

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

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

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>.

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>.

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

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

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 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 "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

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>.

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

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.

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

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.

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 (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

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/>.

²⁵ April 4, 2022.

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.

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>.