bazicki, Department of Motor Vehicles, 6 Empire State Plaza, Rm. 526, Albany, NY 12228, (518) 474-0871, email: heidi.bazicki@dmv.state.ny.us

Revised Regulatory Impact Statement

1. Statutory authority: Vehicle and Traffic Law (VTL) Section 215(a) provides that the Commissioner of Motor Vehicles may enact rules and regulations that regulate and control the exercise of the powers of the Department. Section 225(1) of the VTL provides that the Commissioner may promulgate such regulations as are necessary to effectuate the purposes of Article 2-A of the VTL. Section 225(3) of the VTL provides that the Commissioner may establish a schedule of penalties for violations of the VTL and that such schedule shall be printed on the summons that is issued to the motorist. The motorist may plead guilty, by mail or in person, and pay the fine set forth in such schedule.

2. Legislative objectives: Chapter 1074 of the Laws of 1969 created