LeadingAge New York

September 23, 2022

Katherine Ceroalo
NYS Department of Health
Bureau of Program Counsel
Reg. Affairs Unit
Corning Tower, Room 2438
Empire State Plaza
Albany, NY 12237

RE: HLT-46-21-00005-RP: Nursing Home Minimum Direct Resident Care Spending

Dear Ms. Ceroalo:

I am writing on behalf of the membership of LeadingAge New York to provide input on the revised proposed addition of Section 415.34 to Title 10 NYCRR. This regulation would require each nursing home to spend a minimum of 70 percent of its revenue on direct resident care and 40 percent of its revenue on resident-facing staffing (the "70/40 requirements").

LeadingAge NY and its not-for-profit (NFP) and government-sponsored provider members dedicate the overwhelming majority of their revenue to resident care and continuously strive to deliver the highest quality care. As noted in our Jan. 17th letter commenting on the original proposed regulation, and in spite of the revisions made in this rulemaking, LeadingAge NY and its members remain deeply concerned that this proposed regulation and its companion, the nursing home minimum staffing hours regulation, will impede rather than advance the desired outcome of improving the quality of care in nursing homes. Most critically, the proposed regulation, even with the amendments incorporated, will impede nursing homes from making capital improvements to strengthen their ability to fight the spread of COVID-19 and improve the quality of life of their residents. In addition, these regulations will limit the ability of nursing homes to make necessary expenditures for security staff and medical records. Overall, the rigid and arbitrary definitions of countable spending and revenue set forth in these regulations will impede nursing homes from creating the vibrant communities and homelike environments with strong infection prevention controls that represent the highest quality in nursing home care. We ask that the Department exercise whatever administrative discretion it may have to adopt regulations that promote quality of care and quality of life for nursing home residents, rather than undermine them.

Attached to this letter are our Jan. 17, 2022 comments on the initially proposed rulemaking [HLT-46-21-00005-P: Nursing Home Minimum Direct Resident Care Spending], which were not acknowledged in the Assessment of Public Comment on the original proposed regulation and which generally remain relevant to the revised proposed regulation. LeadingAge NY reiterates and incorporates by reference the general comments incorporated in our Jan. 17, 2022 letter on the initially proposed rulemaking, with the additions, revisions and emphases identified below.

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GENERAL COMMENTS

We acknowledge and appreciate the revisions made to the proposed regulations to align them with amendments to PHL § 2828 by Ch. 57 of the Laws of 2022, specifically: (1) 10 NYCRR § 415.34(b)(4), which would exclude capital costs of certain nursing homes, provider tax reimbursement, and federal COVID-19 grant funds from the definition of "revenue"; and (2) 10 NYCRR § 415.34(e)(1)(ii), which would prorate the remission of any excess revenue in 2022 to the period April 1 through Dec. 31, 2022, the remaining portion of calendar year 2022 subsequent to the expiration of Executive Order 4.4 [see 9 NYCRR § 9.4.4]. We provide further specific comments below.

SPECIFIC COMMENTS

Within the context of our general comments and previously submitted comments, we provide in this section supplemental feedback on selected elements of the revised proposed rulemaking together with the applicable regulatory references in order of their appearance in the regulation, not necessarily in order of priority:

§ 415.34 (b): Definitions:

Even as amended in this rulemaking, the proposed definitions will discourage necessary expenditures that would benefit residents and staff. They will also discourage sound investments of reserves and receipt of philanthropic donations. And, they will unfairly penalize high-quality facilities that receive quality pool awards. In particular, the following definitions raise concerns:

(1) **"Contracted out":** As previously noted, this regulatory definition is overbroad and could be interpreted to include per diem employees. The clear statutory intent is to discount expenditures for individuals retained through an external staffing agency/company, not payments to individuals directly employed by the facility. Even before the pandemic, nursing homes relied on per diem employed nurses and aides to provide direct care services. Usage of per diem staff has continued during the pandemic and could be more prevalent than before with the implementation of minimum nurse staffing requirements [PHL Section 2895-b] as facilities strive to access any available staff, including those individuals who are not willing to work full-time. Unlike the statutory assumption of a "profit factor" in related-company labor contracts, there is no 15 percent "profit margin" built into the amounts paid to individual per diem employees; accordingly, this discount should not be applied under proposed § 415.34(d)(2)(ii), and the definition should be clarified to exclude employed, per diem staff.

(2) **"Direct Resident Care":**

- *Security, Grounds, Medical Records:* The "direct resident care" definition arbitrarily excludes several categories of resident care costs incurred by nursing homes, including, for

example, costs associated with security, grounds, and medical records. The Security cost center contains "…all the expenses associated with maintaining the safety and well-being of residential health care facility patients, personnel and visitors, and protecting the facility by patrolling and guarding designated areas [10 NYCRR § 455.8]. The Grounds cost center contains "…all the expenses associated with the maintenance of grounds of the facility, including landscaped and paved areas, streets on the property, sidewalks, fenced areas and fencing, external recreation areas and parking facilities (e.g., lawn care, repairs and snow removal) [10 NYCRR § 455.7]. The Medical Records cost center contains "…all the expenses associated with maintaining a record system for the use, transcription, retrieval, storage and disposal of patient medical records and production of indexes, abstracts and statistics for residential health care facility management and medical staff use [10 NYCRR § 455.19].

Clearly, these functions are necessary for proper resident safety and care. By discouraging facilities from spending on security, snow removal, pavement repairs, outside recreation areas, and medical records systems, this provision impedes the stated goals of the statute and regulation – i.e, "to help ensure a high quality of resident care . . . reduce errors, complications, and adverse resident care incidents . . . [and] improve the safety and quality of life for all long-term care residents." By excluding these costs from direct care spending, the regulation will only detract from resident safety and quality of life. These expenses should be listed as direct resident care cost centers in this definition.

- *Capital Costs:* Under the revised proposed regulation, capital costs (including debt service, depreciation, rent and leases) would remain excluded from the definition of "direct resident care" (the numerator), while most Medicaid capital reimbursement[1] would continue to be included in the definition of "revenue" (the denominator). As discussed in greater detail below, this exclusion from the numerator, together with the inclusion of capital reimbursement in the denominator, will make it more difficult for facilities that make capital investments to satisfy the 70 percent and 40 percent tests. It will effectively operate not only to discourage future capital projects that would improve nursing homes' infection prevention posture and the quality of life offered to residents, but also will penalize nursing homes for previously approved capital projects.

(3) **"Revenue":** The definition of revenue must be modified to exclude capital reimbursement on a broader basis, non-operating revenue, quality pool payments, and retroactive Medicaid adjustments.

[1] Approved capital expenditures are reimbursed in Medicaid nursing home rates on a historical cost basis via the capital component of the rate.

- *Capital Reimbursement:* Although capital costs would be excluded from the spending numerator of the 70/40 calculation as described above, capital reimbursement would be included in the revenue denominator. The statute and regulations provide exceptions to this general rule, which were broadened as a result of statutory amendments, but the exceptions remain too narrow and vaguely defined to enable most nursing homes to invest in needed capital projects.

    - Average Increase in Prior 3 Years: First, as under the prior version of the proposed regulation, the average increase in the capital portion of the Medicaid reimbursement rate from the prior three years would be excluded from revenue. However, this time-limited exemption would have no impact on reimbursement associated with a debt instrument entered into more than three years ago or, for example, the last seven years on a ten-year loan executed today. Nor would it affect the reimbursement that a non-profit facility receives for the depreciation expense associated with a capital asset acquisition that is more than three years old. This exemption is too narrowly drawn to offer much relief from the capital investment penalty imposed by the statute and regulation.

    - Star Ratings: Second, the recently enacted exclusion of certain capital reimbursement from revenue based on star ratings would not apply to the majority of nursing homes. The revisions made to PHL § 2828 by Ch. 57 of the Laws of 2022 now exclude from the revenue element of the calculation the capital reimbursement paid to facilities with CMS star ratings of 4 or 5, as long as the reimbursement is not attributable to a capital expenditure paid to a related entity. Specifically, capital reimbursement received by facilities that have overall CMS star ratings of less than 4 stars must be counted as revenue, as well as the portion of capital reimbursement that is "attributable to a capital expenditure made to a corporation, other entity, or individual, with a common or familial ownership to the operator or the facility."

      Currently, approximately 60 percent of New York's nursing homes have a 1-, 2-, or 3-star overall rating in the CMS Five-Star Quality Rating System. Thus, only approximately 40 percent of nursing homes will be eligible for the exclusion of capital reimbursement from their revenues. This distribution of overall ratings is fairly regular, by design. The distribution is due to the heavy weighting of the inspection rating in the overall rating methodology and the prescribed method of distributing facilities into each inspection star rating (i.e., only the top 10 percent will receive 5 stars, and the next 23 percent will receive 4 stars for inspections). Moreover, the star ratings change frequently, making it difficult for facilities to predict whether they will qualify for the capital reimbursement exclusion when evaluating the financial impact of a project. CMS refreshes its data monthly, and nursing home star ratings can change monthly, but for a majority of facilities, ratings change at least quarterly.

      Public Health Law Section 2828 does not specify the point in time at which a facility's star rating must be 4 or 5 in order to qualify for the exclusion of capital reimbursement from revenue. In the absence of a statutory specification, the proposed regulation should,

but does not, provide further information on how this provision would be implemented. At what point in time will the star rating be selected as the basis for this determination? Without this information, the facilities cannot plan for the financial implications of capital improvements and will therefore be deterred from initiating them.

The Department should implement the statute to achieve its stated purpose by adopting regulations that allow for the exclusion of capital reimbursement from revenues for purposes of the 70/40 calculations, based on the attainment of a 4- or 5-star rating in any quarter that includes or follows the date of submission of a certificate of need application or other DOH approval needed for the capital project, including any quarter subsequent to CON or other DOH approval. The attainment of a 4- or 5-star rating in any quarter should enable the reimbursement to be excluded from revenues for the duration of the project-related reimbursement.

- Related Entity Reimbursement: Third, the inclusion in revenue of capital reimbursement for expenditures paid to a related entity is not well-defined. The proposed regulation should, but does not, define "common or familial ownership," nor does it provide further information on how this provision would be implemented. Presumably, this provision is aimed at arrangements involving real property leases in which the nursing home operator makes payments (which include a profit factor) to a related party lessor. Accordingly, it should not apply to a capital payment made by a: (1) NFP facility to its parent organization and/or sponsor; (2) hospital-based nursing home to its hospital sponsor; or (3) public facility to its governmental sponsor. In these instances, existing statute and regulations already provide that Medicaid capital reimbursement is based on actual historical costs and made without regard to any related party transactions. The regulation should define common or familiar relationship and exclude the above relationships from that definition.

Facilities should be encouraged to make capital improvements that strengthen their defenses against airborne infections and promote high-quality care for residents. Instead, the treatment of capital reimbursement in the proposed regulation would actually discourage, if not outright prevent, facilities from making capital improvements that support high quality care and infection prevention efforts.

- *Other Operating Revenue:* The statute, like the proposed regulation, defines "revenue" as "total operating revenue from or on behalf of residents . . . to pay for a resident's occupancy of the residential health care facility, resident care, and the operation of the residential health care facility."[PHL §2828(2)(a)] The apparent intent of the statute and regulation is to compare direct care costs with resident care revenues. However, the proposed definition of "revenue" in the regulation lacks clarity and could be interpreted to include other operating revenue, such as investment income, grants (the revised regulations now exclude from revenue federal grant funds to assist nursing homes during the COVID-19

pandemic, which we support), charitable donations, VAP and CINERGY payments, and revenues from other non-patient care activities.

Since the definition arguably includes funds that are not paid as reimbursement for resident care and in some cases do not derive from State sources, there is no basis for the State to seize them. Moreover, to include these resources as revenue for purposes of the 70/40 calculation would create perverse incentives to minimize receipts of charitable donations or investment returns. These non-patient care revenues should be excluded from the definition of "revenue" and not require any application or demonstration under proposed §415.34(d)(3)(ii) that they are exceptional or unexpected.

- *Quality Pool Distributions:* Quality pool distributions, under 10 NYCRR §86-2.42, should be specifically excluded from the calculation of revenue. Including these distributions in the definition of "revenue" (the denominator) will have the perverse effect of diluting a high-quality facility's percentage of revenues spent on direct resident care when, ironically, the facility's distribution is intended to reward it for providing high quality care (typically after spending more to achieve those results). Furthermore, the State's distribution of quality pool funds is often subject to delays which could result in payment in the following year (e.g., the 2020 distribution was paid in December 2021). If the payments are delayed, they could end up being reported in the following year's cost reports, resulting in artificially inflated revenues in that year that are misaligned with the reporting year's expenditures. As a result, high quality facilities may face seizures of revenue through no fault of their own.

- *Retroactive Medicaid rate payments to facilities.* Payments made to facilities that are the result of successful Medicaid rate appeals should also be categorically excluded from the definition of "revenue." Nursing homes often wait several months or even years for these appeals to be processed and are not paid interest on these appeals while they are awaiting processing. If appeal revenues are reported in the year they are received and also relate to prior years, the funds received will not align with the facility's current year expenditures and may trigger a recoupment. Other rate setting delays can also result in year-to-year timing issues. Facilities should not be penalized for the State's delays in processing rate appeals and keeping Medicaid rates up-to-date or be required to pursue individual waivers under proposed § 415.34(d)(3)(ii).

§ 415.34(c)(2): Additional Waivers

This section of the proposed regulations contemplates that individual facilities may apply for waivers of the direct care spending requirements "…on the basis of unexpected or exceptional circumstances that prevented compliance." Similarly, proposed § 415.34(d)(3) would allow facilities to apply individually for exclusions of certain revenues and expenses due to natural disasters or for other reasons. The COVID-19 pandemic, which remains a federal public health emergency, continues to result in

unexpected and exceptional circumstances that can materially affect both nursing home revenues and expenditures. In light of these circumstances, DOH should not seize excess revenues for the duration of the federal public health emergency.

§415.34(d)(2)(ii): Costs of Contract Staffing

Proposed §415.34(d)(2)(ii) would discount by 15 percent the reported costs of nurse and aide services obtained under contract. This discount would be deducted from the calculation of the amount spent on resident-facing staffing and on direct resident care. As previously noted, we urge DOH to clarify that amounts paid to individual per diem employees are not subject to this discount.

Presumably, the rationale behind this 15 percent discount is that these contracts most often include payment of a profit factor to the staffing agency, which in some cases may be related to the nursing home operator. However, when a nursing home is faced with a severe staffing shortage and is unable to hire enough staff, its payments to unrelated staffing agencies for nurse and aide services should not be discounted. Under those circumstances, it should be irrelevant where staff is hired from. Indeed, DOH has previously referred nursing home operators to specific third-party staffing agencies to assist in staffing shortages during the pandemic. In these cases, the local labor market determines the amounts that must be paid for staffing, and the facility's operator does not directly or indirectly "profit" from the transaction. Moreover, Section 167 of the Labor Law requires nursing homes to first attempt to call in agency staff before mandating nurse overtime. It is incongruous that employers would be penalized for following the requirements of the Labor Law. This aspect of the proposed regulation and, if necessary, the statute should be revisited to limit the application of this provision to related-party staffing contracts.

§ 415.34(d)(3): Revenue and Expense Exclusions

Proposed § 415.34(d)(3) would allow facilities to apply individually for exclusions of "extraordinary, nonrecurring revenue" received by a facility. We recommend that DOH clarify in writing that any grant funds awarded to nursing homes under the Statewide Health Care Facility Transformation Program will be excluded from the definition of "revenue" without requiring awardees to apply for an exclusion under proposed § 415.34(d)(3). These funds are aimed at supporting facility capital expenditures to facilitate service transformation. In effect, not excluding these funds from facility revenue would result in less than the legislatively authorized amount being available for the intended purpose.

Furthermore, any awards made under the Vital Access Provider program [Public Health Law § 2826], or similar programs for distressed facilities, should also be categorically excluded from the definition of "revenue" as they are for a limited time period and are made for express purposes identified in law related to financial solvency and service continuation.

§ 415.34(e): Recoupment

Proposed § 415.34(e)(2)(ii) would require a facility to remit the total amount indicated in the notice of noncompliance by Nov. 1st in the year following the reporting year. Any delay in the cost reporting deadline or other associated delays could prevent DOH from issuing a notice of noncompliance in time to allow adequate notice to a facility and for a payment to be made by Nov. 1st. This subparagraph should be revised to provide a reasonable timeframe (i.e., thirty days) from the date of the notice of noncompliance for the facility to make its payment.

Under proposed § 415.34(e)(3)(ii), seized funds would be deposited into the Nursing Home Quality Pool account. It is unclear how and when these additional funds would be distributed to facilities receiving awards under the Quality Pool. The lack of clarity is, in part, because DOH has not submitted a state plan amendment to CMS for changes to the Quality Pool to implement PHL §2828. Could a facility that itself was subject to recoupment under this proposed regulation actually receive an allocation of funds from the seized amounts if it were also a Quality Pool awardee? Furthermore, proposed § 415.34(e)(3)(i) authorizes penalties under Section 12 of the Public Health Law. The proposed rulemaking is unclear as to whether any such Section 12 penalty amounts would also be deposited into the Quality Pool account and, if not, how these funds will be utilized. These issues should be clarified.

§ 415.34(f): Residential Health Care Facility Cost Reports

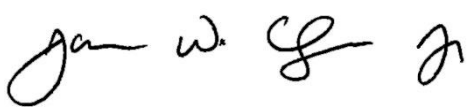
The proposed regulation fails to identify how direct resident care and resident facing staffing expenses will be calculated for hospital-based nursing homes which do not file the standard RHCF-4 Medicaid cost report. Those facilities do not accumulate or allocate costs in the same manner as a nursing home that files the RHCF-4 report. Under the Assessment of Public Comment, the regulatory publication indicates that "[a]dditional guidance will be provided for hospital-based nursing homes." We respectfully urge DOH to work with LeadingAge NY and other associations that represent hospital-based nursing homes on a reliable reporting alternative that is not financially or otherwise burdensome on affected facilities, with sufficient advance notice to enable timely reporting for the relevant fiscal year."

CONCLUSION

LeadingAge NY remains convinced that the proposed regulation and PHL § 2828 will prove to be misguided and ultimately impede efforts to improve nursing home quality of care. Instead of addressing the genuine underlying threats to nursing home quality – Medicaid underpayment and workforce shortages – they impose unclear and overly-simplistic spending formulas and revenue seizures that actually discourage needed investments in quality, facility improvements, and pandemic response. We would like to take this opportunity to partner with the State to attempt to turnaround the State's flawed approach to regulating and financing nursing home care. Nursing home residents -- our parents, grandparents, friends and neighbors -- deserve more than these regulations can offer.

Thank you in advance for considering our comments and recommendations.

Sincerely yours,



James W. Clyne, Jr.
President and CEO

cc:

Angela Profeta
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Attachment

ATTACHMENT

January 17, 2022

Katherine Ceroalo
NYS Department of Health
Bureau of Program Counsel
Reg. Affairs Unit
Corning Tower, Room 2438
Empire State Plaza
Albany, NY 12237

RE: HLT-46-21-00005-P: Nursing Home Minimum Direct Resident Care Spending

Dear Ms. Ceroalo:

I am writing on behalf of the membership of LeadingAge New York to provide input on the proposed addition of Section 415.34 to Title 10 NYCRR. This regulation would require each nursing home to spend a minimum of 70 percent of its revenue on direct resident care and 40 percent of its revenue on resident-facing staffing. LeadingAge NY and its not-for-profit (NFP) and publicly-sponsored provider members dedicate the overwhelming majority of their revenue to resident care and continuously strive to deliver the highest quality care. However, we are concerned that this proposed regulation and the associated statute (NYS Public Health Law Section 2828) will work against this desired outcome, will have a deleterious impact on the delivery of long-term/post-acute care services in New York, and must be revisited.

General Comments

Meaningful improvements in the quality of care provided in New York's nursing homes are simply not possible without addressing the patent inadequacy of Medicaid reimbursement. New York's Medicaid nursing home rates are based on 2007 costs, with no cost-of-living increase provided since 2008. Not only has the State failed to raise rates to keep up with rising labor and other costs; it has actually imposed significant cuts. In fact, even in 2020 during the pandemic, the State cut nursing home rates by $168 million annually, while most states increased funding for nursing homes.[1] As a result of these policies, 40 percent of New York's facilities have a ***lower*** Medicaid operating rate today than they did in 2016. According to the latest update to a report commissioned by the American Health Care Association, New York's nursing home Medicaid rate falls short of costs by $55 per resident, per day, indicating that New York's nursing home Medicaid rates are among the worst in the country in relation to the actual costs of operation.[2]

Whether it is the byproduct of deliberate State policy or of neglect, the inadequacy of New York's Medicaid rates is forcing many providers that are committed to delivering high quality care to leave the market. Since 2014, more than twenty nursing homes have consolidated or closed, and approximately fifty public and NFP

[1] These cuts include a 1.5 percent across-the-board cut to Medicaid payments and a cut to capital reimbursement. Musumeci, M. State Actions to Sustain Medicaid Long-Term Services and Supports During COVID-19. Kaiser Family Foundation. Aug. 26, 2020.
[2] Hansen Hunter & Company, "Report on Shortfalls in Medicaid Funding for Nursing Center Care – 2018 Update." The brief update estimates that unreimbursed, allowable Medicaid costs in New York in FY 2018 exceeded $1.2 billion, averaging $54.77 per Medicaid resident day. Prior to that, the most recent full "Report on Shortfalls in Medicaid Funding for Nursing Center Care" issued in Nov. 2018 found New York's Medicaid shortfall to be even greater ($64 per day, the largest shortfall of the 28 states the report analyzed.)

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nursing homes have been sold to for-profit entities. This trend accelerated during the pandemic, with 7 closures and at least three NFP nursing homes in New York City sold to FP operators in 2020-2021. Several others are in the process of being sold or are in sale negotiations, and several high quality NFP homes are considering significant bed reductions. We fully expect these numbers to grow, leading to diminished quality and more limited choices for consumers. As the predominant payer of nursing home care, New York's Medicaid program bears significant responsibility for this troubling trend.

Draining facilities of funds based on arbitrary formulas will not enable them to hire more staff, nor will it help them to create the vibrant communities and home-like environments with strong infection prevention controls that ensure resident safety and quality of life. Public Health Law § 2828 and this proposed rulemaking represent misguided attempts to increase nursing home staffing that overlook crucial elements of nursing home finances and operations. Sadly, they will impede nursing home capital investments that would enhance infection control efforts and otherwise benefit residents and staff, while interfering with nursing homes' ability to comply with ever expanding State and federal mandates. At the same time that the State would impose this direct care spending requirement and limit the amount that facilities can spend on administration, the State and federal governments continue to impose onerous administrative requirements on nursing homes, without adjusting rates to cover the added costs. The daily and weekly HERDS surveys; weekly NHSN surveys; oversight, recordkeeping, and reporting of staff and visitor COVID testing and staff COVID vaccinations; and numerous mandated postings and notices of various laws, ratings, and contractual relationships are just a few recent examples of unfunded mandates.

Perhaps the most egregious and legally questionable aspect of this proposed rulemaking and the underlying statute is that it seeks to regulate facility spending of revenues emanating from sources other than New York State. This includes payments from the Medicare program, the Veteran's Administration, private insurers, residents and their families, and potentially other operating revenues from donors, grantors, non-patient care activities, and investments/reserves. It is ironic and inappropriate for the State, which pays Medicaid rates that are well below the actual costs of providing care, to regulate (and potentially seize) funds from other sources which are used to subsidize inadequate Medicaid payments.

Specific Comments

Within the context of our general comments, we provide in this section detailed feedback on the specific elements of the proposed rulemaking together with the applicable regulatory references.

§ 415.34 (b): Definitions:

The definitions in the regulations generally do not reflect the realities of nursing home operations and will discourage necessary expenditures that would benefit residents and staff, such as investments in physical plant improvements that support homelike environments and infection control, in security, and in medical records systems. Further, the overbroad and arbitrary definition of revenue will unfairly penalize facilities for quality pool awards, sound investments of reserves, receipt of philanthropic donations, and pass-through reimbursement of capital expenses and state taxes.

(1) **"Contracted out":** This definition is over-broad and could be interpreted to include per diem employees. The intent of the statute is to discount expenditures for individuals retained through an external agency/company, not payments to individuals directly employed by the facility. Even before the pandemic, nursing homes relied on per diem nurses and aides to provide direct care services. Usage of per diem staff has continued during the pandemic and could be more prevalent

than before as facilities strive to access any available staff, including those who are not willing to work full-time. Unlike the statutory assumption of a "profit factor" in related-company labor contracts, there is no 15 percent "profit margin" built into the amounts paid to individual per diem employees and this discount should not be taken under proposed § 415.34(d)(2)(ii).

(2) "Direct Resident Care":

- *Security, Grounds, Medical Records:* The "direct resident care" definition arbitrarily excludes several categories of resident care costs incurred by nursing homes, including, for example, costs associated with security, grounds and medical records. The Security cost center contains "…all the expenses associated with maintaining the safety and well-being of residential health care facility patients, personnel and visitors, and protecting the facility by patrolling and guarding designated areas [10 NYCRR § 455.8]. The Grounds cost center contains "…all the expenses associated with the maintenance of grounds of the facility, including landscaped and paved areas, streets on the property, sidewalks, fenced areas and fencing, external recreation areas and parking facilities (e.g., lawn care, repairs and snow removal) [10 NYCRR § 455.7]. The Medical Records cost center contains "…all the expenses associated with maintaining a record system for the use, transcription, retrieval, storage and disposal of patient medical records and production of indexes, abstracts and statistics for residential health care facility management and medical staff use [10 NYCRR § 455.19]. Clearly, these functions are necessary for proper resident safety and care and should be listed as direct resident care cost centers in this definition.

- *Capital Costs:* Under the proposed regulation, capital costs (including debt service, depreciation, rent and leases) would be specifically excluded from the definition of "direct resident care." However, capital reimbursement[3] would be included in the definition of "revenue," with the exception of "the average increase in the capital portion of the Medicaid reimbursement rate from the prior 3 years." Although the scope of this exclusion is not clarified in the proposed regulations, it appears that only incremental capital reimbursement over a very brief timeframe would be excluded from the calculation of "revenue."

  The omission of capital costs from direct resident care, together with the inexplicable inclusion of most Medicaid capital reimbursement in the definition of "revenue" [see proposed § 415.34(b)(4)], will actually discourage, if not outright prevent, facilities from making capital improvements that support infection control efforts during a pandemic involving an airborne, highly contagious virus. It could also force facilities to choose between complying with these regulations and making debt service payments for prior capital projects.

  The "Green House" model nursing homes have been particularly successful in preventing COVID-19 outbreaks in their homes, and the Department of Health (DOH) requires COVID-based cohorting of residents and socially-distanced visitation. Yet, this aspect of the proposed regulation will discourage, if not prevent, facilities from creating smaller units or small house models (like the Green House) to control the spread of disease, from upgrading their HVAC systems, from creating separate cohort-specific break rooms for staff, and from expanding spaces for visitation or staff testing. If State lawmakers and regulators genuinely want to strengthen infection prevention for

[3] Approved capital expenditures are reimbursed in Medicaid nursing home rates on a historical cost basis via the capital component of the rate.

residents and staff, create home-like environments for residents, and support the development and operations of "Green Houses" and similar models as indicated in the Governor's State of the State address, they should modify the underlying statute and ensure the regulations do not treat capital costs and reimbursements in this inconsistent and haphazard way.

(4) **"Revenue":** This definition must be clarified. The apparent intent of the statute and regulation is to compare direct care costs with patient/resident care revenues. However, the proposed definition of "revenue" is overbroad and inappropriately includes other operating revenue, such as investment income, grants (including federal grants to assist nursing homes during the pandemic), and revenues from other non-patient care activities. Since the definition arguably includes funds that are not paid as reimbursement for resident care and in some cases do not derive from State sources, there is no basis for the State to claim them. As noted above, these non-patient care revenues should be excluded from the definition of "revenue" and not require any application or demonstration under proposed § 415.34(d)(3)(ii) that they are exceptional or unexpected.

We are also concerned that the definition of "revenue" appears to include the following Medicaid payments that are inappropriate for inclusion. These payments should be specifically excluded from the calculation of revenue:

- *Reimbursement for the 6 percent cash receipts assessment payments levied on nursing homes pursuant to Public Health Law § 2807-d.* Similar to the treatment of capital costs, the cost of this State government-mandated tax would be excluded from direct resident care, but the associated Medicaid reimbursement is included in "revenue," thereby unfairly diluting the percentage of revenues directed towards direct resident care. The reimbursement for the assessment is cost neutral for the nursing home in that it is revenue received to offset a state tax paid by the nursing home. Including it as "revenue," without including it as a cost, artificially inflates the revenue of the nursing home. Furthermore, including this reimbursement in the definition of "revenue" could effectively result in levying a fee on a provider tax reimbursement, which could have federal regulatory implications for New York's cash receipts assessment program [see 42 CFR § 433.68].

- *Distributions to facilities from the nursing home quality pool under 10 NYCRR § 86-2.42.* Including these distributions in the definition of "revenue" would have the perverse effect of diluting a recipient facility's percentage of revenues spent on direct resident care when, ironically, the facility is being rewarded for providing high quality of care (and presumably spending more to achieve those results). Furthermore, the State's distribution of these funds is often subject to delays which could result in payment in the following year (e.g., the 2020 distribution was paid in December 2021). If the payments are delayed, they could end up being reported in the following year's cost reports, resulting in artificially inflated revenues in the following year that are misaligned with the reporting year's expenditures. As a result, high quality facilities that receive distributions could be forced to pay them back as recoupments through no fault of their own.

- *Retroactive Medicaid payments to facilities.* Payments made to facilities that are the result of successful Medicaid rate appeals should be categorically excluded from the definition of "revenue." Nursing homes often wait several months or even years for these appeals to be processed and are not paid interest on these appeals while they are awaiting processing. If appeal revenues are reported in the year they are received and also relate to prior years, the funds received will not align with the facility's current year expenditures and may trigger a recoupment. Other rate setting delays can also result in year-to-year timing issues. Facilities should not be penalized by the

State's delays in processing rate appeals and keeping Medicaid rates up-to-date or be required to pursue individual waivers under proposed § 415.34(d)(3)(ii).

§ 415.34(c)(2): Additional Waivers

The effective date of this proposed rulemaking is January 1, 2022 [see proposed § 415.34(d)]. As a result of the continued consequences of the COVID-19 pandemic, the federal government has declared a public health emergency which has existed since January 31, 2020. New York is currently operating under a disaster emergency in effect statewide through February 14, 2022. In addition, the Governor has declared a healthcare staffing shortage emergency and temporarily suspended the effectiveness of the statute underlying these regulations through January 30, 2022. It is certainly conceivable, possibly likely, that the conditions that triggered these federal and State emergency declarations will continue through much of 2022.

This section of the regulations contemplates that individual facilities may apply for waivers of applicability of the proposed direct care spending requirements "…on the basis of unexpected or exceptional circumstances that prevented Compliance." Similarly, proposed § 415.34(d)(3) would allow facilities to apply individually for exclusions of certain revenues and expenses due to natural disasters or for other reasons. The pandemic continues to result in unexpected and exceptional circumstances that can materially affect both nursing home revenues and expenditures. In light of these circumstances, in order to alleviate administrative burdens on the State and individual facilities, DOH should grant a broad-based waiver of applicability of the proposed direct care spending requirements to all nursing homes during 2022 if the conditions underlying the federal and State emergency declarations remain in place at the time of official adoption of these regulations.

§ 415.34(d)(2)(ii): Costs of Contract Staffing

Proposed § 415.34(d)(2)(ii) would discount by 15 percent the reported costs of nurse and aide services obtained under contract. This discount would be deducted from the calculation of the amount spent on resident-facing staffing and on direct resident care. As previously noted, we urge the Department to clarify that amounts paid to individual per diem employees are not subject to this discount.

We surmise that the rationale behind this discount on the amounts paid by nursing homes to companies that provide nurse and aide services is that these contracts most often include payment of a profit factor to the owner, which in some cases may be affiliated with the nursing home operator. However, when a nursing home is faced with a severe staffing shortage and is unable to hire enough staff, its payments to unrelated staffing agencies for nurse and aide services should not be discounted. Under those circumstances, it should be irrelevant where staff is hired from, as long as adequate staff is provided. Indeed, the Department has recently referred nursing home operators to specific third party staffing agencies to assist in staffing shortages during the pandemic. In these cases, the local labor market determines the amounts that must be paid for staffing, and the facility's operator does not directly or indirectly "profit" from the transaction. Moreover, it is noteworthy that Section 167 of the Labor Law requires nursing homes to first attempt to call in agency staff before mandating nurse overtime. It is therefore incongruous that employers are penalized for following the requirements of the Labor Law. This aspect of the proposed regulation and, if necessary, the statute should be revisited to limit the application of this provision to related-party staffing contracts.

§ 415.34(d)(3): Revenue and Expense Exclusions

Proposed § 415.34(d)(3) would allow facilities to apply individually for exclusions of "extraordinary, non-recurring revenue" received by a facility. The Department just released a request for applications (RFA) for the Statewide Health Care Facility Transformation Program III [RFA # 18406], which includes a minimum allocation of $23.1 million of grant funds to nursing homes. We recommend that DOH clarify in writing that any grant funds awarded to nursing homes under this RFA will be excluded from the definition of "revenue" without requiring awardees to apply for an exclusion under proposed § 415.34(d)(3).

Furthermore, any awards made under the Vital Access Provider program [Public Health Law § 2826], or similar programs for distressed facilities, should also be categorically excluded from the definition of "revenue" as they are for a limited time period and are made for express purposes identified in law related to financial solvency and service continuation.

§ 415.34(e): Recoupment

Proposed § 415.34(e)(2)(ii) would require a facility to remit the total amount indicated in the notice of noncompliance by November first in the year following the reporting year. It is possible that due to a delay in the cost reporting deadline or other associated delays that the Department may not issue a notice of noncompliance in time to allow adequate notice to a facility and for a payment to be made by November first. This subparagraph should be revised to provide a reasonable timeframe (i.e., thirty days) from the date of the notice of noncompliance for the facility to make its payment.

Under proposed § 415.34(e)(3)(ii), recouped funds would be deposited into the Nursing Home Quality Pool account. The proposed rulemaking does not address whether any amounts deposited in the Quality Pool account will be used to offset the Medicaid rate reductions (currently $50 million in total) that are used to fund the pool [see 10 NYCRR § 86-2.42(c)]. If there is no offset or the total recoupment amounts exceed $50 million, how and when would these additional funds be distributed to facilities receiving awards under the Quality Pool? Is it possible that a facility that itself was subject to recoupment under this proposed regulation could receive an allocation of funds from the recouped amounts if it was also a Quality Pool awardee? Furthermore, proposed § 415.34(e)(3)(i) authorizes penalties under Section 12 of the Public Health Law. The proposed rulemaking is unclear as to whether any such Section 12 penalty amounts would also be deposited into the Quality Pool account and, if not, how these funds will be utilized. This should be clarified.

§ 415.34(f): Residential Health Care Facility Cost Reports

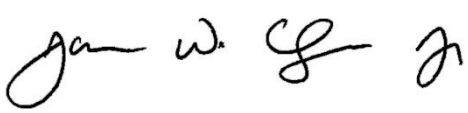
The proposed regulation fails to identify how direct resident care and resident facing staffing expenses will be calculated for hospital-based nursing homes which do not file the standard RHCF-4 Medicaid cost report. Those facilities do not accumulate or allocate costs in the same manner as a nursing home that files the RHCF-4 report. The Paperwork section of the Regulatory Impact Statement suggests that the only new data requirement would be for those facilities that did not submit a complete 2019 cost report and that this requirement is "merely a temporary measure to substitute for a missing 2019 cost report." However, this fails to address what could be an ongoing and substantial reporting requirement for hospital-based nursing homes that do not file the RHCF-4 report.

Conclusion

In conclusion, LeadingAge NY believes that the proposed regulation and Public Health Law § 2828 will prove to be misguided and ultimately disruptive to efforts to improve the quality of care in nursing homes. New York State lawmakers and regulators must revisit the genuine underlying threats to nursing home quality – Medicaid underpayment, workforce shortages and ineffective regulation and oversight – if meaningful improvements are to be made. "Cookie-cutter" spending formulas and additional financial penalties are simply not the answer and should be revisited.

Thank you in advance for carefully considering our comments and recommendations.

Sincerely yours,



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