

# Public Health and Health Planning Council

## *Codes, Regulations and Legislation Committee Meeting Agenda and Informational Announcements*

*Thursday, August 8, 2019  
9:15 AM*

*Location: 90 Church Street 4<sup>th</sup> Floor, Room 4A & 4B, New York City*

### **A. Agenda**

#### **For Adoption**

Amendment of Sections 415.2 and 415.3 of Title 10 NYCRR – Residents’ Rights

#### **Program Area**

Office of Primary  
Care and Health  
Systems Management

#### **Unit Representative**

Laura Palmer

#### **For Information**

Amendment of Sections 405.7 and 751.9 of Title 10 NYCRR – Patients’ Bill of Rights

#### **Program Area**

Office of Primary  
Care and Health  
Systems Management

#### **Unit Representative**

Deirdre Astin

Amendment of Sections 405.5 and 405.19 of Title 10 NYCRR – Registered Nurses in the Emergency Department

Office of Primary  
Care and Health  
Systems Management

Deirdre Astin

Amendment of Subpart 5-1 of Title 10 NYCRR – Maximum Contaminant Levels

Center for  
Environmental Health

Kristine Wheeler

### **B. Information Announcements**

1. Anyone wishing to make oral comments at this meeting should contact the Bureau of Policy and Standards Development by 11:00 A.M. on Wednesday, August 7, at (212) 417-6218 to arrange for placement on the speakers’ list. Please give your name, affiliation, if any and the agenda item(s) you wish to address. To ensure that all commenters have an opportunity to address the Committee, speakers should limit their comments to 3-4 minutes maximum.
2. All meeting attendees including Committee members are requested to sign the Attendance Sheet, which will be circulated in the meeting room.

Pursuant to the authority vested in the Public Health and Health Planning Council and subject to approval by the Commissioner of Health by Sections 2800 and 2803-c of the Public Health Law, Sections 415.2 and 415.3 of Title 10 (Health) of the Official Compilation of Codes, Rules and Regulations of the State of New York are amended to be effective upon publication of a Notice of Adoption in the New York State Register to read as follows:

Section 415.2 is amended to add a new subdivision (v) to read as follows:

(v) Local Contact Agency shall mean an agency designated by the Department to accept referrals of nursing home residents that wish to receive information about services in the community. Local Contact Agencies shall contact referred nursing home residents and provide them with information and counseling on available home- and community-based services. Local Contact Agencies shall also either assist residents directly with transition services or refer residents to organizations that assist with transition services, as appropriate.

Section 415.3(a) is amended to read as follows:

(a) The facility shall ensure that all residents are afforded their rights to a dignified existence, self-determination, respect, full recognition of their individuality, consideration and privacy in treatment and care for personal needs, and communication with and access to persons and services inside and outside the facility. The facility shall protect and

promote the rights of each resident, and shall encourage and assist each resident in the fullest extent possible exercise of these rights as set forth in subdivisions (b) – [(h)] (i) of this section. The facility shall also consult with the residents in establishing and implementing facility policies regarding residents’ rights and responsibilities.

(1) The facility shall advise each member of the staff of his or her responsibility to understand, protect and promote the rights of each resident as enumerated in this section.

(2) The facility shall fully inform the resident and the resident’s designated representative both orally and in writing in a method of communication that the individuals understand the resident’s rights and all rules and regulation governing resident conduct and responsibilities during the stay in the facility. Such notification shall be made prior to or upon admission and during the resident’s stay. Receipt of such information, and any amendments to it, shall be acknowledged in writing. A summary of such information shall be provided by the Department and posted in the facility in large print and in language that is easily understood.

(3) The written information provided pursuant to paragraph (2) of this subdivision shall include but not be limited to a listing of those resident rights and facility responsibilities enumerated in subdivisions (b) through [(h)] (i) of this section. The facility’s policies and procedures shall also be provided to the resident and the resident’s designated representative upon request.

(4) The facility shall communicate to the resident an explanation of his or her responsibility to obey all reasonable regulations of the facility and to respect the personal rights and private property of other residents.

(5) Any written information required by this Part to be posted shall be posted conspicuously in a public place in the facility that is frequented by residents and visitors, posted at wheelchair height.

Subdivisions (c) and (d) of section 415.3 of Title 10 of the NYCRR are re-lettered (d)-(e) and a new subdivision (c) is added to read as follows:

(c) Right to Information on Home and Community-Based Services. The nursing home shall ensure that all residents are provided with information on home and community-based services and community transitions programs that may be available to support the resident in returning to the community. To ensure that all residents are afforded the right to exercise their right to live in the most integrated setting, the facility shall:

(1) advise all residents upon admission, of their right to live in the most integrated and least restrictive setting, with considerations for the resident's medical, physical, and psychosocial needs;

(2) provide all residents upon admission with information on home and community-based services and community transition programs;

(3) refer all residents to the Local Contact Agency or a community-based provider of the resident or designated representative's choosing whenever the resident requests information about returning to the community, or whenever the resident requests to talk to someone about returning to the community during any state or federally mandated assessment;

(4) post in a public area of the facility, at wheelchair height, contact information for the Local Contact Agency;

(5) have staff available to discuss options for discharge planning, with consideration for the resident's medical, physical, and psychosocial needs; and

(6) ensure that all discharge activities align with subdivision (i) of this section.

Subdivision (e) of section 415.3 is re-lettered (f) and amended to read as follows:

[(e)] (f) Right to Clinical Care and Treatment. (1) Each resident shall have the right to:

(i) adequate and appropriate medical care, and to be fully informed by a physician in a language or in a form that the resident can understand, using an interpreter when necessary, of his or her total health status, including but not limited to, his or her medical condition including diagnosis, prognosis and treatment plan. Residents shall have the right to ask questions and have them answered;

(ii) refuse to participate in experimental research and to refuse medication and treatment after being fully informed and understanding the probable consequences of such actions;

(iii) choose a personal attending physician from among those who agree to abide by all federal and state regulation and who are permitted to practice in the facility;

(iv) be fully informed in advanced about care and treatment and of any changes in that care of treatment that may affect the resident's well-being;

(v) participate in planning care and treatment or changes in care and treatment. Residents adjudged incompetent or otherwise found to be incapacitated under the laws of the State

of New York shall have such rights exercised by a designated representative who will act in their behalf in accordance with State law;

(vi) self-administer drugs of the interdisciplinary team, as defined by Section 415.11, has determined for each resident that this practice is safe.

(2) With respect to its responsibilities to the resident, the facility shall:

(i) inform each resident of the name, office address, phone numbers and specialty of the physician responsible for his or her own care.

(ii) except in a medical emergency, consult with the resident immediately if the resident is competent, and notify the resident's physician and designated representative within 24 hours when there is:

(a) an accident involving the resident which results in injury requiring professional intervention;

(b) a significant improvement or decline in the resident's physical, mental, or psychosocial status in accordance with generally accepted standards of care and services;

(c) a need to alter treatment significantly; or

(d) a decision to transfer or discharge the resident from the facility as specified in subdivision [(h)] (i) of this section; and

(iii) provide all information a resident or the resident's designated representative when permitted by State law, may need to give informed consent for an order not to resuscitate and comply with the provisions of section 405.53 if this Subchapter regarding orders not to resuscitate. Upon resident request the facility shall furnish a copy of the pamphlet, "Do Not Resuscitate Orders – A Guide for Patients and Families".

Subdivisions (f)-(h) of section 415.3 are re-lettered (g)-(i).

## **REGULATORY IMPACT STATEMENT**

### **Statutory Authority:**

Section 2800 of Article 28 of the Public Health Law provides that the Department of Health (Department) has the central and comprehensive responsibility for the development and administration of the State's policies with respect to hospital and residential health care facilities, including nursing homes, in order to provide for the protection and promotion of the health of the inhabitants of the state.

Section 2803-c of Article 28 of the Public Health Law provides, in part, that the Commissioner shall require every nursing home and facility providing health related services to adopt and make public a statement of the rights and responsibilities of the patients who are receiving care in such facilities. Section 2003-c sets forth the minimum content of such a statement and requires that each facility provide a copy of the statement to each patient prior to, or at, the time of admission to the facility.

### **Legislative Objectives:**

The proposed rule accords with the legislative objectives of PHL §§ 2800 and 2803-c, which are to protect and promote the health and rights of all nursing home residents, and to ensure that nursing home residents are made aware of their rights prior to, or at, their admission to such a facility.

**Needs and Benefits:**

This rule furthers the Department's efforts to promote the right of all nursing home residents to live in the most integrated setting possible.

In 1999, the United States Supreme Court, in *Olmstead v. L. C. by Zimring*, 527 U.S. 581 (1999), ruled that the segregation of individuals with disabilities violated title II of the Americans with Disabilities Act (ADA). The Court ruled that individuals with disabilities must be provided services through community-based organizations when (1) such services are appropriate; (2) the affected persons do not oppose community-based treatment; and (3) community-based services can be reasonably accommodated.

Since the *Olmstead* decision, the Department has sought to ensure that individuals are afforded the right to live in the most integrated setting possible. The Department currently oversees and operates the federally funded Money Follows the Person program, which provides transition assistance and support to those residents of nursing homes that express a desire to return to the community. Residents are asked on at least a quarterly basis if they wish to receive information about returning to the community. Any resident that answers affirmatively is to be referred to the Local Contact Agency and connected with a Transition Specialist who will assist them with transitioning to community living, as appropriate.

To further the State's efforts to encourage and facilitate community-based living for individuals with disabilities, Governor Andrew M. Cuomo released his Able New York agenda, a multi-agency initiative aimed at enhancing accessibility to state programs and services for New Yorkers with disabilities. This proposal is part of a series of actions to support the Able New York agenda and promote community living for New Yorkers.

**Costs:**

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

There will be little to no additional cost to regulated entities for the implementation of or continuing compliance with the regulation. Currently, nursing homes are required to provide a statement of residents' rights to the resident and their designated representative prior to or upon admission. This proposed regulation will require nursing homes to replace their existing resident rights materials with an amended version, requiring some cost for the printing of the materials. Nursing homes will also be required to replace their existing signage with new signage that includes the amended residents' rights.

**Costs to State and Local Governments:**

The proposed changes are not expected to impose any costs upon State or local governments, unless they operate a nursing home. In such cases, the impact will be the same as for regulated entities, discussed above.

**Costs to the Department of Health:**

The Department owns and operates five veterans' homes. The impact on these facilities will be the same as for regulated entities, discussed above.

**Local Government Mandates:**

The proposed regulations do not impose any new mandates on local governments, except where they operate nursing homes. In such cases, the impact will be the same as for regulated parties, discussed above.

**Paperwork:**

All nursing homes will be expected to replace their residents' rights signage and replace their residents' rights materials as soon as they are available from the Department. Nursing homes may be subject to review upon annual survey to ensure compliance with the rule.

**Duplication:**

This rule does not duplicate, overlap, or conflict with any other legal requirements of the state or federal government. This rule aligns with the federal resident rights guidelines outlines in Section 483.10 of Title 42 (Health) of Code of Federal Regulations.

**Alternatives:**

Alternatives considered included issuing a mandate requiring nursing facilities to provide information to all residents on the availability of home and community-based services. This alternative was not chosen as the issuance of a mandate would be duplicative of what is already required of nursing facilities. The amendment language proposed provides additional clarity to the type of information to be provided to nursing facility residents upon admission and builds upon the requirement of nursing facilities to

ensure that residents are made aware of their rights prior to, or at, their admission to a nursing facility.

**Federal Standards:**

This rule meets the minimum standards set forth in Section 483.10 of Title 42 (Health) of Code of Federal Regulations.

**Compliance Schedule:**

This regulation will be effective upon publication of a Notice of Adoption in the New York State Register.

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**STATEMENT IN LIEU OF  
REGULATORY FLEXIBILITY ANALYSIS**

No regulatory flexibility analysis is required pursuant to section 202-(b)(3)(a) of the State Administrative Procedure Act. The proposed amendment does not impose an adverse economic impact on small businesses or local governments, and it does not impose reporting, record keeping or other compliance requirements on small businesses or local governments.

**STATEMENT IN LIEU OF  
RURAL AREA FLEXIBILITY ANALYSIS**

A Rural Area Flexibility Analysis for these amendments is not being submitted because amendments will not impose any adverse impact or significant reporting, record keeping or other compliance requirements on public or private entities in rural areas.

There are no professional services, capital, or other compliance costs imposed on public or private entities in rural areas as a result of the proposed amendments.

**STATEMENT IN LIEU OF  
JOB IMPACT STATEMENT**

A Job Impact Statement for these amendments is not being submitted because it is apparent from the nature and purposes of the amendments that they will not have a substantial adverse impact on jobs and/or employment opportunities.

Pursuant to the authority vested in the Public Health and Health Planning Council and Commissioner of Health by section 2803 of the Public Health Law, sections 405.7 and 751.9 of Title 10 of the Official Compilation of Codes, Rules and Regulations of the State of New York (NYCRR) are hereby amended, to be effective upon publication of a Notice of Adoption in the New York State Register:

Paragraph (10) of subdivision (c) of section 405.7 of Title 10 is amended to read as follows:

(10) Receive all the information you need to give informed consent for an order not to resuscitate. You also have the right to designate an individual to give this consent for you if you are too ill to do so. If you would like additional information, please ask for a copy of the pamphlet “[Do Not Resuscitate Orders] Deciding About Health Care - A Guide for Patients and Families.”

Subdivision (l) of section 751.9 is amended to read as follows:

(l) express complaints about the care and services provided and to have the center investigate such complaints. The center is responsible for providing the patient or his/her designee with a written response within 30 days if requested by the patient indicating the findings of the investigation. The center is also responsible for notifying the patient or his/her designee that if the patient is not satisfied by the center response, the patient may complain to the New York State Department of [Health’s Office of Health Systems Management] Health;

Subdivisions (p) and (q) of section 751.9 are amended, and new subdivisions (r) and (s) are added to read as follows:

(p) authorize those family members and other adults who will be given priority to visit consistent with your ability to receive visitors; [and]

(q) when applicable, make known your wishes in regard to anatomical gifts. Persons sixteen years of age or older may document their consent to donate their organs, eyes and/or tissues, upon their death, by enrolling in the NYS Donate Life Registry or by documenting their authorization for organ and/or tissue donation in writing in a number of ways (such as health care proxy, will, donor card, or other signed paper). The health care proxy is available from the center[.];

(r) view a list of the health plans and the hospitals that the center participates with; and

(s) receive an estimate of the amount that you will be billed after services are rendered.

## **REGULATORY IMPACT STATEMENT**

### **Statutory Authority:**

Public Health Law (PHL) § 2803 authorizes the Public Health and Health Planning Council (PHHPC) to adopt and amend rules and regulations, subject to the approval of the Commissioner of Health (Commissioner), to implement the purposes and provisions of PHL Article 28 and to establish minimum standards governing the operation of health care facilities.

PHL § 24 requires diagnostic and treatment centers (D&TCs) to disclose the health care plans in which they are participating providers and the hospitals with which they are affiliated; and it also requires D&TCs to make available estimates of the amounts patients will be billed.

### **Legislative Objectives:**

The legislative objectives of PHL Article 28 include the protection of the health of the residents of the State by promoting the efficient provision and proper utilization of high quality health services at a reasonable cost.

PHL § 24 is intended to protect D&TC patients against unknowingly receiving care from out-of-network providers, resulting in surprise medical bills.

### **Needs and Benefits:**

Under PHL §24, D&TC patients have the right to receive information regarding the health plans and the hospitals that the center participates with and an estimate of the amount that the patient will be billed after services are rendered. The purpose of this disclosure is to ensure that patients have the information that they need to make decisions about their healthcare and to protect themselves against receiving unexpected bills. This proposed regulation revises the

D&TC Patients' Bill of Rights to inform patients of their rights under PHL §24 by adding new subdivisions (r) and (s) to 10 NYCRR §751.9. The proposed regulation mirrors similar provisions in the Patients' Bill of Rights applicable to general hospitals under 10 NYCRR 405.7.

The proposed amendment to Section 405.7 reflects a change to the Department publication that patients can request to provide them with additional information regarding medical decision-making, resuscitation, health care proxies and other end-of-life decision-making. This information was updated to implement the Family Health Care Decisions Act, effective in 2010. This regulation amendment will bring the regulations into conformance with the current Department publications.

The amendment to Section 751.9(l) deletes a reference to a Department office that has been renamed.

#### **COSTS:**

##### **Costs to Private Regulated Parties:**

This amendment is a clarification of rights that patients already have in New York State. D&TCs will incur minimal costs to change the Patients' Bill of Rights made available to patients. D&TCs may also need to update training materials for staff.

##### **Costs to Local Government:**

This proposal will not impact local governments unless they operate a general hospital or D&TC, in which case the impact would be the same as outlined above for private parties.

**Costs to the Department of Health:**

The proposed regulatory changes will not result in any additional operational costs to the Department of Health, other than to provide for translations of the newly updated Bills of Rights.

**Costs to Other State Agencies:**

The proposed regulatory changes will not result in any additional costs to other state agencies.

**Local Government Mandate:**

The proposed regulations do not impose any new programs, services, duties or responsibilities upon any county, city, town, village, school district, fire district or other special district.

**Paperwork:**

D&TCs are already required to make the Patients' Bill of Rights available to patients. Therefore, the proposed regulations should not increase their paperwork.

**Duplication:**

There are no relevant State regulations which duplicate, overlap or conflict with the proposed regulations.

**Alternatives:**

The alternative would be to take no action, which would result in a lack of consistency

between PHL §24 and the Patients' Bill of Rights.

**Federal Standards:**

The proposed regulations do not duplicate or conflict with any federal regulations.

**Compliance Schedule:**

The regulations will be effective upon publication of a Notice of Adoption in the New York State Register.

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**REGULATORY FLEXIBILITY ANALYSIS  
FOR SMALL BUSINESSES AND LOCAL GOVERNMENTS**

**Effect of Rule:**

The proposed regulation will apply to all diagnostic and treatment centers (D&TCs) in New York State. This proposal will not impact local governments or small business unless they operate a general hospital or D&TC. In such case, the flexibility afforded by the regulations is expected to minimize any costs of compliance as described below.

**Compliance Requirements:**

These regulations will require D&TCs to change their Patients' Bill of Rights.

**Professional Services:**

This proposal will not require any additional use of professional services.

**Compliance Costs:**

Compliance costs are minimal, as they only require editing and reprinting the Patients' Bill of Rights.

**Economic and Technological Feasibility:**

This proposal is economically and technically feasible.

**Minimizing Adverse Impact:**

The anticipated impact of the proposal is minimal. D&TCs are already required to make

the Patients' Bill of Rights available to patients.

**Small Business and Local Government Participation:**

Organizations that include D&TCs as members were consulted on the proposed regulations. Additionally, the proposed regulation will have a 60-day public comment period.

**Cure Period:**

Chapter 524 of the Laws of 2011 requires agencies to include a “cure period” or other opportunity for ameliorative action to prevent the imposition of penalties on a party subject to enforcement when developing a regulation or explain in the Regulatory Flexibility Analysis why one is not included. As this proposed regulation does not create a new penalty or sanction, no cure period is necessary.

## RURAL AREA FLEXIBILITY ANALYSIS

### Types and Estimated Numbers of Rural Areas:

This rule applies uniformly throughout the state, including rural areas. Rural areas are defined as counties with a population less than 200,000 and counties with a population of 200,000 or greater that have towns with population densities of 150 persons or fewer per square mile. The following 43 counties have a population of less than 200,000 based upon the United States Census estimated county populations for 2010 (<http://quickfacts.census.gov>).

Approximately 17% of small health care facilities are located in rural areas.

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

The following counties have a population of 200,000 or greater and towns with population densities of 150 persons or fewer per square mile. Data is based upon the United States Census estimated county populations for 2010.

.Albany County	.Monroe County	.Orange County
.Broome County	.Niagara County	.Saratoga County
.Dutchess County	.Oneida County	.Suffolk County
.Erie County	.Onondaga County	

There are approximately 90 diagnostic and treatment centers (D&TCs) in rural areas.

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

The proposed regulation is applicable to those D&TCs located in rural areas and is expected to impose minimal costs, because regulated facilities are already required to make the Patients' Bill of Rights available to patients. Because the proposed regulatory requirements can be incorporated into existing processes, they are not expected to increase the administrative burden on these entities.

**Costs:**

D&TCs are already required to post the Patients' Bill of Rights in areas that are highly visible to patients. The cost of the small wording change to the Patients' Bill of Rights will be insubstantial.

**Minimizing Adverse Impact:**

The impact is minimal.

**Rural Area Participation:**

Organizations that include as members general hospitals and D&TCs located in rural areas were consulted on the proposed regulations.

**STATEMENT IN LIEU OF JOB IMPACT STATEMENT**

No job impact statement is required pursuant to section 201-a(2)(a) of the State Administrative Procedure Act. No adverse impact on jobs and employment opportunities is expected as a result of these proposed regulations.

Pursuant to the authority vested in the Public Health and Health Planning Council and Commissioner of Health by section 2803 of the Public Health Law, sections 405.5 and 405.19 of Title 10 of the Official Compilation of Codes, Rules and Regulations of the State of New York (NYCRR) are hereby amended, to be effective upon publication of a Notice of Adoption in the New York State Register:

A new paragraph (7) is added to subdivision (a) of section 405.5, to read as follows:

(7) Nursing services personnel employed in specialty areas, including, but not limited to, emergency services, must complete training and education specific to the specialty area. Nursing services personnel must be periodically reevaluated for competency and ongoing education and training provided to maintain competency in the specialty area.

Subparagraphs (ii) and (iii) of paragraph (2) of subdivision (d) of section 405.19 are amended to read as follows:

(ii) Emergency services supervising nurses shall be licensed and currently registered and possess current, comprehensive knowledge and skills in emergency health care. They shall [have at least one year of clinical experience,] be able to demonstrate skills and knowledge necessary to perform basic life support measures, and be current in ACLS and PALS or have current training and experience equivalent to ACLS and PALS, and meet the competency requirements of Section 405.5(a)(7);

(iii) Registered professional nurses in the emergency service shall be licensed and currently registered professional nurses who possess current, comprehensive knowledge and skills in emergency health care. They shall have [at least one year of clinical experience, have] successfully completed an emergency nursing orientation program, [and] be able to demonstrate skills and knowledge necessary to perform basic life support measures and meet the competency requirements of Section 405.5(a)(7). Within one year of assignment to the emergency service, each emergency service nurse shall be current in ACLS and PALS or have current training and experience equivalent to ACLS and PALS [and shall maintain current competence in ACLS as determined by the hospital].

## **REGULATORY IMPACT STATEMENT**

### **Statutory Authority:**

Public Health Law (PHL) § 2803 authorizes the Public Health and Health Planning Council (PHHPC) to adopt and amend rules and regulations, subject to the approval of the Commissioner of Health (Commissioner), to implement the purposes and provisions of PHL Article 28 and to establish minimum standards governing the operation of health care facilities.

### **Legislative Objectives:**

The legislative objectives of PHL Article 28 include the protection of the health of the residents of the State by promoting the efficient provision and proper utilization of high quality health services at a reasonable cost.

The Department of Health, pursuant to former PHL §2807-h(1), has granted hospitals limited waivers of 405.19(d)(2)(iii), allowing them to develop new graduate training programs based on training, education, and competency assessment. This authority expired on July 1, 2017. See L. 2014, Ch. 60, Pt. C, §67-b. Nevertheless, the results of these programs have been very successful. Therefore, removing the need to secure a waiver and allowing a training, education and competency-based program through regulation is sound public policy.

### **Needs and Benefits:**

The nursing shortages that currently exist both nationally and in New York State are expected to increase as both the age of the general population and working nurses increases. Similarly, shortages of nurses that work in high-stress specialty areas, such as critical care and the emergency department, will continue to occur during this nurse shortage and as hospitals

struggle with improving the recruitment and retention rates of new and seasoned nurses.

Recruiting nurses for emergency departments, specifically, is made even more challenging by current requirements, in 10 NYCRR Section 405.19, that all nurses working in emergency departments have one year of clinical experience and possess current, comprehensive knowledge and skills in emergency care. This results in hospitals being unable to recruit new graduates. Often, once these new graduates attain the required year of clinical experience, they are unwilling to transfer to the emergency department, preferring to use their newly gained competencies in the clinical area in which they were trained.

The Department of Health, pursuant to former PHL §2807-h(1), has granted hospitals limited waivers of 405.19(d)(2)(iii), allowing them to develop new graduate training programs based on training, education, and competency assessment. This authority expired on July 1, 2017. See L. 2014, Ch. 60, Pt. C, §67-b. Nevertheless, the results of these programs have been very successful.

The proposed regulations will allow hospitals to keep pace with demand for highly trained, emergency department nurses by allowing hospitals to recruit new graduate nurses to work in the emergency department, following a training, education and competency monitoring program developed and administered by the hospital's nursing education program required by 10 NYCRR Section 405.5. By eliminating the one year requirement, hospitals will be able to recruit new graduates and train them for work specifically in the emergency department. Similar to learning experiences in other parts of the hospital, new graduates would develop their clinical competencies by working alongside experienced staff who would supervise and mentor the new staff. This approach could also be adapted for float nurses who may have one year of experience but in a clinical specialty that does not specifically translate to emergency department

competency.

Patient safety and quality of care will be maintained, despite eliminating this nursing experience requirement, as hospitals will be responsible for developing, implementing and monitoring a training and education program that will allow nurses to obtain required skills while gaining invaluable experience within the emergency department.

## **COSTS:**

### **Costs to Private Regulated Parties:**

This amendment will allow general hospitals to expand their current nurse training programs to include curriculum for emergency department new graduates. Health care facilities will incur minimal costs in order to implement these programs.

### **Costs to Local Government:**

This proposal will not impact local governments unless they operate a general hospital, in which case costs will be the same as costs for private entities.

### **Costs to the Department of Health:**

The proposed regulatory changes will not result in any additional operational costs to the Department of Health.

### **Costs to Other State Agencies:**

The proposed regulatory changes will not result in any additional costs to other state agencies.

**Local Government Mandate:**

The proposed regulations do not impose any new programs, services, duties or responsibilities upon any county, city, town, village, school district, fire district or other special district.

**Paperwork:**

General hospitals will be required to develop, implement and monitor nurse training programs for the emergency department, as they are currently required to do for other parts of the hospital. The regulation may initially increase paperwork as programs are in development, but overall the impact should be minimal.

**Duplication:**

There are no relevant State regulations which duplicate, overlap or conflict with the proposed regulations.

**Alternatives:**

The alternative would be to take no action, which represents no change in current requirements for general hospitals. However, the barrier to recruiting newly graduated nurses in emergency departments would still exist, making it increasingly difficult for hospitals to address their staffing shortages.

**Federal Standards:**

The proposed regulations do not duplicate or conflict with any federal regulations.

**Compliance Schedule:**

The regulations will be effective upon publication of a Notice of Adoption in the New York State Register.

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## **REGULATORY FLEXIBILITY ANALYSIS FOR SMALL BUSINESSES AND LOCAL GOVERNMENTS**

### **Effect of Rule:**

The proposed regulation will apply to all general hospitals with emergency departments in New York State. This proposal will not impact local governments or small business unless they operate a general hospital. In such cases, the flexibility afforded by the regulations is expected to minimize any costs of compliance as described below.

### **Compliance Requirements:**

These regulations will require general hospitals to develop, implement and monitor training programs for emergency department nurses. This requirement expands requirements for nursing training and education that currently exist in Section 405.5.

### **Professional Services:**

General hospitals are already required to have nursing training programs; however, this amendment will make the programs available to new graduate nurses who are interested in emergency nursing.

### **Compliance Costs:**

Compliance costs are minimal, as they build upon existing requirements for nursing training and education found in Section 405.5.

**Economic and Technological Feasibility:**

This proposal is economically and technically feasible.

**Minimizing Adverse Impact:**

The anticipated adverse impact of the proposal is minimal. General hospitals, through their training programs, will ensure patient safety while new graduates are gaining competency and skill.

**Small Business and Local Government Participation:**

Organizations that include general hospitals as members were consulted on the proposed regulations. Additionally, the proposed regulation will have a 60-day public comment period.

**Cure Period:**

Chapter 524 of the Laws of 2011 requires agencies to include a “cure period” or other opportunity for ameliorative action to prevent the imposition of penalties on a party subject to enforcement when developing a regulation or explain in the Regulatory Flexibility Analysis why one is not included. As this proposed regulation does not create a new penalty or sanction, no cure period is necessary.

## RURAL AREA FLEXIBILITY ANALYSIS

### Types and Estimated Numbers of Rural Areas:

This rule applies uniformly throughout the state, including rural areas. Rural areas are defined as counties with a population less than 200,000 and counties with a population of 200,000 or greater that have towns with population densities of 150 persons or fewer per square mile. The following 43 counties have a population of less than 200,000 based upon the United States Census estimated county populations for 2010 (<http://quickfacts.census.gov>).

Approximately 17% of small health care facilities are located in rural areas.

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

The following counties have a population of 200,000 or greater and towns with population densities of 150 persons or fewer per square mile. Data is based upon the United States Census estimated county populations for 2010.

.Albany County	.Monroe County	.Orange County
.Broome County	.Niagara County	.Saratoga County
.Dutchess County	.Oneida County	.Suffolk County
.Erie County	.Onondaga County	

There are 47 general hospitals, approximately 90 diagnostic and treatment centers (D&TCs), 159 nursing homes, and 92 certified home health agencies in rural areas.

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

The proposed regulation is applicable to those general hospitals located in rural areas and is expected to impose minimal costs. Because the proposed regulatory requirements can be incorporated into existing processes, they are expected to minimally increase the administrative burden on these entities.

**Costs:**

General hospitals are already required to have nurse training and education programs. The cost of developing these training programs should be minimal.

**Minimizing Adverse Impact:**

The impact is minimal.

**Rural Area Participation:**

Organizations that include as members general hospitals located in rural areas were consulted on the proposed regulations.

**STATEMENT IN LIEU OF JOB IMPACT STATEMENT**

No job impact statement is required pursuant to section 201-a(2)(a) of the State Administrative Procedure Act. No adverse impact on jobs and employment opportunities is expected as a result of these proposed regulations.

Pursuant to the authority vested in the Public Health and Health Planning Council and the Commissioner of Health by section 225 of the Public Health Law, Subpart 5-1 of Title 10 (Health) of the Official Compilation of Codes, Rules and Regulations of the State of New York is amended, to be effective upon publication of a Notice of Adoption in the New York State Register, to read as follows:

Section 5-1.52, Table 3 is amended to read as follows:

**Table 3. Organic Chemicals Maximum Contaminant Level Determination**

Contaminants	MCL (mg/L)	Type of water system	Determination of MCL violation
General organic chemicals		Community, NTNC and Noncommunity	If the results of a monitoring sample analysis exceed the MCL, the supplier of water shall collect one to three more samples from the same sampling point, as soon as practical, but within 30 days. An MCL violation occurs when at least one of the confirming samples is positive <sup>1</sup> and the average of the initial sample and all confirming samples exceeds the MCL.
Principal organic contaminant (POC)	0.005		
Unspecified organic contaminant (UOC)	0.05		
Total POCs and UOCs	0.1		
Disinfection byproducts <sup>2,3</sup>		Community and NTNC	For systems required to monitor quarterly, the results of all analyses at each monitoring location per quarter shall be arithmetically averaged and shall be reported to the State within 30 days of the public water system's receipt of the analyses. A violation occurs if the average of the four most recent sets of quarterly samples at a particular monitoring location (12-month locational running annual average (LRAA)) exceeds the MCL. If a system collects more than one sample per quarter at a monitoring location, the system shall average all samples taken in the quarter at that location to determine a quarterly average to be used in the LRAA calculation. If a system fails to complete four consecutive quarters of monitoring, compliance with the MCL will be based on an average of the available data from the most recent four quarters. An MCL violation for systems on annual or less frequent monitoring that have been increased to quarterly monitoring as outlined in Table 9A, is determined after four quarterly samples are taken.
Total trihalomethanes	0.080		
Haloacetic acids	0.060		
		Transient noncommunity	Not applicable.

**Table 3. Organic Chemicals Maximum Contaminant Level Determination (continued)**

<b>Contaminants</b>	<b>MCL (mg/L)</b>	<b>Type of Water System</b>	<b>Determination of MCL violation</b>
Specific Organic Chemicals		Community, NTNC and Noncommunity	If the results of a monitoring sample analysis exceed the MCL, the supplier of water shall collect one to three more samples from the same sampling point, as soon as practical, but within 30 days. An MCL violation occurs when at least one of the confirming samples is positive <sup>1</sup> and the average of the initial sample and all confirming samples exceeds the MCL.
Alachlor	0.002		
Aldicarb	0.003		
Aldicarb sulfone	0.002		
Aldicarb sulfoxide	0.004		
Atrazine <sup>4</sup>	0.003		
Benzo(a)pyrene	0.0002		
Carbofuran	0.04		
Chlordane	0.002		
Di(2-ethylhexyl)phthalate	0.006		
Dibromochloropropane (DBCP)	0.0002		
2,4-D	0.05		
Dinoseb	0.007		
<u>1,4-Dioxane</u>	<u>0.0010</u>		
Diquat	0.02		
Endrin	0.002		
Ethylene dibromide (EDB)	0.00005		
Heptachlor	0.0004		
Heptachlor epoxide	0.0002		
Hexachlorobenzene	0.001		
Lindane	0.0002		
Methoxychlor	0.04		
Methyl-tertiary-butyl-ether (MTBE)	0.010		
Pentachlorophenol	0.001		
Perfluorooctanesulfonic acid (PFOS)	<u>0.0000100</u>		
<u>Perfluorooctanoic acid (PFOA)</u>	<u>0.0000100</u>		
Polychlorinated biphenyls (PCBs) <sup>5</sup>	0.0005		
Propylene glycol	1.0		
Simazine	0.004		
Toxaphene	0.003		
2,4,5-TP (Silvex)	0.01		

2,3,7,8-TCDD (Dioxin) Vinyl chloride	0.00000003 0.002		
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<sup>1</sup> A sample is considered positive when the quantity reported by the State approved laboratory is greater than or equal to the method detection limit.

<sup>2</sup> For systems monitoring yearly or less frequently, the sample results for each monitoring location is considered the LRAA for that monitoring location. Systems required to conduct monitoring at a frequency that is less than quarterly shall monitor in the calendar month identified in the monitoring plan developed under section 5- 1.51(c). Compliance calculations shall be made beginning with the first compliance sample taken after the compliance date.

<sup>3</sup> Systems that are demonstrating compliance with the avoidance criteria in section 5-1.30(c), shall comply with the TTHM and HAA5 LRAA MCLs; however the LRAA MCLs are not considered for avoidance purposes. For avoidance purposes, TTHMs and HAA5s are based on a running annual average of analyses from all monitoring locations.

<sup>4</sup> Syngenta Method AG-625, "Atrazine in Drinking Water by Immunoassay," February 2001, available from Syngenta Crop Protection, Inc., 410 Swing Road, P.O. Box 18300, Greensboro, NC 27419. Telephone: 336-632-6000, may not be used for the analysis of atrazine in any system where chlorine dioxide is used for drinking water treatment. In samples from all other systems, any result for atrazine generated by Method AG-625 that is greater than one-half the maximum contaminant level (MCL) (in other words, greater than 0.0015mg/L or 1.5 µg/L) must be confirmed using another approved method for this contaminant and should use additional volume of the original sample collected for compliance monitoring. In instances where a result from Method AG-625 triggers such confirmatory testing, the confirmatory result is to be used to determine compliance

<sup>5</sup> If PCBs (as one of seven Aroclors) are detected in any sample analyzed using EPA Method 505 or 508, the system shall reanalyze the sample using EPA Method 508A to quantitate PCBs (as decachlorobiphenyl). Compliance with the PCB MCL shall be determined based upon the quantitative results of analyses using Method 508A.

Section 5-1.52, Table 9C is repealed and replaced with the following:

**Table 9C. Additional Organic Chemicals - Minimum Monitoring Requirements**

Contaminant		Type of water system	Initial requirement <sup>1</sup>	Continuing requirement where detected <sup>1,2,3,4</sup>	Continuing requirement where not detected <sup>1</sup>
Alachlor Aldicarb Aldicarb sulfone Aldicarb sulfoxide Aldrin	Ethylene Dibromide Glyphosate Heptachlor Heptachlor epoxide Hexachlorobenzene	Community and Nontransient Noncommunity serving 3,300 or more persons <sup>3</sup>	Quarterly sample per source, for one year <sup>5</sup>	Quarterly	One sample every eighteen months per source <sup>6,7,8</sup>
Atrazine Benzo(a)pyrene Butachlor Carbaryl Carbofuran Chlordane Dalapon Di(2-ethylhexyl)adipate Di(2-ethylhexyl)phthalate Dibromochloropropane Dicamba 2,4-D Dieldrin Dinoseb 1,4-Dioxane Diquat Endothall Endrin	Hexachlorocyclopentadiene 3-Hydroxycarbofuran Lindane Methomyl Methoxychlor Metolachlor Metribuzin Oxamyl (vydate) Pentachlorophenol Perfluorooctanesulfonicacid (PFOS) Perfluorooctanoic acid (PFOA) Picloram Polychlorinated biphenyls Propachlor Simazine 2,3,7,8-TCDD (Dioxin) 2,4,5-TP (Silvex) Toxaphene	Community and Nontransient Noncommunity serving fewer than 3,300 persons and more than 149 service connections	Quarterly samples per entry point, for one year <sup>6,7,8</sup>	Quarterly	Once per entry point every three years <sup>6,7,8</sup>
		Community and Nontransient Noncommunity serving fewer than 3,300 persons and fewer than 150 service connections	Quarterly samples per entry point for one year <sup>6,7,8</sup>	Quarterly	Once per entry point every three years <sup>6,7,8</sup>

		Noncommunity excluding NTNC	State discretion <sup>9</sup>	State discretion <sup>9</sup>	State discretion <sup>9</sup>
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**Table 9C (continued)**

<sup>1</sup>The location for sampling of each ground water source of supply shall be between the individual well and at or before the first service connection and before mixing with other sources, unless otherwise specified by the State to be at the entry point representative of the individual well. Public water systems which take water from a surface water body or watercourse shall sample at points in the distribution system representative of each source or at entry point or points to the distribution system after any water treatment plant.

<sup>2</sup>The State may decrease the quarterly monitoring requirement to annually provided that system is reliably and consistently below the MCL based on a minimum of two quarterly samples from a ground water source and four quarterly samples from a surface water source. Systems which monitor annually must monitor during the quarter that previously yielded the highest analytical result. Systems serving fewer than 3,300 persons and which have three consecutive annual samples without detection may apply to the State for a waiver in accordance with footnote 6.

<sup>3</sup>If a contaminant is detected, repeat analysis must include all analytes contained in the approved analytical method for the detected contaminant.

<sup>4</sup>Detected as used in the table shall be defined as reported by the State approved laboratory to be greater than or equal to the method detection levels.

<sup>5</sup>The State may allow a system to postpone monitoring for a maximum of two years, if an approved laboratory is not reasonably available to do a required analysis within the scheduled monitoring period.

<sup>6</sup>The State may waive the monitoring requirement for a public water system that submits information every three years to demonstrate that a contaminant or contaminants was not used, transported, stored or disposed within the watershed or zone of influence of the system.

<sup>7</sup>The State may reduce the monitoring requirement for a public water system that submits information every three years to demonstrate that the public water system is invulnerable to contamination. If previous use of the contaminant is unknown or it has been used previously, then the following factors shall be used to determine whether a waiver is granted.

- a. Previous analytical results.
- b. The proximity of the system to a potential point or nonpoint source of contamination. Point sources include spills and leaks of chemicals at or near a water treatment facility or at manufacturing, distribution, or storage facilities, or from hazardous and municipal waste landfills and other waste handling or treatment facilities. Nonpoint sources include the use of pesticides to control insect and weed pests on agricultural areas, forest lands, home and gardens, and other land application uses.
- c. The environmental persistence and transport of the pesticide or PCBs.
- d. How well the water source is protected against contamination due to such factors as depth of the well and the type of soil and the integrity of the well casing.
- e. Elevated nitrate levels at the water supply source.
- f. Use of PCBs in equipment used in production, storage or distribution of water.

<sup>8</sup>The State may allow systems to composite samples in accordance with the conditions in Appendix 5-C of this Title.

<sup>9</sup>State discretion shall mean requiring monitoring when the State has reason to believe the MCL has been violated, the potential exists for an MCL violation or the contaminant may present a risk to public health.

## **SUMMARY OF REGULATORY IMPACT STATEMENT**

### **Statutory Authority:**

The statutory authority for the proposed revisions is set forth in Public Health Law (PHL) sections 201 and 225. Section 201(1)(l) of the PHL establishes the powers and duties of the New York State Department of Health (Department), which include the supervision and regulation of the sanitary aspects of public water systems. Section 225 of the PHL sets forth the powers and duties of the Public Health and Health Planning Council (PHHPC), which include the authority to establish, amend and repeal sanitary regulations to be known as the State Sanitary Code (SSC), subject to the approval of the Commissioner of Health. Further, section 225(5)(a) of the PHL allows the SSC to deal with any matter affecting the security of life or health, or the preservation or improvement of public health, in New York State.

### **Legislative Objective:**

The legislative objective of sections 201 and 225 of the PHL is to ensure that PHHPC, in conjunction with the Commissioner of Health, protect public health by adopting drinking water sanitary standards. In accordance with that objective, this regulation amends the SSC by revising Part 5 to enhance current protections governing public water systems. Furthermore, this amendment will update the SSC in accordance with the recommendations of the Drinking Water Quality Council, by establishing specific maximum contaminant levels (MCLs) for perfluorooctanoic acid (PFOA), perfluorooctanesulfonic acid (PFOS) and 1,4-dioxane.

**Needs and Benefits:**

In 2017, New York State (NYS) identified PFOA, PFOS and 1,4-dioxane as emerging contaminants in drinking water. That same year, the Drinking Water Quality Council (DWQC) was created, with direction to recommend MCLs for these emerging contaminants. After discussions and deliberations, the DWQC recommended MCLs to the Department for PFOA, PFOS and 1,4-dioxane. Specifically, the DWQC recommended: an MCL of 10.0 parts per trillion (ppt) (or, expressed in different units, 0.0000100 milligrams per liter (mg/L)) for PFOA; 10.0 ppt (or 0.0000100 mg/L) for PFOS; and 1.0 part per billion (ppb) (or 0.0010 mg/L) for 1,4-dioxane.

From 2015 through 2018, the Department coordinated targeted sampling of 278 public water systems for PFOA and PFOS. The 278 public water systems were mainly medium (serving 3,300 to 10,000 persons) to small (serving less than 3,300 persons) community water systems and non-transient noncommunity systems typically with a groundwater source located near a potential source of PFOA and/or PFOS. The results of this testing are shown in Figures 1A and 1B.

Figure 1A.

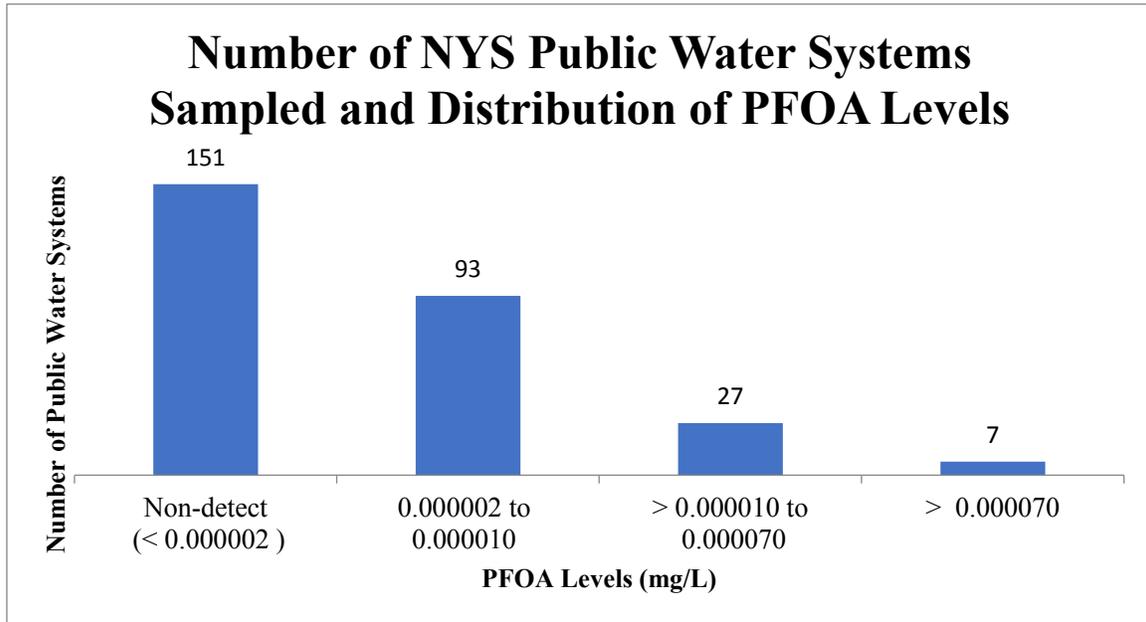
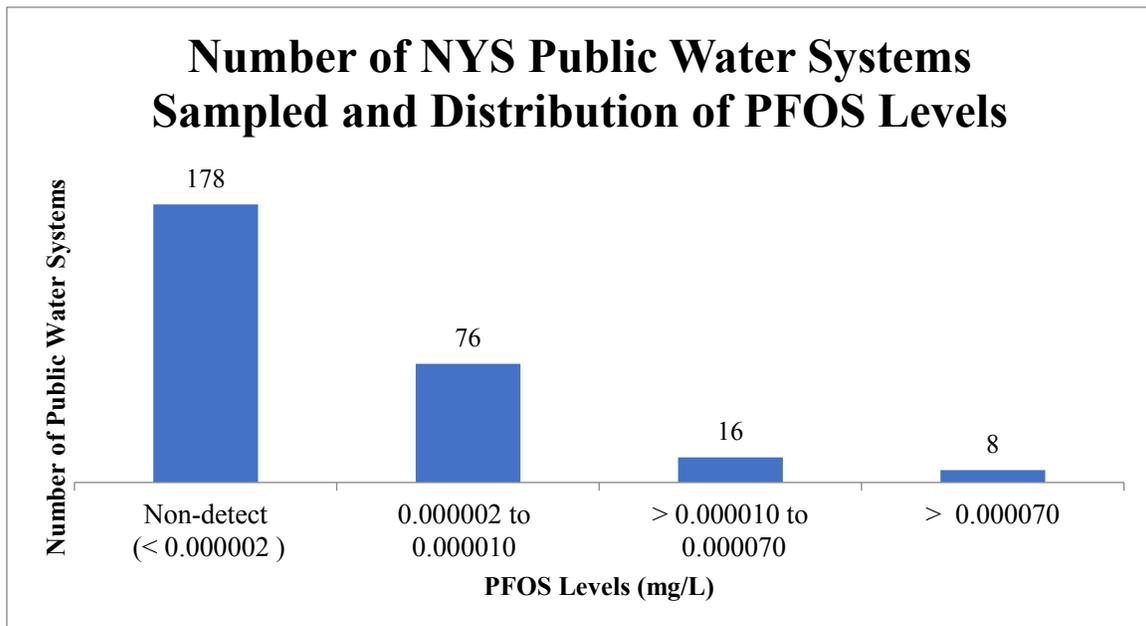


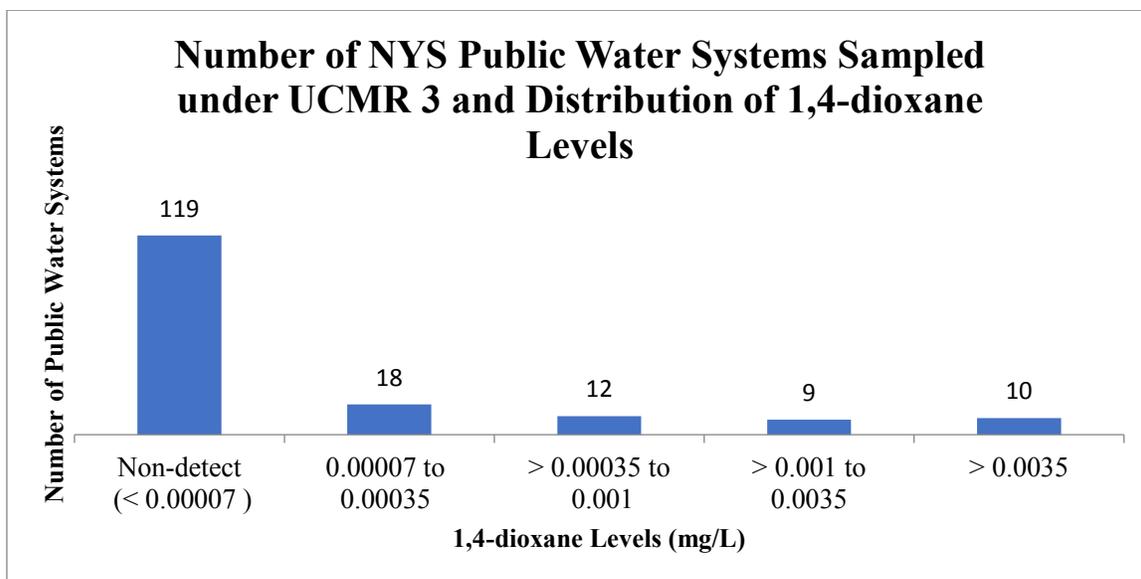
Figure 1B.



From 2013 through 2015 public water systems across NYS, under the United States Environmental Protection Agency (US EPA) Unregulated Contaminant Monitoring Rule

3 (UCMR 3), tested for 1,4-dioxane. All large public water systems (serving 10,000 persons or more) and 32 randomly selected medium and small water systems (serving less than 10,000 persons) in NYS conducted testing. Figure 2 shows that 11 percent (%) of the water systems tested had 1,4-dioxane levels above the DWQC's recommended MCL of 0.0010 mg/L.

Figure 2.



Based on the UCMR3 data, 51% of the samples from Long Island public water systems had levels of 1,4-dioxane above the reporting level of 0.00007 mg/L compared to 6% for NYS excluding Long Island.

The Department provided the DWQC with technical information on a range of health-based drinking water values for PFOA, PFOS and 1,4-dioxane after an evaluation of the available health effects information on the chemicals from toxicological studies. These values included current national and state guidelines and advisory levels, as well as

potential health based values developed by the Department. Based on their review of this information, the DWQC recommended an MCL of 0.0000100 mg/L for PFOA and PFOS as individual compounds, which is within the range of the potential health based water values presented to the DWQC by the Department (0.000006 to 0.000070 mg/L for PFOA and 0.000008 to 0.000070 mg/L for PFOS). The DWQC recommended an MCL of 0.0010 mg/L for 1,4-dioxane, which is within the range of current national and state guidelines and advisory levels presented by the Department (0.00035 to 0.2 mg/L).

In the absence of federal regulations governing PFOA, PFOS and 1,4-dioxane in drinking water, and after consideration of the recommendations provided by the DWQC, the Department is proposing to amend 10 NYCRR Part 5 to establish MCLs for these contaminants. The Department is proposing an MCL of 0.0000100 mg/L for PFOA and PFOS as individual contaminants, and 0.0010 mg/L for 1,4-dioxane. These MCLs will apply to all public water supplies regulated by the Department and provide a sufficient margin of protection against adverse health effects in the most sensitive populations, including fetuses during pregnancy, breastfed infants, and infants bottle fed with formula reconstituted using tap water. In addition, the MCLs provide a sufficient margin of protection for lifetime exposure through drinking water for the general population.

### **Compliance Costs**

#### **Cost to Private Regulated Parties:**

There are approximately 7,200 privately owned public water systems in NYS. Of these, an estimated 2,100 systems serve residential suburban areas, manufactured housing communities and apartment buildings, residential and non-residential health care

facilities, industrial and commercial buildings, private schools and colleges, and other facilities. The remaining 5,100 privately owned public water systems serve restaurants, convenient stores, motels, campsites and other transient systems. Costs will include initial monitoring, continued routine monitoring and treatment in the event of a MCL exceedance for PFOS, PFOA and/or 1,4-dioxane.

Monitoring and treatment costs for privately-owned public water systems is dependent upon the system size, the number of affected entry points/sources and the concentration of each contaminant. The exact costs for monitoring and treatment of PFOS, PFOA and 1,4-dioxane for public water systems, including privately-owned public water systems, cannot be determined due to several variables. The cost for a single PFOA/PFOS analysis is between \$200-\$300 per sample. The cost of a single 1,4-dioxane analysis is between \$100-\$250.

It is estimated that approximately 21% of all public water systems, including privately-owned public water systems, will have levels of PFOA or PFOS above the proposed MCLs of 0.0000100 mg/L. For small systems serving less than 3,300 persons, capital and annual maintenance costs are estimated to be approximately \$400,000 and \$25,000, respectively. For medium systems (serving 3,300 or more persons but less than 10,000 persons), capital and annual maintenance costs are estimated to be approximately \$2,400,000 and \$125,000, respectively. For large systems (serving 10,000 persons or more), capital and annual maintenance costs are estimated to be approximately \$15,000,000 and \$725,000, respectively.

It is estimated that eighty-nine (89) public water *facilities*, (a single public water system may be comprised of multiple public water facilities), will have a detection of 1,4-dioxane above the proposed MCL of 0.0010 mg/L. The average cost of treatment for 1,4-dioxane is estimated to be \$3,570,000 per system, with an estimated average annual operation and maintenance cost of approximately \$150,000 per system.

Public water systems will likely make rate adjustments to accommodate these additional capital and operational costs.

**Cost to State Government:**

State agencies that operate public water systems will be required to comply with the proposed amendments. There are approximately 250 State-owned or operated facilities with a public water system. Examples of such facilities are State-owned schools, buildings, correctional facilities, Thruway services areas, and any other State-owned structure or property that serves an average of at least 25 individuals daily at least 60 days out of the year.

Costs will include initial monitoring for PFOA, PFOS and/or 1,4-dioxane, continued routine monitoring, and treatment in the event of a MCL exceedance. These potential costs will be the same as the costs to private regulated parties.

The proposed regulation will also impose administrative costs to the Department relating to implementation and oversight of the drinking water monitoring requirements including

review and approval of sampling schedules; review and reporting of sample results; providing technical assistance to the public water suppliers; review and approval of plans (i.e., treatment plans); and activities associated with enforcement and public notification of MCL exceedances.

Additionally, the Department and NYS Department of Environmental Conservation (NYSDEC) will incur costs associated with the investigation, remediation, and long-term monitoring associated with the release of these contaminants.

Although the proposed regulations do not apply to private wells, costs will be incurred by NYSDEC, as the lead agency for investigating, remediating, and monitoring of contaminated sites, as the MCLs will be used by the NYSDEC as guidance to determine whether a private well in NYS is contaminated by PFOA, PFOS and/or 1,4-dioxane. There are an estimated 800,000 private water supply wells in NYS. At this time, it is not possible to estimate the number of private wells that might be affected by contamination and, therefore, associated costs to NYSDEC cannot be determined.

**Cost to Local Government:**

The regulations will apply to local governments—including towns, villages, counties, cities, and authorities or area wide improvement districts—which own or operate a public water system subject to this regulation. There are approximately 1,500 public water systems that are owned or operated by local governments.

Costs will include initial monitoring for PFOA, PFOS and/or 1,4-dioxane, continued routine monitoring, and treatment in the event of a MCL exceedance. These potential costs will be the same as the costs to private regulated parties.

Local health departments that regulate drinking water will also incur administrative costs related to local implementation and oversight of the drinking water monitoring requirements including review and approval of sampling schedules; review and reporting of sample results; providing technical assistance to the public water suppliers; review and approval of plans (i.e., treatment plans); and activities associated with enforcement and public notification of MCL exceedances.

**Local Government Mandates:**

Local governments will be required to comply with this regulation as noted above.

**Paperwork:**

The additional monitoring, reporting, recordkeeping and paperwork needed for PFOA, PFOS and 1,4-dioxane is expected to be minimal because operators of public water supplies are currently required to keep such records for existing MCLs, and these regulations only add three additional chemicals. The reporting and recordkeeping requirements will increase if MCLs are exceeded and/or treatment is required.

**Duplication:**

There will be no duplication of existing State or federal regulations.

**Alternatives:**

One alternative is to maintain the existing MCL of 0.05 mg/L that applies to all unspecified organic chemicals when no chemical-specific MCL exists. Another alternative is to wait for the US EPA to issue a federal MCL. Based on DWQC deliberations and the additional analysis done by the Department it was determined that the current MCL of 0.05 mg/L, which is a generic standard for a broad class of organic chemicals is not protective of public health for these three specific chemicals. Waiting for the US EPA to set a new MCL was impractical due to the prevalence and concerns surrounding PFOA, PFOS and 1,4-dioxane. Therefore, the Department determined that adoption of the DWQC MCL recommendations for PFOA, PFOS and 1,4-dioxane is in the best interest of protecting the public health of NYS residents.

**Federal Standards:**

There is no federal MCL for PFOA, PFOS or 1,4-dioxane.

**Compliance Schedule:**

The MCLs will be immediately effective upon publication of a Notice of Adoption in the New York State Register. Public water systems serving 10,000 persons or more must begin monitoring within 60 days of adoption. Water systems serving 3,300 to 9,999 people must begin monitoring within 90 days of adoption and water systems serving less than 3,300 must begin monitoring within 6 months of adoption.

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(518) 473-2019 (FAX)  
[REGSQNA@health.ny.gov](mailto:REGSQNA@health.ny.gov)

## REGULATORY IMPACT STATEMENT

### **Statutory Authority:**

The statutory authority for the proposed revisions is set forth in Public Health Law (PHL) sections 201 and 225. Section 201(1)(l) of the PHL establishes the powers and duties of the New York State Department of Health (Department), which include the supervision and regulation of the sanitary aspects of public water systems. Section 225 of the PHL sets forth the powers and duties of the Public Health and Health Planning Council (PHHPC), which include the authority to establish, amend and repeal sanitary regulations to be known as the State Sanitary Code (SSC), subject to the approval of the Commissioner of Health. Further, section 225(5)(a) of the PHL allows the SSC to deal with any matter affecting the security of life or health, or the preservation or improvement of public health, in New York State.

### **Legislative Objective:**

The legislative objective of sections 201 and 225 of the PHL is to ensure that PHHPC, in conjunction with the Commissioner of Health, protect public health by adopting drinking water sanitary standards. In accordance with that objective, this regulation amends the SSC by revising Part 5 to enhance current protections governing public water systems . Furthermore, this amendment will update the SSC in accordance with the recommendations of the Drinking Water Quality Council by establishing specific maximum contaminant levels (MCLs) for perfluorooctanoic acid (PFOA), perfluorooctanesulfonic acid (PFOS) and 1,4-dioxane.

**Needs and Benefits:**

In 2017, New York State (NYS) identified PFOA, PFOS and 1,4-dioxane as emerging contaminants in drinking water. That same year, the Drinking Water Quality Council (DWQC) was created, with direction to recommend MCLs for these emerging contaminants. After discussions and deliberations, the DWQC recommended MCLs to the Department for PFOA, PFOS and 1,4-dioxane. Specifically, the DWQC recommended: an MCL of 10.0 parts per trillion (ppt) (or, expressed in different units, 0.0000100 milligrams per liter (mg/L)) for PFOA; 10.0 ppt (or 0.0000100 mg/L) for PFOS; and 1.0 part per billion (ppb) (or 0.0010 mg/L) for 1,4-dioxane.

PFOA, PFOS and 1,4-dioxane are anthropogenic chemicals that have been manufactured or used throughout the United States. PFOA and PFOS have been used for their emulsifier and surfactant properties in fire-fighting foam, polishes, and cleaners. PFOA has also been used in fluoropolymers (e.g. Teflon), cosmetics, lubricants, paints, coatings, laminates, adhesives and photographic films. 1,4-dioxane has been used as a stabilizer for chlorinated solvents, as a laboratory reagent and as a solvent in the manufacture of other chemicals. 1,4-dioxane is also found in paint strippers, antifreeze, dyes, greases, detergents, cosmetics and other consumer products.

PFOA and PFOS are no longer manufactured in the United States, but there may be some limited ongoing uses of these chemicals. The use of 1,4-dioxane as a solvent and solvent stabilizer has decreased because of the phase out of many chlorinated solvents, but it is

still used as a chemical intermediate and laboratory solvent, and can be found in some consumer products.

From 2015 through 2018, the Department coordinated targeted sampling of 278 public water systems for PFOA and PFOS. The 278 public water systems were mainly medium (serving 3,300 to 10,000 persons) to small (serving less than 3,300 persons) community water systems and non-transient noncommunity systems typically with a groundwater source located near a potential source of PFOA and/or PFOS. The results of this testing are shown in Figures 1A and 1B.

Figure 1A.

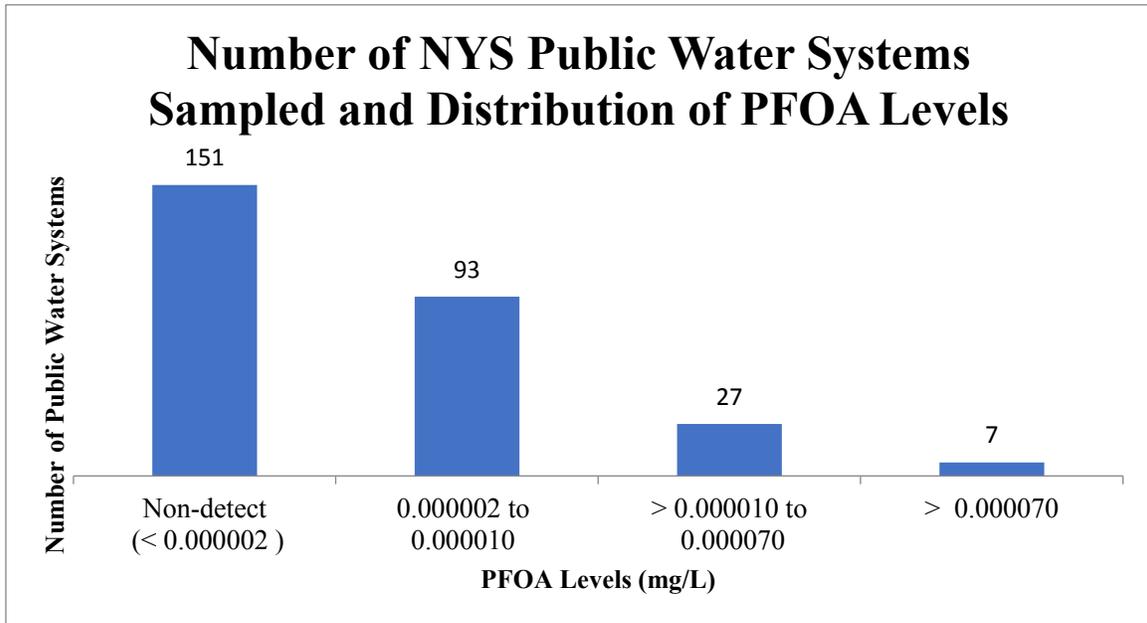
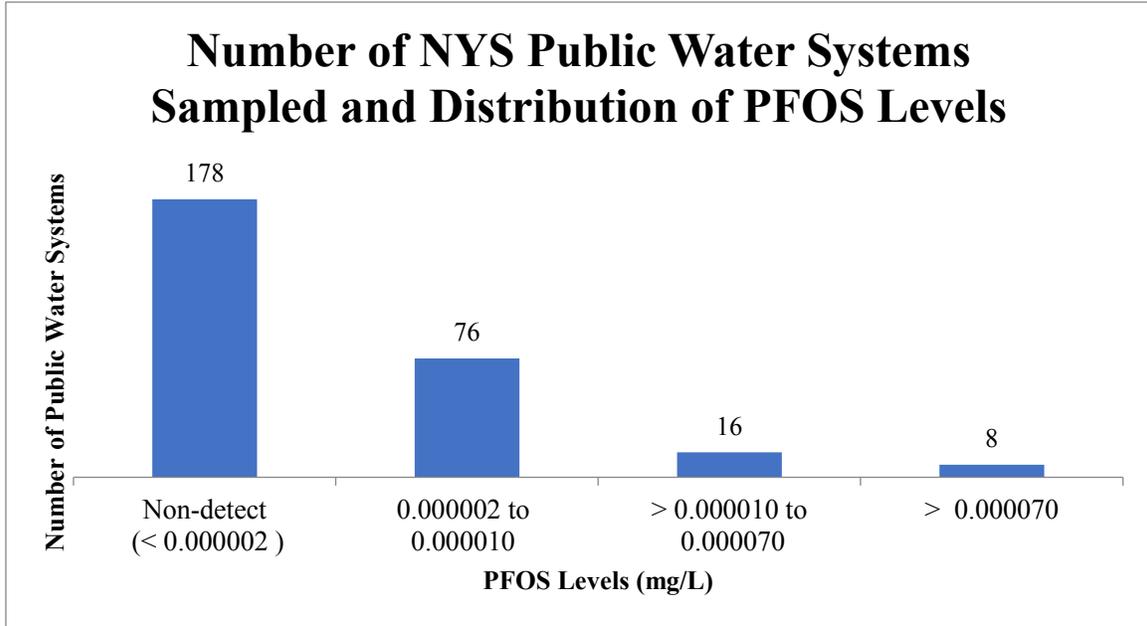
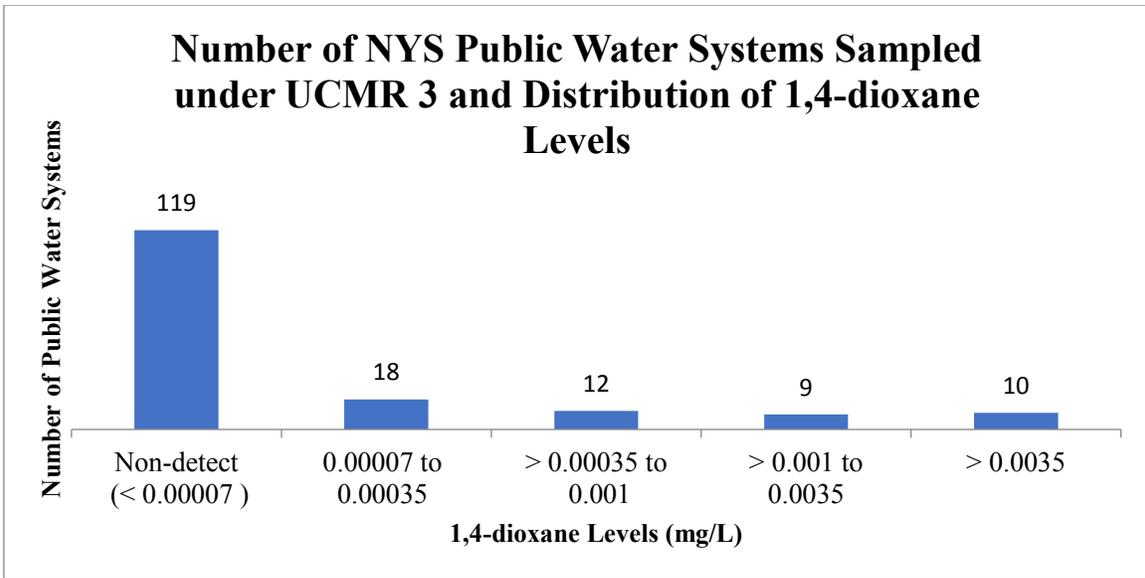


Figure 1B.



From 2013 through 2015 public water systems across NYS, under the United States Environmental Protection Agency (US EPA) Unregulated Contaminant Monitoring Rule 3 (UCMR 3), tested for 1,4-dioxane. All large public water systems (serving 10,000 persons or more) and 32 randomly selected medium and small water systems (serving less than 10,000 persons) in NYS conducted testing. Figure 2 shows that 11 percent (%) of the water systems tested had 1,4-dioxane levels above the DWQC's recommended MCL of 0.0010 mg/L.

Figure 2.



Based on the UCMR3 data, 51% of the samples from Long Island public water systems had levels of 1,4-dioxane above the reporting level of 0.00007 mg/L compared to 6% for NYS excluding Long Island.

The toxicity of PFOA has been extensively reviewed, evaluated and summarized by several authoritative bodies, including the US EPA, the Agency for Toxic Substances and Disease Registry (ATSDR), Health Canada, and the states of New Jersey and Minnesota. These evaluations indicate associations between increased PFOA exposure in humans and an increased risk for several types of health effects. These include effects on the liver, kidney, immune system, thyroid gland, cholesterol levels, uric acid levels, pre-eclampsia (a complication of pregnancy that includes high blood pressure), ulcerative colitis, development effects, and kidney and testicular cancer. Exposure to PFOA has also been shown to cause several adverse health effects in laboratory animals. PFOA caused cancer of the liver, pancreas, and testis in rats exposed for their lifetimes. Noncancer health effects caused by PFOA exposure in animals include liver toxicity, kidney toxicity,

developmental toxicity and immune system toxicity. The US EPA considers PFOA to have suggestive evidence of carcinogenic potential.

The toxicity of PFOS has also been extensively reviewed, evaluated and summarized by several authoritative bodies, including the US EPA, ATSDR, Health Canada, European Food Safety Authority, the Organization for Economic Co-operation and Development and the states of New Jersey and Minnesota. These evaluations indicate associations between increased PFOS exposure in humans and an increased risk for several health effects, including increases in total serum cholesterol, triglycerides, and uric acid, altered immune response, and effects on reproduction and development. PFOS exposure has also been shown to cause several adverse health effects in laboratory animals including liver and thyroid cancer in rats exposed for their lifetimes. Noncancer effects caused by PFOS in animals include effects on the liver, immune system, cholesterol levels, and the developing nervous system, and reduced survival in offspring born to rats. The US EPA considers PFOS to have suggestive evidence of carcinogenic potential.

The toxicity of 1,4-dioxane has been extensively reviewed, evaluated and summarized by the US EPA and ATSDR. 1,4-dioxane causes liver cancer in several species of laboratory animals (rats, mice and guinea pigs) exposed to high levels for their lifetimes. Other cancers caused by 1,4-dioxane in laboratory animals include breast cancer and cancer of the peritoneum and nasal cavity. Laboratory animals exposed to large amounts of 1,4-dioxane in drinking water for long periods of time also had noncancer health effects on the liver, kidney, nasal cavity and respiratory system. Based on sufficient evidence for

carcinogenicity in animals, the USEPA classifies 1,4-dioxane as likely to be carcinogenic to humans by all routes of exposure, and the United States Department of Health and Human Services includes 1,4-dioxane in its list of chemicals that are reasonably anticipated to be human carcinogens.

The Department provided the DWQC with technical information on a range of health-based drinking water values for PFOA, PFOS and 1,4-dioxane after an evaluation of the available health effects information on the chemicals from toxicological studies. These values included current national and state guidelines and advisory levels, as well as potential health based values developed by the Department. Based on their review of this information, the DWQC recommended an MCL of 0.0000100 mg/L for PFOA and PFOS as individual compounds, which is within the range of the potential health based water values presented to the DWQC by the Department (0.000006 to 0.000070 mg/L for PFOA and 0.000008 to 0.000070 mg/L for PFOS). The DWQC recommended an MCL of 0.0010 mg/L for 1,4-dioxane, which is within the range of current national and state guidelines and advisory levels presented by the Department (0.00035 to 0.2 mg/L).

In the absence of federal regulations governing PFOA, PFOS and 1,4-dioxane in drinking water, and after consideration of the recommendations provided by the DWQC, the Department is amending 10 NYCRR Part 5 to establish MCLs for these contaminants. The Department is proposing an MCL of 0.0000100 mg/L for PFOA and PFOS as individual contaminants, and 0.0010 mg/L for 1,4-dioxane. These MCLs will apply to all public water supplies regulated by the Department and provide a sufficient margin of

protection against adverse health effects in the most sensitive populations, including fetuses during pregnancy, breastfed infants, and infants bottle fed with formula reconstituted using tap water. In addition, the MCLs provide a sufficient margin of protection for lifetime exposure through drinking water for the general population.

These regulations will amend 10 NYCRR 5-1.52, Table 3, to list PFOA, PFOS and 1,4-dioxane and their proposed MCLs. In addition, these regulations will amend 10 NYCRR 5-1.52, Table 9C, to include these three contaminants in the current minimum monitoring requirements for additional organic chemicals. Table 9C was also amended to remove references to “Group 1” and “Group 2” chemicals as these groupings are outdated and no longer relevant. The MCLs apply to finished water. Initial monitoring for community and non-transient noncommunity public water systems will be quarterly for one year depending on system size. Monitoring at transient noncommunity public water systems will be at the Department’s discretion. Previous testing conducted using an Environmental Laboratory Approval Program (ELAP) approved method and laboratory may satisfy some or all of the initial monitoring requirements at the Department’s discretion, or the local health department’s discretion in consultation with the Department. Specifically, sample results for PFOA and PFOS analyzed after June 1, 2016 may be used to satisfy the initial monitoring requirements for 2019-20. Sample results for 1,4-dioxane analyzed after June 14, 2017 may be used to satisfy the initial monitoring requirements for 2019-20.

## **Compliance Costs**

### **Cost to Private Regulated Parties:**

There are approximately 7,200 privately owned public water systems in NYS. Of these, an estimated 2,100 systems serve residential suburban areas, manufactured housing communities and apartment buildings, residential and non-residential health care facilities, industrial and commercial buildings, private schools and colleges, and other facilities. The remaining 5,100 privately owned public water systems serve restaurants, convenient stores, motels, campsites and other transient systems. Costs will include initial monitoring, continued routine monitoring and treatment in the event of a MCL exceedance for PFOS, PFOA and/or 1,4-dioxane.

Monitoring and treatment costs for privately-owned public water systems is dependent upon the system size, the number of affected entry points/sources and the concentration of each contaminant. The exact costs for monitoring and treatment of PFOS, PFOA and 1,4-dioxane for public water systems, including privately-owned public water systems, cannot be determined due to several variables. The cost for a single PFOA/PFOS analysis is between \$200-\$300 per sample. The cost of a single 1,4-dioxane analysis is between \$100-\$250.

It is estimated that approximately 21% of all public water systems, including privately-owned public water systems, will have levels of PFOA or PFOS above the MCLs of 0.0000100 mg/L. For small systems serving less than 3,300 persons, capital and annual maintenance costs are estimated to be approximately \$400,000 and \$25,000, respectively.

For medium systems (serving 3,300 or more persons but less than 10,000 persons), capital and annual maintenance costs are estimated to be approximately \$2,400,000 and \$125,000, respectively. For large systems (serving 10,000 persons or more), capital and annual maintenance costs are estimated to be approximately \$15,000,000 and \$725,000, respectively.

It is estimated that eighty-nine (89) public water *facilities*, (a single public water system may be comprised of multiple public water facilities), will have a detection of 1,4-dioxane above the MCL of 0.0010 mg/L. The average cost of treatment for 1,4-dioxane is estimated to be \$3,570,000 per system, with an estimated average annual operation and maintenance cost of approximately \$150,000 per system.

Public water systems will likely make rate adjustments to accommodate these additional capital and operational costs.

**Cost to State Government:**

State agencies that operate public water systems will be required to comply with the proposed amendments. There are approximately 250 State-owned or operated facilities with a public water system. Examples of such facilities are State-owned schools, buildings, correctional facilities, Thruway services areas, and any other State-owned structure or property that serves an average of at least 25 individuals daily at least 60 days out of the year.

Costs will include initial monitoring for PFOA, PFOS and/or 1,4-dioxane, continued routine monitoring, and treatment in the event of a MCL exceedance. These potential costs will be the same as the costs to private regulated parties.

The proposed regulation will also create administrative costs to the Department relating to implementation and oversight of the drinking water monitoring requirements including review and approval of sampling schedules; review and reporting of sample results; providing technical assistance to the public water suppliers; review and approval of plans (i.e., treatment plans); and activities associated with enforcement and public notification of MCL exceedances.

Additionally, the Department and NYS Department of Environmental Conservation (NYSDEC) will incur costs associated with the investigation, remediation, and long-term monitoring associated with the release of these contaminants.

Although the proposed regulations do not apply to private wells, costs will be incurred by NYSDEC, as the lead agency for investigating, remediating, and monitoring of contaminated sites, as the MCLs will be used by the NYSDEC as guidance to determine whether a private well in NYS is contaminated by PFOA, PFOS and/or 1,4-dioxane.

There are an estimated 800,000 private water supply wells in NYS. At this time, it is not possible to estimate the number of private wells that might be affected by contamination and therefore costs to NYSDEC cannot be determined.

**Cost to Local Government:**

The regulations will apply to local governments—including towns, villages, counties, cities, and authorities or area wide improvement districts—which own or operate a public water system subject to this regulation. There are approximately 1,500 public water systems that are owned or operated by local governments.

Costs will include initial monitoring for PFOA, PFOS and/or 1,4-dioxane, continued routine monitoring, and treatment in the event of a MCL exceedance. These potential costs will be the same as the costs to private regulated parties.

Local health departments that regulate drinking water will also incur administrative costs related to local implementation and oversight of the drinking water monitoring requirements including review and approval of sampling schedules; review and reporting of sample results; providing technical assistance to the public water suppliers; review and approval of plans (i.e., treatment plans); and activities associated with enforcement and public notification of MCL exceedances.

**Local Government Mandates:**

Local governments will be required to comply with this regulation as noted above.

**Paperwork:**

The additional monitoring, reporting, recordkeeping and paperwork needed for PFOA, PFOS and 1,4-dioxane is expected to be minimal because operators of public water

supplies are currently required to keep such records for existing MCLs, and these regulations only add three additional chemicals. The reporting and recordkeeping requirements will increase if MCLs are exceeded and/or treatment is required.

**Duplication:**

There will be no duplication of existing State or federal regulations.

**Alternatives:**

One alternative is to maintain the existing MCL of 0.05 mg/L that applies to all unspecified organic chemicals when no chemical-specific MCL exists. Another alternative is to wait for the US EPA to issue a federal MCL. Based on DWQC deliberations and the additional analysis done by the Department it was determined that the current MCL of 0.05 mg/L, which is a generic standard for a broad class of organic chemicals is not protective of public health for these three specific chemicals. Waiting for the US EPA to set a new MCL was impractical due to the prevalence and concerns surrounding PFOA, PFOS and 1,4-dioxane. Therefore, the Department determined that adoption of the DWQC MCL recommendations for PFOA, PFOS and 1,4-dioxane is in the best interest of protecting the public health of NYS residents.

**Federal Standards:**

There is no federal MCL for PFOA, PFOS or 1,4-dioxane.

**Compliance Schedule:**

The MCLs will be immediately effective upon publication of a Notice of Adoption in the New York State Register. Public water systems serving 10,000 persons or more must begin monitoring within 60 days of adoption. Water systems serving 3,300 to 9,999 people must begin monitoring within 90 days of adoption and water systems serving less than 3,300 must begin monitoring within 6 months of adoption.

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## **REGULATORY FLEXIBILITY ANALYSIS FOR SMALL BUSINESS AND LOCAL GOVERNMENTS**

### **Effect on Small Business and Local Governments:**

Many of the public water systems affected by the new regulations are owned or operated by either small businesses or local governments. The Department does not maintain information on the exact number of the public water systems owned by small businesses. There are approximately 1500 water systems owned by local governments.

### **Reporting and Recordkeeping and Other Compliance Requirements:**

The obligations on small businesses and local governments are the same as for all owners or operators of public water systems. The regulations require additional monitoring, reporting, recordkeeping and public notification requirements for three additional contaminants, PFOA, PFOS and 1,4-dioxane. These requirements will increase if MCLs are exceeded and/or treatment is required.

Local health departments that regulate drinking water will also incur administrative costs related to local implementation and oversight of the drinking water monitoring requirements including review and approval of sampling schedules; review and reporting of sample results; providing technical assistance to the public water suppliers; review and approval of plans (i.e., treatment plans); and activities associated with enforcement and public notification of MCL exceedances.

**Professional Services:**

Public water systems impacted by the amended regulations will require the services of a laboratory to analyze samples for PFOA, PFOS and 1,4-dioxane. The laboratory must be approved by the Department under its Environmental Laboratory Approval Program (ELAP). Sufficient laboratory capability and capacity is anticipated to be available to process the initial staggered testing demands and future testing. If an MCL is exceeded, a licensed professional will be required to design changes to the public water system to meet the MCL.

**Compliance Costs:****Cost to Private Regulated Parties and Local Governments:**

A small business or local government will incur the same costs as other regulated parties. Costs will include initial monitoring, continued routine monitoring, and treatment in the event of a MCL exceedance for PFOS, PFOA and 1,4-dioxane.

Monitoring and treatment costs for small businesses and local government owned public water systems is dependent upon the system size, the number of affected entry points/sources and the concentration of each contaminant. The exact costs for monitoring and treatment of PFOS, PFOA and 1,4-dioxane for public water systems, including privately-owned public water systems, cannot be determined due to several variables.

The cost for a single PFOA/PFOS analysis is between \$200-\$300 per sample. The cost of a single 1,4-dioxane analysis is between \$100-\$250. For small systems serving less than 3,300 persons, capital and annual maintenance costs are estimated to be approximately \$400,000 and \$25,000, respectively. For medium systems (serving 3,300 or more persons

but less than 10,000 persons), capital and annual maintenance costs are estimated to be approximately \$2,400,000 and \$125,000, respectively. For large systems (serving 10,000 persons or more), capital and annual maintenance costs are estimated to be approximately \$15,000,000 and \$725,000, respectively.

It is estimated that eighty-nine (89) public water *facilities*, (a single public water system may be comprised of multiple public water facilities), will detect 1,4-dioxane above the MCL of 0.0010 mg/L. The average cost of treatment for 1,4-dioxane is estimated to be \$3,570,000 per system, with an estimated average annual operation and maintenance cost of approximately \$150,000 per system.

Public water systems will likely make rate adjustments to accommodate these additional capital and operational costs.

Local health departments that regulate drinking water will also incur administrative costs related to local implementation and oversight of the drinking water monitoring requirements including review and approval of sampling schedules; review and reporting of sample results; providing technical assistance to the public water suppliers; review and approval of plans (i.e., treatment plans), and activities associated with enforcement, including public notification of MCL exceedances.

**Economic and Technological Feasibility:**

These regulations are economically and technologically feasible for small businesses and local governments. Analytical methods exist for accurate sample analysis to detect PFOA, PFOS and 1,4-dioxane. There are also technologically feasible treatment solutions for all three contaminants. Treatment may present a greater challenge to smaller systems that typically have less resources including financial and technical expertise than larger systems.

**Minimizing Adverse Impact:**

The Department has included several provisions that minimize the impacts on regulated parties. Previous testing conducted using an ELAP approved method and laboratory may satisfy some or all of the initial monitoring requirements at the Department's discretion, or the local health department's discretion in consultation with the Department; sampling frequency will decrease after the first year if a contaminant (or the contaminants) is/are not detected at a public water system; the start of initial sampling is proposed to be staggered, requiring large systems to test first (within 60 days of adoption) and providing more time for smaller systems such that water systems serving between 3,300 to 10,000 persons should sample within 90 days of adoption and water systems serving less than 3,300 persons must begin sampling within 6 months of adoption.

In addition, New York State offers programs to support public water systems with infrastructure investments including but not limited to treatment and development/connection to alternate sources of water. Programs include the Drinking Water State Revolving Fund which provides market rate, low to no interest loans and

grants available to many municipally and privately-owned public water systems based on need and financial hardship. In addition, the New York State Clean Water Infrastructure Act of 2017 invests \$2.5 billion in clean and drinking water infrastructure projects and water quality protection across the State. It provides funding to the New York State Water Infrastructure Improvement Act of 2017 (WIIA) for grants to assist municipalities with water quality infrastructure. A separate \$200 million has been provided to support grants for drinking water projects that will address emerging contaminants such as PFOA, PFOS or 1,4-dioxane.

**Small Business and Local Government Participation:**

Small business and local governments were not specifically consulted on this proposal, however the MCLs set forth in this proposed rule were recommendations from the Drinking Water Quality Council (DWQC) which met numerous times in a public forum and were also recorded. The recordings are publicly available on the Department's website. During each DWQC meeting, members of the public were allowed to comment, and comments were provided to the Department outside of the meetings. Based on the information available it is not possible to determine the number of small businesses that participated during the meetings or provided comments, but from sign in sheets at the meetings some businesses did participate in the meetings. All comments provided by the public were made available to the DWQC for their consideration.

## **RURAL AREA FLEXABILITY ANALYSIS**

### **Types and Estimated Numbers of Rural Areas:**

These regulations apply to rural areas of the state, where approximately 6,400 small public water systems are located, in the same manner as the rest of the state.

### **Reporting, Record keeping and Other Compliance Requirements**

#### **Reporting and Recordkeeping:**

The obligations imposed on rural area public water systems are the same as for all owners or operators of public water systems. The regulations require additional monitoring, reporting, recordkeeping and public notification requirements for three additional contaminants, PFOA, PFOS and 1,4-dioxane. These requirements will increase if MCLs are exceeded and/or treatment is required.

#### **Professional Services:**

Like all public water systems, rural area public water systems impacted by the amended regulations will require the services of a laboratory to analyze samples for PFOA, PFOS and 1,4-dioxane. The laboratory must be approved by the Department under its Environmental Laboratory Approval Program (ELAP). Sufficient laboratory capability and capacity is anticipated to be available to process the initial staggered testing demands and future testing. If an MCL is exceeded, a licensed professional will be required to design changes to the public water system to meet the MCL.

**Compliance Costs:**

Rural area public water systems will incur the same costs as other regulated parties. Costs will include initial monitoring, continued routine monitoring, and treatment in the event of a MCL exceedance for PFOS, PFOA and 1,4-dioxane. There are approximately 7,200 privately-owned water systems. Of these, an estimated 2,100 systems serve residential suburban areas, manufactured housing communities and apartment buildings, residential and non-residential health care facilities, industrial and commercial buildings, private schools and colleges, and other facilities. The remaining 5,100 privately-owned systems, such as those at restaurants, motels and campsites, serve transient populations.

Monitoring and treatment costs for rural area public water systems is dependent upon the system size, the number of affected entry points/sources and the concentration of each contaminant. The exact costs for monitoring and treatment of PFOS, PFOA and 1,4-dioxane for public water systems, including rural area public water systems, cannot be determined due to several variables. The cost for a single PFOA/PFOS analysis is between \$200-\$300 per sample. The cost of a single 1,4-dioxane analysis is between \$100-\$250. For small systems serving less than 3,300 persons, capital and annual maintenance costs are estimated to be approximately \$400,000 and \$25,000, respectively. For medium systems (serving 3,300 or more persons but less than 10,000 persons), capital and annual maintenance costs are estimated to be approximately \$2,400,000 and \$125,000, respectively. For large systems (serving 10,000 persons or more), capital and annual maintenance costs are estimated to be approximately \$15,000,000 and \$725,000, respectively.

It is estimated that eighty-nine (89) public water *facilities*, (a single public water system may be comprised of multiple public water facilities), will have a detection of 1,4-dioxane above the MCL of 0.0010 mg/L. The average cost of treatment for 1,4-dioxane is estimated to be \$3,570,000 per system, with an estimated average annual operation and maintenance cost of approximately \$150,000 per system.

**Economic and Technological Feasibility:**

These regulations are economically and technologically feasible for rural area public water systems. Analytical methods exist for accurate sample analysis to detect PFOA, PFOS and 1,4-dioxane. There are also technologically feasible treatment solutions for all three contaminants. Treatment may present a greater challenge to smaller systems that typically have less resources including financial and technical expertise than larger systems.

**Minimizing Adverse Economic Impact on Rural Areas:**

The Department has included several provisions that minimize the impacts on regulated parties. Previous testing conducted using an ELAP approved method and laboratory may satisfy some or all of the initial monitoring requirements at the Department's discretion, or the local health department's discretion in consultation with the Department; sampling frequency will decrease after the first year if a contaminant (or the contaminants) is/are not detected at a public water system; the start of initial sampling is proposed to be staggered, requiring large systems to test first (within 60 days of adoption) and providing more time for smaller systems such that water systems serving between 3,300 to 10,000

persons should sample within 90 days of adoption and water systems serving less than 3,300 persons must begin sampling within 6 months of adoption.

In addition, New York State offers programs to support public water systems with infrastructure investments including but not limited to treatment and development/connection to alternate sources of water. Programs include the Drinking Water State Revolving Fund which provides market rate, low to no interest loans and grants available to many municipally and privately-owned public water systems based on need and financial hardship. In addition, the New York State Clean Water Infrastructure Act of 2017 invests \$2.5 billion in clean and drinking water infrastructure projects and water quality protection across the State. It provides funding to the New York State Water Infrastructure Improvement Act of 2017 (WIIA) for grants to assist municipalities with water quality infrastructure. A separate \$200 million has been provided to support grants for drinking water projects that will address emerging contaminants such as PFOA, PFOS or 1,4-dioxane.

**Rural Area Participation:**

Rural area stakeholders were not specifically consulted on this proposal, however the MCLs set forth in this proposed rule were recommendations from the Drinking Water Quality Council (DWQC) which met numerous times in a public forum and were also recorded. The membership of the DWQC included members from rural areas. The recordings are publicly available on the Department's web-site. During each DWQC meeting, members of the public could comment, and comments were provided to the

Department outside of the meetings. Based on the information available it is not possible to determine the exact number of rural stakeholders that participated during the meetings or provided comments, but from sign in sheets at the meetings rural communities attended DWQC meetings. All comments provided by the public were made available to the DWQC for their consideration.

## **JOB IMPACT STATEMENT**

### **Nature of the Impact:**

The Department expects there to be a positive impact on jobs or employment opportunities. A subset of public water system owners will likely hire firms or individuals to assist with regulatory compliance. Public water systems impacted by this amendment will require the professional services of a certified or approved laboratory to perform the analyses for PFOA, PFOS and 1,4-dioxane, which may create a need for additional laboratory capability and capacity. Additionally, a subset of owners will require the services of a licensed professional engineer to design facilities to meet the MCLs through treatment, or to access an alternate source.

### **Categories and Numbers Affected:**

The Department anticipates no negative impact on jobs or employment opportunities as a result of the proposed regulations.

### **Regions of Adverse Impact:**

The Department anticipates no negative impact on jobs or employment opportunities in any particular region of the state.

### **Minimizing Adverse Impact:**

Not applicable.