

## Analysis

### Current Policy Approach

On April 7, 2021, the New York State Legislature passed the State Budget for Health and Mental Hygiene, creating a new Public Health Law Section 2828. Under this new law, nursing homes are required to spend at least 70 percent of their operating revenue on direct resident care, of which 40 percent must be spent on resident-facing staffing. Facilities failing to meet this minimum spending requirement must pay the state the difference between their actual spending and their required minimum spending amount.

In addition, the law requires nursing homes with total operating revenues exceeding expenses by more than five percent to return that excess revenue to the state. The Department of Health is authorized to collect these excess funds through deductions or offsets to what Medicaid pays the facility or through legal action. Any recouped funds are to be placed into the nursing home quality pool which provides financial incentives for certain identified higher performing facilities.

Not subject to these requirements are continuing care retirement communities and facilities that primarily care for medically fragile children, HIV/AIDS residents, residents requiring behavior intervention or neurodegenerative services, or other specialized populations deemed appropriate by the Commissioner. In addition, the Department of Health may waive these requirements on a case-by-case basis for certain nursing homes unable to comply due to "unexpected or exceptional circumstances." The Commissioner may also exclude on a case-by-case basis, "extraordinary revenues and capital expenses, incurred due to a natural disaster or other circumstances...."

### Key Definitions in the Law

A facility's **total operating revenue** includes funds that come from or on behalf of its residents (such as individuals who pay privately), government payers (such as Medicare and Medicaid) or third-party payers (such as long-term care insurance) to pay for a resident's occupancy, care, and the operation of the facility. Revenue excludes the average increase in the capital portion of the Medicaid reimbursement rate from the prior three years.

**Expenses** include all operating and non-operating expenses, before "extraordinary gains." Expressly excluded from the calculation of expenses are "any related-party transaction or compensation to the extent that the value of such transaction is greater than fair market value, and the payment of compensation for employees who are not actively engaged in or providing services at the facility." Related-party transactions are those a nursing home conducts with third parties they control or in which they have a financial interest or other type of close association. By contracting with these related-party individuals and organizations for services such as management services, nursing and therapy services, and lease agreements and loans, companies can pull money out of the nursing homes as expenses and increase profits.

Nearly three-quarters of US nursing homes had related-party business transactions accounting for \$11 billion of nursing home spending in 2015 according to Medicare cost reports.<sup>17</sup> For-profit nursing homes use related corporations more frequently than nonprofits. An analysis from Kaiser Health News revealed that "nursing homes that outsource to related organizations tend to have significant shortcomings: They have fewer nurses and aides per patient, they have higher rates of patient injuries and unsafe practices, and they are the subject of complaints almost twice as often as independent homes."<sup>18</sup> A recent Washington Post article sheds additional light on how related-party vendors and real estate owners siphon money away from care.<sup>19</sup>

The 70 percent Minimum Spending on **Direct Resident Care** requirement calculation includes a wide range of expenditures including, but not limited to, medical staff services (Registered Nurses (RNs), Licensed Practical Nurses (LPNs) and Certified Nursing Assistants (CNAs)), transportation, social services, pharmacy, housekeeping, food services, activities, nursing administration, social services, and medical education. Direct resident care **does not** include administrative costs (other than nurse administration), capital costs, debt service, taxes (other than sales taxes or payroll taxes), capital depreciation, rent and leases, or fiscal services.

**Resident-facing staffing** includes all staffing expenses included in facility cost reports in the "ancillary and program service categories" such as nursing, therapy, and medical services. Fifteen percent of resident-facing staffing costs that are paid to outside contractors for RN, LPN or CNA services are to be deducted from the resident-facing staffing and direct resident care calculations. The rationale for this discounting of contract staff is to encourage nursing homes to utilize permanent staff, which generally leads to better and more humane care for residents, as well as better working conditions for staff.

## Status in New York

### Regulations

The Department of Health's (DOH) proposed regulations setting minimums for nursing home direct care spending were published for comment in the State Register on November 17, 2021. According to the regulatory publication, the new requirements would take effect starting January 1, 2022, after public comment period and final adoption. Governor Hochul's three Executive Orders which delayed enforcement of the law put this process on hold. However, according to the DOH's testimony before the state's Public Health and Health Planning Council (PHHPC), the law was sufficiently prescriptive and detailed that regulations may not be

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<sup>17</sup> Harrington, C., Montgomery, A., King, T., Grabowski, D.C., and Wasserman, M., *Health Affairs Blog*, "These Administrative Actions Would Improve Nursing Home Ownership And Financial Transparency In The Post COVID-19 Period," (February 11, 2021). Available at <https://www.healthaffairs.org/doi/10.1377/forefront.20210208.597573/>.

<sup>18</sup> Rau, Jordan, *Kaiser Health News*, "Care Suffers as More Nursing Homes Feed Money Into Corporate Webs," (December 31, 2017). Available at <https://khn.org/news/care-suffers-as-more-nursing-homes-feed-money-into-corporate-webs/>.

<sup>19</sup> Cenziper, D., Jacobs, J., Crites, A., and Englund, W., *The Washington Post*, "How Brius, California's largest nursing home chain amassed millions as scrutiny mounted," (December 31, 2020). Available at <https://www.washingtonpost.com/business/2020/12/31/brius-nursing-home/>.

necessary.<sup>20</sup> Executive Order 4.7, issued on March 31, 2022 reinstated the minimum spending provisions<sup>21</sup> and DOH has notified nursing homes that these provisions are in “full effect” as of April 1, 2022.<sup>22</sup>

As justification for the regulations, the DOH stated that, “Requiring nursing homes to spend an appropriate amount of revenue on the direct care of residents and resident-facing staffing will reduce errors, complications, and adverse resident care incidents. It will also improve the safety and quality of life for all long-term care residents in New York State.” As for the financial impact of these regulations once implemented, the DOH underscored that, “Residential health care facilities are not necessarily required to expend additional resources to meet these minimum spending requirements, but rather may appropriately manage expenditures to balance overall expenditures to meet the minimum spending thresholds.”<sup>23</sup>

*“Requiring nursing homes to spend an appropriate amount of revenue on the direct care of residents and resident-facing staffing will reduce errors, complications, and adverse resident care incidents.”*  
- NYSDOH

The proposed regulations, which essentially follow the language of the legislation, set forth:

- The manner in which facilities that fail to meet the statutory minimum spending requirements will reimburse the state,
- The type of facilities excluded from the requirements,
- The circumstances where requirements can be waived (e.g., what constitutes unexpected or exceptional circumstances), and
- The factors to be used in determining whether to exclude extraordinary revenues and capital expenses from the calculations.

### **Litigation**

New York's law was set to go into effect on January 1, 2022. However, as discussed above, Governor Hochul, by executive order, temporarily suspended enforcement of the law after

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<sup>20</sup> Recordings of the PHHPC meetings are available at <https://www.health.ny.gov/events/webcasts/archive/>. Scroll down to 10/7/21 to find the recording for this meeting.

<sup>21</sup> State of New York Executive Order 4.7, (March 31, 2022). Available at <https://www.governor.ny.gov/executive-order/no-47-continuing-declaration-statewide-disaster-emergency-due-healthcare-staffing>. (The law is now in effect as of April 1, 2022.)

<sup>22</sup> Letter from New York State Department of Health to New York State Nursing Home Administrators, (March 31, 2022). Available at <https://www.leadingageny.org/linkservid/FFA5B686-F449-96E6-242478D1EA89FCB9/showMeta/0/>.

<sup>23</sup> Section 2828 of Public Health Law, Part 415 Title 10 of NYCRR 414.34. Available at <https://www.manatt.com/Manatt/media/Documents/Articles/Proposed-Minimum-Direct-Resident-Care-Spending-regulation.pdf>.

nursing homes and industry trade groups filed suit on December 29, 2021, to block its implementation.

In their lawsuit,<sup>24</sup> the nursing homes are challenging the 70/40 minimum spending requirements and the penalties for non-compliance. They are asking the court to permanently block these provisions (along with other nursing home reforms passed in 2021, including requirements for nursing homes to provide a set minimum number of direct care staffing hours for residents).

The nursing homes challenging the law contend, among other arguments, that the spending requirements and profit limits are unconstitutional (including a challenge to the Eighth Amendment's prohibition against excessive fines) and interfere with the collective bargaining process.

The complaint sets out the amount of money that each of over 200 nursing homes would have had to pay back in 2019 had the law been in effect at that time. These facilities reported excess income totaling over \$510 million for that year alone.<sup>25</sup> The average excess annual income disclosed by nursing homes was \$2,144,770. According to a recent report by The Center for Medicare Advocacy (CMA),<sup>26</sup> these plaintiff nursing facilities include a Special Focus Facility (SFF), one of three in New York, five of New York's 15 candidates for the SFF Program,<sup>27</sup> and seven of 11 facilities sued by the U.S. Attorney for the Southern District of New York in June 2021 for allegedly fraudulently billing Medicare for unnecessary services, in violation of the federal False Claims Act. According to the CMA, these 13 facilities alone received \$19,529,428 in Provider Relief Funds which do not need to be repaid.

The nursing homes' lawsuit is still pending as of this publication.<sup>28</sup>

## 2022 Developments

On January 18, 2022, Governor Kathy Hochul released her budget proposal for State Fiscal Year 2023.<sup>29</sup> The Executive Budget proposed several amendments to the minimum direct resident care spending requirements that were passed in the enacted law and which will

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<sup>24</sup> *Home for the Aged of the Little Sisters of the Poor v. Mary T. Bassett*, No. 1:21-cv-01384 (BKS/CFH) (N.D.N.Y., filed Dec. 29, 2021). Available at <https://nursinghome411.org/wp-content/uploads/2022/02/Filed-Complaint.pdf>.

<sup>25</sup> *Long Term Care Community Coalition*, "LTCCC Alert: NY Nursing Homes Admit Excess Profits," (January 21, 2022). Available at <https://nursinghome411.org/nys-provider-lawsuit/>.

<sup>26</sup> Edelman, T., *Center for Medicare Advocacy*, "New York Nursing Homes Suing the State Received Federal Provider Relief Funds," (February 3, 2002). Available at <https://medicareadvocacy.org/new-york-nursing-homes-suing-the-state-received-federal-provider-relief-funds/>.

<sup>27</sup> SFFs and SFF Candidates are nursing homes that have a history of serious quality issues or are included in the Centers for Medicare & Medicaid Services (CMS) program to stimulate improvements in quality of care.

<sup>28</sup> May 13, 2022.

<sup>29</sup> New York State Fiscal Year 2023 Executive Budget. Available at <https://www.budget.ny.gov/pubs/archive/fy23/ex/index.html>.

impact the extent to which nursing home operators are held accountable for the use of the funds they receive for resident care.

The enacted provisions include:

- Exclusion from the revenue calculation of nursing home assessment fees. In general, these are fees (sometimes referred to as provider taxes) the nursing home pays to the state to help generate additional Medicaid dollars from the federal government. The assessment fees are matched with federal Medicaid funds, and then, in most cases, returned to the nursing homes in the form of an increase in their reimbursement rate.
- Exclusion from the revenue calculation of the “capital per diem” portion of the Medicaid reimbursement rate for nursing homes with an overall four- or five-star CMS rating. This provision is especially concerning from a consumer perspective since, if the capital per diem part of their payments from the state are not included as revenue, nursing homes will be able to report far less revenue, and thus will be required to spend far less on direct resident care.

The enacted budget also increased the overall Medicaid reimbursement rate for nursing homes by one percent.

### *State Legislation*

A number of states, including California and Connecticut, are considering legislation to establish a direct care spending requirement in their 2022 legislative sessions.

- California's bill, AB-2079,<sup>30</sup> introduced February 14, 2022, requires a minimum of 85 percent of nursing homes' revenue be spent on the direct care of residents. Direct care includes a broader range of staff members than New York's law such as in-house clerical staff that regularly interacts with residents and caregivers. Capital costs, such as depreciation, leases and rentals and property taxes and insurance are not considered direct care, nor are administrative costs paid to contractors or related-parties for staffing services. Exceptions to non-direct care may be made on a case-by-case basis for certain high-cost expenditures “that directly benefit residents, such as establishing single rooms and private bathrooms.”
- Connecticut's bill, H.B. 5310,<sup>31</sup> introduced March 3, 2022, would require a nursing home facility to spend not less than 90 percent of the Medicaid funding it receives on residents' direct care. The percentage may be reduced on a case-by-case basis for certain facilities with a capital improvement project or a fair rent increase. "Direct care" is defined as “hands-on care provided to a resident by nursing personnel” which is limited to advanced practice registered nurses, registered nurses, practical nurses, and nurse's aides.

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<sup>30</sup> Assembly Bill No. 2079 (2022). Available at [https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill\\_id=202120220AB2079](https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=202120220AB2079).

<sup>31</sup> House Bill No. 5310 (2022). Available at [https://www.cga.ct.gov/asp/cgabilstatus/cgabilstatus.asp?selBillType=Bill&bill\\_num=HB-5310](https://www.cga.ct.gov/asp/cgabilstatus/cgabilstatus.asp?selBillType=Bill&bill_num=HB-5310).

### ***Precedents for New York Minimum Direct Care Ratio Law***

Requiring an insurer or provider to spend a certain amount of their income on health care and quality improvement, and a much lesser amount on administration, marketing, and profits, is not a new concept. While the Medical Loss Ratio requirements set forth in the Affordable Care Act (ACA) enacted in 2010 are the most well-known example, a number of states, including New York, have had laws related to medical loss ratios created long before the ACA was enacted. In addition, there were MLR requirements for Medicare Supplement policies as far back as 1990.

The ACA requires most health insurance companies that cover individuals and small businesses to spend at least 80 percent of the moneys they receive from premiums on health care claims and quality improvement, leaving the remaining 20 percent for administration, marketing, and profit. The MLR threshold is higher for large group plans (generally, those that cover employers with 51 or more employees) which must spend at least 85 percent of premium dollars on health care and quality improvement. Under the ACA, states have the flexibility to set higher MLR standards. The ACA also permits adjustments to the MLR requirements in a state if it is determined by the federal government that the 80 percent MLR requirement could destabilize the state's individual insurance market.

The nursing home industry itself has come out in support of MLRs, with one industry group stating that “[t]he ACA recognizes the value of minimum MLR standards as a health reform measure . . . in order to maximize that portion of premiums spent on health care rather than administration and profit.”<sup>32</sup>

In 2016, the Centers for Medicare and Medicaid Services (CMS) established new MLR requirements for state Medicaid Managed Care Plans.<sup>33</sup> These requirements went into effect in 2019. Unlike Medicare Advantage and private plans that are required to issue rebates to the state or plan enrollees if they fail to meet MLR standards, the state may choose to require Medicaid managed care organizations (MCO's) to return excess funds or not. As of 2021, more than half the states, including New York and New Jersey, that contract with MCO's always require MCO's to pay remittances when MLR requirements are not met. Massachusetts is among nine states that contract with MCOs that require remittances under certain circumstances.<sup>34</sup>

The concept of using an MLR for nursing home providers was introduced by academics and resident advocates as early as 2013<sup>35</sup> and this proposal has since been echoed by many others.

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<sup>32</sup> *American Health Care Association*, “Issue Brief: Minimum Medical Loss Ratio Requirements”. Available at <https://studylib.net/doc/7948160/issue-brief--minimum-medical-loss-ratio-requirements>.

<sup>33</sup> Managed care is the primary Medicaid delivery system in at least three-fourths of the states.

<sup>34</sup> *Kaiser Family Foundation*, “States Respond to COVID-19 Challenges but Also Take Advantage of New Opportunities to Address Long-Standing Issues Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2021 and 2022,” (October 2021). Available at <https://files.kff.org/attachment/Report-States-Respond-to-COVID-19-Challenges.pdf>.

<sup>35</sup> Harrington, C., Ross, L., Mukamel, D., Rosenau, P., *The Kaiser Commission on Medicaid and the Uninsured*, “Improving the Financial Accountability of Nursing Facilities,” (June 2013). Available at

Building on that foundation, the momentum initiated by the MLR requirements imposed on insurers and MCOs by states and federal regulators, the unique and devastating quality failures of COVID, and the unprecedented influx of vast sums of taxpayer dollars distributed to facilities, policymakers in three states in 2020 (Massachusetts, New Jersey, and New York) enacted similar MLR laws directed at nursing home facilities.

These laws refer to the MLR by different names; in Massachusetts it is referred to as a “nursing facility direct care cost quotient,” in New Jersey it is called a “direct care ratio” or “nursing facility patient care ratio” (PCR), and in New York, “minimum direct resident care spending.”

The following is a description of the NJ and MA laws:

### ***New Jersey***

On September 9, 2020, the New Jersey legislature passed legislation (A4482/S2758) establishing direct care ratio (DCR) requirements for nursing homes. Signed by the Governor on September 16, 2020, the legislation<sup>36</sup> requires the state Commissioner of Human Services to establish a *direct care ratio reporting and rebate requirement* to take effect no later than July 1, 2021.

The DCR requires that 90 percent of a facility's aggregate revenue in each fiscal year is to be expended on the direct care of residents. Nursing homes must report total revenues collected, along with the portion of revenues that are spent on direct care staff wages, other staff wages, taxes, administrative costs, investments in improvements to the facility's equipment and physical plant, profits, and any other factors as the Commissioner requires.

Nursing facilities that fail to meet the DCR will be required to pay a rebate to the state. The state Department of Human Services (or other entities it designates) is authorized to conduct an audit of the financial information reported by the nursing facilities to ensure the accuracy of the information and compliance with the requirements of the rule.

Regulations to implement the New Jersey law were proposed April 19, 2021, adopted September 14, 2021, and became effective October 18, 2021. According to explanatory language in the proposed regulations, the “COVID-19 pandemic demonstrated a profound need for focus on the resiliency of the State's nursing facilities and for accountability in the use of revenue to ensure high-quality resident care”. The patient care ratio (PCR) reporting and rebate requirement in this law, is a tool (in addition to other laws and directives passed by the New Jersey legislature in 2020, including minimum wage levels for CNAs and required staffing ratios) “to ensure that State resources are expended in support of quality care for individuals receiving services.”

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<https://sites.mitre.org/nhccovidcomm/wp-content/uploads/sites/19/ninja-forms/3/improving-the-financial-accountability-of-nursing-facilities.pdf>.

<sup>36</sup> P.L. 2020, c. 89. Available at <https://www.njleg.state.nj.us/Bills/2020/PL20/89 .PDF>.

The final regulations (September 14, 2021) appear to deviate from the language and intent of the statute by narrowly defining the patient care ratio as a percentage of a facility's revenue from Medicaid only, and not from its aggregate revenue.

Fiscal Year 2022 will be the first reporting period upon which a rebate will be calculated.

### ***Massachusetts***

Massachusetts now requires nursing homes to spend at least 75 percent of their total revenue on the direct care of residents. This measure was borne out of the state's [Nursing Facility Task Force](#) comprised of advocates, state, industry and union officials. The Task Force produced two Nursing Facility Accountability and Supports packages.

The first, released in April 2020, allocated \$82 million to increase reimbursement rates to be used for staffing, infection control services, personal protection equipment (PPE) and other supports that directly benefit staff. A second package of funding in September 2020 included a requirement that nursing facilities spend at least 75 percent of their revenue towards direct care staffing costs, effective October 1, 2020. Regulations implementing this new "nursing Facility Direct Care Cost Quotient (DCC-Q)" were issued and made effective February 10, 2021.

In general, facilities are required to report an interim compliance report and a final compliance report each year. Facilities that do not meet the 75 percent threshold for the previous fiscal year will have their reimbursement rate reduced for the following year. In addition, facilities that fail to comply with the reporting requirements may be fined up to \$5,000.

A report for the period October 1, 2020 through June 30, 2021<sup>37</sup> shows that more than one-third of the state's nursing homes fell below the minimum 75 percent spending threshold, when all revenue from federal and state sources, including COVID-19 relief funds, was counted, as is required by statute. Even when only standard revenue sources (e.g., Medicaid) were included, 15 percent of nursing facilities did not meet the required threshold.

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<sup>37</sup> *MassHealth*, "Direct Care Cost Quotient (DCC-Q) Report." Available at <https://www.mass.gov/info-details/direct-care-cost-quotient-dcc-q-reports>.