



LTCCC POLICY BRIEF:

DIRECT CARE MINIMUM SPENDING LAWS

*A Critical Tool for Improving Care for Nursing Home Residents and
Accountability for Taxpayer Funds*

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Introduction

As of January 30, 2022, more than 200,000 nursing home residents and staff in the United States have died from COVID-19. These deaths make up at least 23 percent of all deaths in the US¹ and are likely undercounted as they exclude many resident deaths that have resulted from social isolation, insufficient staffing, and overall failure of many nursing home operators to meet minimum health and safety standards. These numbers also do not account for the over two million resident and staff COVID infections² which can have long-lasting negative health implications, especially for vulnerable individuals.

These COVID-related deaths and infections were not inevitable. Nor were the many needless and untimely deaths of nursing home residents that occurred prior to the pandemic. They are largely the product of widespread and longstanding failures by regulators, over the course of decades, to effectively enforce the basic standards of care for nursing homes, and of the nursing home operators that have taken advantage of this environment of lax enforcement to maximize their income at the expense of their residents' safety and dignity.

Because of lax oversight, many nursing home owners and operators have become increasingly sophisticated in using taxpayer dollars to benefit themselves rather than those for whom these funds are intended – their residents. The millions of dollars of Medicare and Medicaid funds (including COVID-19 related funds) operators receive to care for nursing home residents are increasingly diverted away from resident care and towards items such as administrative salaries, capital expenditures, and other unrelated expenses. Public funds that are paid to operators for resident care often find their way into the coffers of companies owned or controlled by these operators. These “related-party” transactions have become a common business arrangement.

Another development in recent years has been the growth in the number of private equity-owned nursing homes. An increasingly robust and disturbing body of research finds that quality of care for residents declines when private equity firms take over nursing facilities.³ Because private equity firms strive to generate high, short-term

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¹ Chidambaram, P., *Kaiser Family Foundation*, “Over 200,000 Residents and Staff in Long-Term Care Facilities Have Died From COVID-19,” (February 3, 2022). Available at <https://www.kff.org/policy-watch/over-200000-residents-and-staff-in-long-term-care-facilities-have-died-from-covid-19/>

² *Centers for Medicare & Medicaid Services* <https://data.cms.gov/covid-19/covid-19-nursing-home-data> (data downloaded March 17, 2022).

³ Braun, R.T., Jung H., Casalino L.P., Myslinski Z., and Unruh, M.A., *JAMA Health Forum*, “Association of Private Equity Investment in US Nursing Homes With the Quality and Cost of Care for Long-Stay Residents,” (November 19, 2021). Available at <https://jamanetwork.com/journals/jama-health-forum/fullarticle/2786442>; Gupta, A., Howell, S.T., Yannelis, C., and Gupta, A., *National Bureau of Economic Research*, “Does Private Equity Investment in Healthcare Benefit Patients? Evidence from Nursing Homes,” (February 2021). Available at <https://www.nber.org/papers/w28474>.

profits for their investors, the facilities they own tend to reduce spending on nurse staffing and other resident-facing services and supplies, and increase spending on management expenses, related-party fees and antipsychotic drugs, the latter too often used as a substitute for adequate nursing staff.

The Biden Administration’s recent nursing home reform proposals⁴ underscore the growing awareness of this environment, and the urgent need for swift action “to ensure taxpayer dollars go toward the safe, adequate, and respectful care seniors and people with disabilities deserve – not to the pockets of predatory owners and operators who seek to maximize their profits at the expense of vulnerable residents’ health and safety.”

These laws will improve safety, quality of care, and quality of life for the nation’s nursing home residents and will provide a critical tool for sorely needed transparency and accountability.

Contrary to the nursing home industry’s claims, COVID has had little negative impact on nursing home finances.⁵ In response to the pandemic, the country’s nursing homes have received millions of dollars from the Provider Relief Fund, the Paycheck Protection Program, and Medicare accelerated payment funds. These funds are in addition to the large sums of money nursing homes regularly receive from Medicare, Medicaid, and private pay residents.

Until recently, nursing homes have not been required to spend a set minimum percentage of the funds they receive on the care of their residents, nor have the public or policymakers had an effective tool to require accountability for these expenditures. In May 2020, as the number of COVID-19 deaths continued to mount in New Jersey, that state enlisted the Manatt Health consulting firm to make a series of substantive recommendations for reforming its troubled nursing home industry during the pandemic and beyond. One of the recommendations, designed to address both the lack of transparency on how taxpayer funds are spent, as well as the need to require that the bulk of funds be spent on resident care, called for the establishment of a nursing home direct care ratio reporting and rebate requirement.⁶

In September 2020, the New Jersey Legislature passed and the Governor signed legislation (A4482/S2758) establishing a direct care ratio (DCR) requirement for nursing homes.⁷ The New Jersey 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, and facilities that fail to meet the DCR will be required

⁴ Fact Sheet: Protecting Seniors by Improving Safety and Quality of Care in the Nation’s Nursing Homes (February 28, 2022). Available at <https://www.whitehouse.gov/briefing-room/statements-releases/2022/02/28/fact-sheet-protecting-seniors-and-people-with-disabilities-by-improving-safety-and-quality-of-care-in-the-nations-nursing-homes/>.

⁵ Kingsley, D.E., and Harrington, C., *Journal of the American Geriatrics Society*, “COVID-19 had little financial impact on publicly traded nursing home companies,” (May 24, 2021). Available at <https://agsjournals.onlinelibrary.wiley.com/doi/10.1111/jgs.17288>.

⁶ Manatt, “Recommendations to Strengthen the Resilience of New Jersey’s Nursing Homes in the Wake of COVID-19,” (June 2, 2020). Available at <https://manatt.com/Manatt/media/Documents/NJ-LTC-Report.pdf>.

⁷ P.L. 2020, c. 89. Available at <https://www.njleg.state.nj.us/Bills/2020/PL20/89 .PDF>.

to pay a rebate to the state. The state is authorized to audit the financial information reported by nursing facilities to ensure accuracy and compliance with the law. New Jersey's legislation was enacted nearly the same time that the Commonwealth of Massachusetts established a similar requirement for nursing homes to spend at least 75 percent of their revenue on direct care staffing costs, effective October 1, 2020.⁸ New York followed soon after in April 2021 with the passage of its own direct care spending law, which requires nursing homes 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.⁹ In 2022, other states are considering similar legislation.¹⁰

Similar laws requiring health insurers to spend a set minimum amount on healthcare have existed for decades. These laws, called Medical Loss Ratios (MLRs), have given policymakers and regulators the ability to ensure accountability for taxpayer funds, and prioritize their use for health care. Applying this concept to nursing homes – requiring nursing homes to spend an appropriate amount of revenue on the direct care of their residents is urgently needed. These laws will improve safety, quality of care, and quality of life for the nation's nursing home residents and will provide a critical tool for sorely needed transparency and accountability.

Key Components of a Direct Care Minimum Spending Law

The principal goal of a direct care minimum spending law is to ensure that nursing home providers spend the bulk of the funds they receive for the care of residents. To accomplish this goal, these laws generally:

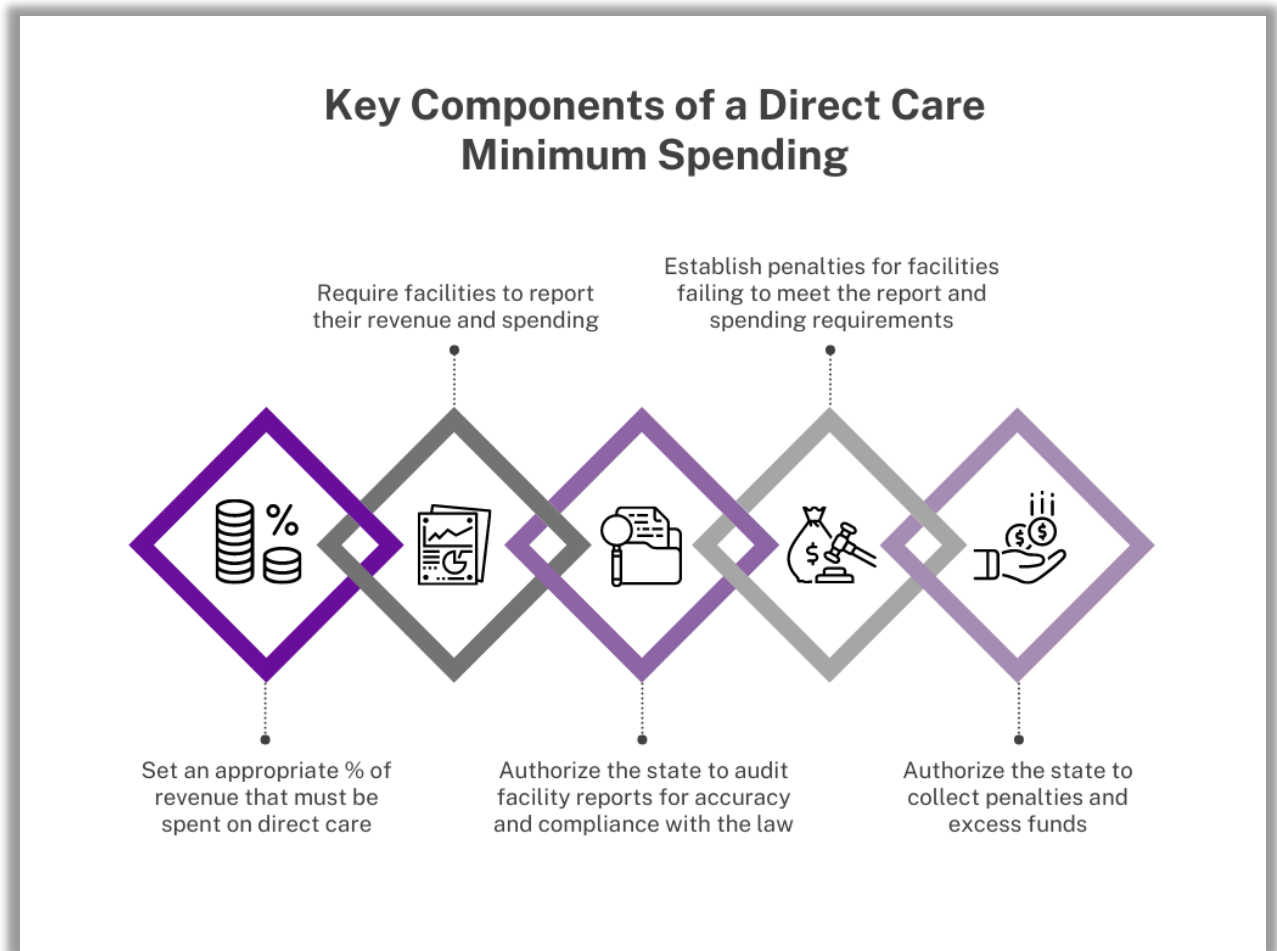
- Set an appropriate percentage of revenue that must be spent on direct care,
- Require facilities to report their revenue and spending,
- Authorize the state to audit facility reports for accuracy and compliance with the law,
- Establish penalties for facilities failing to meet the report and spending requirements, and
- Authorize the state to collect penalties and excess funds.

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⁸ 206.12: Direct Care Cost Quotient (2020). Available at https://www.sec.state.ma.us/reg_pub/pdf/911/E101206.pdf.

⁹ 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>.

¹⁰ See California Assembly Bill No. 2079 (2022). Available at https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=202120220AB2079. See also Connecticut House Bill No. 5310 (2022). Available at https://www.cga.ct.gov/asp/cgabillstatus/cgabillstatus.asp?selBillType=Bill&bill_num=HB-5310.



Calculating the percentage of revenue that facilities must spend appears to be the most challenging task lawmakers confront when drafting, passing, and implementing direct care minimum spending legislation. A major obstacle is how to define key terms.

Revenue

Failing to include a broad definition of “revenue” will thwart the principal goal of the law – to hold nursing facilities accountable for the full range of revenue sources that flow to them.

Recommendation: “Revenue” should include total operating revenue from all major revenue sources, including, but not limited to Medicaid, Medicare, private pay, Veterans Affairs, and long-term care insurance benefits. Limiting revenue sources to Medicaid reimbursement payments could encourage facilities to inappropriately utilize their non-Medicaid sources of revenue on non-resident-facing expenditures such as administrative fees and profits. It may also result in increased discrimination against Medicaid beneficiaries (since providers will have additional incentives to reject them as residents or inappropriately discharge them from the facility when their Medicare or other short-term benefits run out), thus exacerbating existing inequities in access to decent care for Medicaid beneficiaries.

Direct Care

A well-crafted definition of “direct care” can help ensure that revenue is spent largely for the benefit of residents.

Recommendation: The definition of what constitutes “direct care” should have at its foundation those expenditures related to the hands-on care provided by nursing personnel and other in-house staff who regularly interact with residents. Direct care expenses should also include ancillary services (pharmacy, housekeeping, food services, and activities) and support service (laundry, linen, dietary and social services). Most administrative costs (management and executive wages and benefits), capital costs, debt service, capital depreciation, rent and leases or fiscal services should not be considered “direct care.” To encourage nursing facilities to utilize permanent staff, which generally leads to better care for residents, legislative drafters should strongly consider discounting payments to outside contractors for nursing services. Payments to related parties where the value is greater than fair market value, and payments to employees who are not actively engaged in or providing services at the facility should be excluded as direct care expenditures.

Reporting Requirements

While most nursing homes are required to submit annual cost reports, these are unwieldy and not particularly suited to the direct care spending calculation. Direct care minimum spending legislation that requires specific annual disclosures and reporting responding to the exact provisions of the law will help regulators more effectively and efficiently ascertain compliance.

Recommendation: Each facility should be required to submit a report, and owners of multiple facilities should be required to submit a separate report for each facility. Each report should include a plain language summary description of the report, using a standardized form provided by a regulatory agency. The report and the summary should be posted and made readily available to the public by the nursing home and posted, in an electronic format, on a public-facing website. The facility should be required to retain and provide to regulators and other government accountability agencies, upon request, all data and underlying supporting information used to make the report.

Audits

Information submitted by facilities must be evaluated on a regular basis to verify accuracy and ensure compliance with the law.

Recommendation: Every facility should be subject to auditing on a regular basis, with follow-up audits occurring as needed. In addition, a sample percentage of nursing homes should be audited annually. Certain circumstances, such as a reasonable possibility of fraud, should trigger an immediate audit of a facility. Facilities (along with their parent organizations, related parties, subcontractors, etc.) should be required to allow access and entry to their premises and records (including computer systems) by regulators (and other government accountability agencies) for the purposes of the audit. The results of audits should be made available in the facility and posted online for public access.

Penalties and Sanctions

Direct care spending laws require facilities to return excess revenue when they fail to meet the required spending percentage.

Recommendation: Legislation should require facilities found to have not met their required spending amount to return the excess revenue by a date certain. Repeated failures to comply with spending requirements should be met with enhanced sanctions, and greater scrutiny should be imposed on chains or owners/operators of multiple facilities that have repeated violations.

Collection of Penalties

Direct care spending legislation generally authorizes the state to recoup funds by withholding payments due to the facility and through deductions or offsets to prospective payments.

Recommendation: The state should be authorized to use legal action to recover amounts due and to refer cases of nonpayment to the state's debt collection agency. Information on penalties imposed and collected should be made publicly available.

Precedents for a Minimum Direct Care Spending Law

Federal Precedents

Requiring an insurer or health care 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, numerous states have had laws related to medical loss ratios established 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."¹¹

¹¹ *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>.

In 2016, the Centers for Medicare & Medicaid Services (CMS) established new MLR requirements for state Medicaid Managed Care Plans.¹² 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 (MCOs) to return excess funds or not. As of 2021, more than half the states that contract with MCOs always require MCOs to pay remittances when MLR requirements are not met. Another nine states that contract with MCOs require remittances under certain circumstances.¹³

The concept of using an MLR for nursing home providers was introduced by academics and nursing home resident advocates as early as 2013,¹⁴ and this proposal has since been echoed by many others. 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 two states in 2020 (New Jersey and Massachusetts) and in New York in 2021 enacted similar MLR laws directed at nursing home facilities.

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

State Precedents

The following is a summary of the **three state 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 legislation¹⁵ 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 law was based on one of a series of recommendations by Manatt Health in a report commissioned by the state.¹⁶

¹² Managed care is the primary Medicaid delivery system in at least three-fourths of the states.

¹³ *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>.

¹⁴ Harrington, C., Ross, L., Mukamel, D., and Rosenau, P., *The Kaiser Commission on Medicaid and the Uninsured*, “Improving the Financial Accountability of Nursing Facilities,” (June 2013). Available at <https://sites.mitre.org/nhccovidcomm/wp-content/uploads/sites/19/ninja-forms/3/improving-the-financial-accountability-of-nursing-facilities.pdf>.

¹⁵ P.L. 2020, c. 89. Available at <https://www.njleg.state.nj.us/Bills/2020/PL20/89 .PDF>.

¹⁶ Manatt, “Recommendations to Strengthen the Resilience of New Jersey’s Nursing Homes in the Wake of COVID-19,” (June 2, 2020). Available at <https://manatt.com/Manatt/media/Documents/NJ-LTC-Report.pdf>

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 became effective October 18, 2021. Calendar year 2022 will be the first reporting period upon which a rebate will be calculated. The final regulations 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.¹⁷

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, 2021¹⁸ 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. Nevertheless, the state has delayed the implementation of any downward adjustment in rate penalties due to the

¹⁷ 53 N.J.R. 1783(a), (2021). Available at [https://www.nj.gov/humanservices/providers/rulefees/ruleadop/ruleadoptfiles/R.2021%20d.120%20\(53%20N.J.R.%201783\(a\)\).pdf](https://www.nj.gov/humanservices/providers/rulefees/ruleadop/ruleadoptfiles/R.2021%20d.120%20(53%20N.J.R.%201783(a)).pdf).

¹⁸ *MassHealth*, "Direct Care Cost Quotient (DCC-Q) Report." Available at <https://www.mass.gov/info-details/direct-care-cost-quotient-dcc-q-reports>.

“atypical” nature of expenses and revenues as a result of the pandemic, “significant fluctuations in facilities’ expenses and revenues,” and the fact that when the regulations were drafted, not all of the revenue had been anticipated or spent. According to the report, penalties will be enforced in 2023 for nursing homes failing to meet the required direct care cost quotient for rate year 2022 (October 2021 – September 30, 2022).

New York

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 must spend at least 70 percent of their operating revenue on direct resident care, of which 40 percent must be spent on resident-facing staffing.¹⁹ 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.

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. 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.”

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.

¹⁹ <https://nursinghome411.org/ny-minimum-spending-ratio/>.

Regulations to implement the law were published on November 17, 2021, and were due to take effect starting January 1, 2022, after public comment period and final adoption. However, the Governor, by a series of executive orders, temporarily suspended enforcement of the law through March 31, 2022, after nursing homes and industry trade groups filed suit to block its implementation. The regulatory process is currently (as of March 21, 2022) on hold.

However, according to the Department of Health's testimony before the state's Public Health and Health Planning Council (PHHPC), the law is sufficiently prescriptive and detailed that regulations may not be necessary.²⁰

As justification for the regulations, the Department 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 Department 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."²¹

In their lawsuit,²² 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 the 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.²³ 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),²⁴ these plaintiff nursing facilities include a Special Focus Facility

²⁰ 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.

²¹ 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>.

²² *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>.

²³ <https://nursinghome411.org/nys-provider-lawsuit/>. Note: the industry's complaint enumerates over \$510 million for each of the nursing homes listed therein, but claims \$824 million in excess income for the year.

²⁴ 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/>.

(SFF), one of three in New York, five of New York's 15 candidates for the SFF Program, 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 received \$19,529,428 in Provider Relief Funds which do not need to be repaid.

The nursing homes' lawsuit is pending as of this publication.²⁵

On January 18, 2022, the Governor released her budget proposal for State Fiscal Year 2023.²⁶ The Executive Budget would amend the minimum direct resident care spending law to exclude from the revenue calculation 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.

In addition, the budget proposal would not count as revenue the "capital per diem" portion of the Medicaid reimbursement rate for nursing homes with a four- or five-star CMS rating, and, on a case-by-case basis, for nursing homes with a three-star CMS star rating. If the capital per diem part of their payments from the state is not included as revenue, nursing homes would be able to report far less revenue, and thus, would be required to spend far less on direct resident care. Due to longstanding concerns about inflation of facility scores in the five-star rating system,²⁷ and the extent to which four- and five-star facilities provide substandard care, the proposal to hold these providers *less* accountable for appropriate spending on resident care is extremely troubling.

Due to longstanding concerns about inflation of facility scores in the five-star rating system (and the fact that too many four- and five-star facilities provide poor care), the proposal to hold these providers *less* accountable for appropriate spending on resident care is extremely troubling.

The Executive Budget also increases the overall Medicaid reimbursement rate for nursing homes by one percent. These increased rates are intended to help nursing homes compete in the current challenging labor market and compensate for the higher costs of providing care. In addition, the budget provides massive amounts of funding for nursing homes to address the impacts of the pandemic, to improve infrastructure and for bonuses for health care workers.

²⁵ April 4, 2022.

²⁶ New York State Fiscal Year 2023 Executive Budget. Available at <https://www.budget.ny.gov/pubs/archive/fy23/ex/index.html>.

²⁷ Silver-Greenberg, J., and Gebeloff, R., *The New York Times*, "Maggots, Rape and Yet Five Stars: How U.S. Ratings of Nursing Homes Mislead the Public," (March 13, 2021). Available at <https://www.nytimes.com/2021/03/13/business/nursing-homes-ratings-medicare-covid.html>.

State Legislative Highlights in 2022

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-2079,²⁸ introduced February 14, requires a minimum of 85 percent of nursing homes' revenue to be spent on the direct care of residents. Direct care includes a broad range of staff members 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, HB 5310, introduced March 4,²⁹ would require a nursing home facility to spend not less than ninety per cent 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.

Conclusion

Direct Care Minimum Spending laws, which require nursing home providers to spend a set percentage of their revenue, largely taxpayer dollars, on resident care, are a critically needed, reasonable, and carefully targeted solution to address the failure of too many nursing home operators to provide sufficient staffing and supplies to meet the basic needs of their residents. The reporting and auditing requirements in these laws will help provide basic transparency that has been sorely missing, and the enforcement authority provided to regulators will help ensure accountability. Provisions for public reporting of compliance in an easily accessible and consumer-friendly fashion will further strengthen these laws.

Setting a required baseline spending amount has established precedents for health care providers throughout the country. Minimum Loss Ratios have been required of Medicare Supplement plans since 1990, of small and large group plans by the ACA since 2010, and of State Medicaid Managed plans since 2019. Regulators are familiar with these concepts and are experienced in their enforcement. Statutes that require facility reporting that responds specifically to the provisions of the law will make enforcement more efficient and effective.

²⁸ Assembly Bill No. 2079 (2022). Available at https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=202120220AB2079.

²⁹ House Bill No. 5310 (2022). Available at https://www.cga.ct.gov/asp/cgabillstatus/cgabillstatus.asp?selBillType=Bill&bill_num=HB-5310. HB5310 died in Committee on March 11, 2022, but proponents plan to introduce it next session.

With facilities receiving millions of dollars for COVID relief, and with the nursing home industry currently seeking further increases in reimbursement to meet the challenges of staff shortages and other COVID-related expenditures, now is the optimum time to ensure transparency and accountability for this funding. The Biden Administration's recent nursing home proposals have shed further light on the urgent need for swift action to ensure taxpayer dollars go for quality care for nursing home residents. **Direct care minimum spending legislation provides policymakers with an important tool to ensure that a reasonable amount of the money taxpayers provide to nursing homes are actually used to meet the needs of nursing home residents.**

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