November 14, 2022

Jeffrey A. Kraut
Chair, Public Health and Health Planning Council
Thomas Holt
Chair, Committee on Codes, Regulations, and Legislation
c/o Executive Secretary, Public Health and Health Planning Council
Empire State Plaza, Corning Tower, Room 1805
Albany, New York 12237

Re: 21-13 Addition of Section 415.34 to 10 NYCRR (Nursing Home Minimum Direct Care Spending); 21-20 Amendment to Sections 415.2 and 415.3 of 10 NYCRR (Minimum Staffing Requirements for Nursing Homes)

Dear Mr. Kraut, Mr. Holt, and members of the Public Health and Health Planning Council:

I am writing on behalf of the members of LeadingAge New York (LANY) -- non-profit and public providers of long-term and post-acute care services -- to offer comments on two proposed regulations on your agenda for November 17:

- Addition of Section 415.34 to 10 NYCRR (Nursing Home Minimum Direct Care Spending);
- 21-20 Amendment to Sections 415.2 and 415.3 of 10 NYCRR (Minimum Staffing Requirements for Nursing Homes)

We have submitted extensive comments to this Council and to the Department of Health in connection with the promulgation of these regulations. Our most recent comments are attached. LeadingAge NY and its members remain deeply concerned that these proposed regulations will impede rather than advance our shared goal of improving the quality of care in nursing homes. We urge you to take the time to review the comments attached to this letter, as they are not addressed in the current version of the regulation. In addition to the attached comments on the specific provisions of the regulations, the following are updated data and a few key questions that must be addressed.

Minimum Staffing Hours Regulation

In the context of our current statewide healthcare workforce emergency, the nursing home minimum staffing regulations will only contribute to system-wide access problems, as nursing home beds are closed in order to meet staffing mandates, preventing hospitals from discharging patients in need of post-acute care, leading to shortages of hospital beds. Although our members are doing everything within their power to comply with the staffing standards and spending unsustainable sums to do so, most are unable to attain the standards set forth in the law. Our analysis of 2d Quarter of 2022 CMS Payroll-Based Journal (PBJ) data reveals that *75 percent* of all nursing homes statewide failed at least one of the staffing hours tests under the regulation. In order to comply or at least approach compliance, our members are closing units and limiting admissions. Occupancy data reported in September 2022 reveal that not-for-profit facilities are at 86 percent occupancy today in comparison with 95 percent occupancy in 2019; government-sponsored facilities are at 73 percent occupancy today in comparison with 96 percent occupancy in 2019.

Significantly, the State has neglected to answer key questions about the implications of the regulations. We are hoping that these issues will be cleared up at the Codes Committee meeting:

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- **Are the staffing standards being enforced as of January 1, 2022, in violation of EO 4.4 and its successors?** The regulations at 415.13(b)(2) point to an effective date of January 1st , 2022. However, in Executive Order 4.4, Governor Hochul temporarily suspended "in light of the staffing shortage caused by the Covid-19 public health emergency, . . . [s]ubdivision 3 of Section 2895-b of the Public Health Law to the extent that failure of a nursing home to meet the daily average staffing hours *will not be held to be a violation of the Public Health Law*" (emphasis added). This Executive Order was extended monthly through March 31, 2022.

  The regulation states that penalties will not be imposed prior to April 1, 2022. This is required both by the statute, PHL §2895-b(2)(e), and by the timeframes for publication of the PBJ data; it was not a product of the Executive Order. Under Executive Order 4.4 et seq., *the staffing requirements themselves were suspended.* Thus, penalties cannot be imposed for non-compliance with the staffing requirements occurring prior to April 1, 2022. The regulations do not acknowledge this fact; indeed, they imply otherwise.

- **Do the current health care workforce and federal COVID emergencies qualify as extraordinary circumstances, and will facilities that have implemented their pandemic emergency plans and emergency preparedness requirements be absolved of penalties for failing to comply with staffing standards?**

- **Has the Commissioner made the quarterly determination, described in the statute and mandated by the regulation, of whether there is an "acute labor supply shortage?"**

- **Will nursing homes be expected to transfer residents to other facilities in order to qualify for mitigation of penalties? Will the closure of units, without the transfer residents, qualify?** As reflected in a recently issued directive from the Department of Health (DAL NH 19-07, 10/11/22), the ability of facilities to involuntarily transfer residents to another facility is authorized only under limited circumstances, requires physician documentation of the resident's needs that cannot be met, and a 30-day notice to the resident. Involuntary transfers are severely limited with good reason – they are distressing to residents and family. Moreover, given that 75 percent of nursing homes statewide cannot meet these staffing standards, it is unlikely that another nearby nursing home will have the staff to accept additional residents, and the receiving facility, if any, might be a great distance from the residents' loved ones. If transferring residents is a prerequisite for mitigation of penalties, mitigation is unattainable.

Minimum Direct Care Spending Regulation

As we've previously indicated, the most onerous aspect of this regulation is that it will discourage capital improvements that strengthen infection prevention and improve the quality of life of residents. Although the regulation reflects statutory amendments enacted earlier in the year related to capital expenditures, the regulation fails to elaborate on the statute and explain how these provisions will be implemented.

- **At what point(s) in time will the CMS Star Rating be selected for purposes of determining whether capital reimbursement is counted as revenue? How will approved capital expenditures be treated after 3 years, if a facility is no longer a 4 or 5 Star facility?** CMS nursing home Star Ratings change frequently, -- CMS refreshes its data monthly, and nursing home Star Ratings can

change monthly, but for a majority of facilities, ratings change at least quarterly. Without knowing how Star Ratings will be used to determine their compliance with the minimum spending regulation, facilities cannot plan for the financial implications of capital improvements and will therefore be deterred from initiating them.

- **How will related entity payments be defined for purposes of determining whether capital reimbursement that is otherwise exempt from the revenue calculation would be counted? Will a payment of capital reimbursement to a hospital sponsor be counted? Will a payment to a non-profit parent be counted? Will a payment by a State Veterans Home to the State be counted?**

- **Will nursing home Quality Pool distributions, under 10 NYCRR §86-2.42, be excluded from the calculation of revenue, or will nursing homes that earn quality distributions (presumably after spending more in the prior year to achieve quality outcomes) be subject to recoupment of those receipts?**

- **Does "other operating revenue" include non-resident care revenues, such as investment income, grants, charitable donations, VAP and CINERGY payments?**

These regulations will serve to drain nursing home of scarce resources in the midst of a pandemic that disproportionately affects older adults and people with disabilities and will not improve the quality or accessibility of care for our most vulnerable residents. Most other states have stepped up to support long-term care providers through this very challenging time. To date, New York, unfortunately, has not.

Thank you very much for your consideration of these issues.

Sincerely yours,

James W. Clyne, Jr.
President and CEO

Cc: Colleen Leonard
Lisa Thomson
Angela Profeta
Kristin Proud
Adam Herbst
Valerie Deetz
Mark Furnish
Sean Doolan

Attachment 1

September 23, 2022

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

RE: HLT-46-21-00007-RP: Minimum Staffing Requirements for Nursing Homes

Dear Ms. Ceroalo:

I am writing on behalf of the membership of LeadingAge New York -- non-profit and government-sponsored providers of long-term/post-acute care and aging services -- to offer comments on the above-referenced revised proposed amendments of Sections 415.2 and 415.13 of Title 10 NYCRR. This regulation would require all nursing homes to provide an average of 3.5 hours of direct nursing care per resident per day, of which at least 2.2 hours must be provided by a certified nurse aide (CNA) (or nurse aide only during calendar year 2022) and at least 1.1 hours must be provided by a registered nurse (RN) or licensed practical nurse (LPN) ("the minimum hours requirements").

Our members strive to provide the highest quality care and to staff generously to meet the health, personal care, and quality of life needs of their residents. Unfortunately, in the context of the current health care workforce emergency, recruiting and retaining staff has become increasing difficult. While we appreciate the revisions to the prior proposed regulation made through this rulemaking, LeadingAge NY and its members remain deeply concerned that this proposed regulation and the associated statute [NYS Public Health Law Section 2895-b] impose infeasible and arbitrary staffing ratios that will only deprive nursing homes of the resources they need to effectively recruit and retain staff and will exacerbate existing staffing shortages, adversely affect access to care, negatively impact residents and families, and create ripple effects on other sectors of the health care system. This regulation will not achieve its stated purpose of helping to "ensure patient safety and improve the quality of care received by the residents;" in fact, it is more likely to have the opposite effect. As the Department concluded in its 2020 report on minimum staffing levels:

> Maintaining a nursing workforce that effectively meets the needs of patients requires a comprehensive approach to address today's multifaceted and complex healthcare delivery challenges. While the Department supports measures to

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improve quality of care and patient outcomes, the COVID-19 pandemic has only highlighted the need to maintain workforce flexibility.[1]

We would like to reiterate and incorporate by reference the issues raised in our attached Jan. 17. 2022 comments on the initially proposed rulemaking [HLT-46-21-00007-P: Minimum Staffing Requirements for Nursing Homes], which were not addressed in the Assessment of Public Comment in this rulemaking, with the additions, revisions and emphases identified below.

GENERAL COMMENTS

Based on the most recent federal nursing home payroll-based journal (PBJ) data, approximately 80 percent of New York's nursing homes were unable to comply with the minimum staffing hours required by these regulations in the first quarter of 2022. Nursing homes are severely affected by broader healthcare workforce shortages across entire healthcare continuum. At the end of 2021, the Governor issued executive orders (E.O. 4.4 et seq.) declaring a statewide healthcare workforce emergency and suspending enforcement of the minimum hours requirements and the companion minimum direct care spending requirements. She also deployed the National Guard to nursing homes beginning in December 2021, and by March 2022, nearly 500 National Guard members were on duty at 87 nursing homes -- a deployment that continued through May 2022.[2] Although the State's COVID pandemic emergency has been terminated (see E.O. 11, et seq.), the Governor has repeatedly extended the healthcare workforce emergency, recognizing in her latest extension of the emergency that "there are staffing shortages in hospitals and other healthcare facilities and they are expected continue" (see, e.g., E.O. 4.12).

In the context of an extraordinarily challenging labor market, our members continue to struggle desperately to recruit and retain staff, offering increased compensation, shift differentials, bonuses, college tuition reimbursement, and more. Nevertheless, they cannot compete with the hospitals in their communities that are able to pay higher salaries due to more generous reimbursement rates and a more lucrative payer mix. Open positions at our member homes remain vacant with few if any applicants, and nursing homes are forced to pay exorbitant fees to staffing agencies for nurses who leave without notice when a better gig comes along. Most have closed beds and units and/or limited admissions, in order to ensure appropriate levels of staff. This, of course, creates backlogs in hospitals that cannot discharge patients who no longer need acute care. Simply put, compliance with the staffing requirements set forth in this regulation is impossible, and their enforcement will inevitably lead to heavy penalties that will further deplete the resources facilities need to care for their residents.

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[1] Study of Nurse Caregiver Minimum Staffing Levels and Other Staffing Enhancement Strategies and Patient Quality Improvement Initiatives, NYS Dept. of Health, Aug. 2020. See: https://www.health.ny.gov/press/reports/docs/2020-08_staffing_report.pdf.

[2] Harris, J. "At Niagara Falls Nursing home, Troops are 'Doing Things We Never Thought the National Guard Would Do,'" *Buffalo News,* Mar. 8, 2022, available at https://www.stripes.com/branches/army/2022-03-08/national-guard-nursing-homes-new-york-covid-5271202.html .

The combined impact of these regulations with the minimum direct care spending regulations [HLT-46-21-00005-RP] will lead to a death spiral for facilities, including those that are doing everything in their power to comply. Penalties paid for non-compliance with these infeasible minimum staffing requirements will not count toward minimum direct care spending requirements (the "70/40" requirements). As a result of the staffing penalties, nursing homes may fail to meet direct care spending requirements and then face seizures of revenue by the State. The outcome will be even less money to pay staff, leading to inevitable, additional staffing penalties and seizures of revenue, until facilities are forced to close. This punitive cycle of 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 homelike environments with strong infection prevention controls that represent the highest quality in nursing home care.

SPECIFIC COMMENTS

Within the context of our general comments, we provide in this section 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:

§ 415.13(d): Nurse aide

LeadingAge NY is pleased to see the reference in this subdivision to *"…individuals, other than a licensed professional, who have been approved by the Department to administer medications to residents."* We have strongly advocated for several years for legislation that would authorize the use of Medication Technicians – CNAs who receive advanced training to administer medications in nursing homes under the supervision of an RN. Such legislation would improve the quality of care delivered in nursing homes, ease the effects of nursing shortages, provide a career ladder opportunity for CNAs, and promote professionalism in the workplace through education and certification processes. We are hopeful that including this reference in the proposed rulemaking signals DOH's intention to again advance and/or support such legislation, as well as its acknowledgment that the associated hours of care provided by these individuals would count as CNA time for purposes of the minimum staffing requirements.

§ 415.13(f): Non-Compliance with Staffing Standards

- *Measurement Interval*

LeadingAge NY supports the proposed quarterly interval for measuring compliance with the minimum nursing staff requirements, which clearly aligns with the enabling legislation and affords greater simplicity and administrative ease than utilizing a more frequent measurement interval.

- *Mitigating Circumstances*

We appreciate the revision made to the proposed regulations at 10 NYCRR § 415.13(f)(2)(ii), which would eliminate the minimum $300 per day penalty for non-compliance when the Department of Health (DOH) has determined that there are mitigating circumstances. We called for this change in our attached

Jan. 17th comments. Nursing homes that are faced with extraordinary circumstances and/or acute labor supply shortages beyond their control should not be subject to penalties for noncompliance with unrealistic and arbitrary staffing standards. It is indisputable that extraordinary circumstances and acute labor supply shortages, as defined in proposed § 415.13, exist and are likely to continue for the foreseeable future.

However, we are concerned that the revised proposed regulation's standard for mitigation of penalties inexplicably removes the reference to "closing units" as an appropriate step to be taken to ensure resident safety during a staffing shortage, while retaining "transferring residents to another appropriate facility" in the rulemaking. Closure of units is an actual indicator of a staffing crisis and is less distressing to residents than a transfer to a different facility. Many of our member nursing homes have closed units in recent months to improve their staffing position, notwithstanding having waiting lists for admission and the negative fiscal impact of a lower resident census. **Transferring residents from the nursing home they call home to another facility is a drastic step that is agonizing for the residents and their families.** Furthermore, if there is an acute labor shortage in the area within which the facility is located, it is likely that residents may need to be transferred to a distant location, exacerbating the impact on residents and their families. There are also federal and state regulatory constraints on resident transfers. The State should not financially incentivize decisions to transfer residents to other facilities. If the Department, nevertheless, retains this criterion in any final regulation, it should provide clear and timely guidance to facilities that are unable to comply with the staffing requirements as to when they may begin transferring residents, the process for initiating these transfers in compliance with federal and state regulations, and regularly updated lists of facilities that will accept transferred residents.

In addition to extraordinary circumstances and acute labor supply shortages, the underlying statute [PHL § 2895-b(2)(b)(ii)] identifies "the frequency and nature of non-compliance" as a mitigating factor that the Department is to consider in penalty determinations. The proposed regulation should be modified to incorporate this statutory factor, and to provide guidance on how it will be applied in civil penalty determinations.

The proposed regulations omit key details concerning the determination that mitigating factors exist. These details would contribute to transparency, consistency, and predictability in implementation. Specifically, the regulations fail to address the following key issues:

- What process will facilities be required to follow to demonstrate the existence of one or more of the mitigating factors? How will DOH make determinations that mitigating factors exist? Will nursing homes be able to appeal these determinations? The rulemaking should provide further information in this regard.
- In reviewing relevant State and Federal government websites, we can find no definition of the term "acute labor supply shortage," nor is one included in the proposed rulemaking. To ensure transparency and opportunity for public comment, the rulemaking should define this term and include the methodology for determining the existence of an acute labor supply shortage in Metropolitan and Nonmetropolitan Areas.

- The determination of whether such labor shortages exist is to be made by the Commissioner of Health on a quarterly basis. Will the first of these determinations be made prior to the final adoption of these regulations so that regulated parties and the public will have an opportunity to provide input on the methodology utilized by the State? Will there be a regular schedule for the issuance of these findings?
- The only factor identified in the regulation for consideration by the Commissioner in making this determination is "job availability metrics" developed by the NYS Department of Labor (DOL), which may include the list of job openings in New York State. These metrics do not appear to be specific to nursing homes. Nursing homes occupy a quite different position in the labor market for nurses and aides than hospitals and physician practices. In order to determine whether there is an acute labor shortage in nursing homes, the Commissioner will need to consider nursing home-specific metrics. These data and metrics are not currently published by the DOL and is unclear whether they even exist.

- *Effective Date and Enforcement*

According to proposed § 415.13(f), compliance with these requirements would be required effective Jan. 1, 2022, and the associated penalties would be enforceable as of that date. However, PHL § 2895-b(2)(e) provides that, "A civil penalty shall not be imposed under this section until after April first, two thousand twenty-two." The regulation should state explicitly that no such civil penalties will be issued prior to April 1, 2022.

Moreover, enforcement of both the enabling statute for these regulations [PHL § 2895-b], as well as the Minimum Direct Resident Care Spending [PHL § 2828], was suspended until April 1, 2022 by Executive Order 4.4. The revised proposed rulemaking on the *spending* requirements effectively provides for an April 1, 2022 effective date by prorating any penalties to reflect a 9-month period. The analogous treatment in this proposal would be to measure facility compliance in the quarter that begins April 1, 2022, an approach should be included in any final minimum staffing regulation.

§ 415.13(g): Eligibility for Funding to Comply with Minimum Nursing Staff Requirements

Notably, although the proposed regulation appears to require enforcement of the minimum staffing standards as of January 1, 2022, not a single dollar of the funds appropriated to support nursing home staffing in SFY 2021-22 and SFY 2022-23 has been distributed. This adds to the existing infeasibility of complying with the proposed regulations. The State submitted the proposed Medicaid State Plan Amendment 22-0007 (the SPA) to CMS to secure authorization to distribute the funds on June 30, 2022. Although the proposed regulation calls for eligibility for this funding "[p]ursuant to methodology set forth in the current Medicaid State Plan Amendment" (sic), the remainder of the proposed regulation is oddly inconsistent with the proposed SPA. These inconsistencies have made it difficult for stakeholders to discern the Department's intent in relation to the regulations and to provide responsive comments. Adding to the challenge of interpreting both the regulations and the SPA is the conflict between the SPA and the authorizing appropriation legislation for the funding.

- *Compliance with 70/40 Minimum Spending Requirements as a Condition of Eligibility*

Specifically, proposed §415.13(g) of this regulation conditions eligibility to receive additional funding for staffing on a facility's compliance with Public Health Law §2828, the nursing home minimum direct care spending requirements. As detailed below, we agree that facilities that divert funds from resident care should not receive additional State funds. The SPA methodology, however, does not follow this approach and raises questions about the State's actual intent for distribution of the funds.

Section 2828 and the related proposed regulations 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"). Likewise, the appropriation legislation authorizing the distribution of the nursing home staffing funds conditions eligibility for the funds on compliance with the 70/40 requirements:

> Provided however, that nursing homes which spend less than 70 percent of revenues on direct resident care or less than 40 percent of revenues on resident-facing-staffing shall not be eligible for monies authorized herein.

[L.2022, Ch. 53 at pp. 792, 799, 886-87, 894].

The SPA methodology, however, does not condition eligibility on the minimum direct care spending requirements. Rather, it allows facilities that violate the 70/40 requirements to receive funding, but discounts the amount payable to a nursing home by the shortfall, if any, in its compliance with the 40 percent spending requirement. The requirement to spend at least 70 percent of revenue on direct care is ignored in the SPA.

While LeadingAge NY has identified several flaws with Public Health Law §2828 and the proposed minimum direct resident care spending regulations (which we are separately commenting on), **we agree that eligibility for additional staffing funding should, consistent with the appropriation legislation, be based on compliance with the 70/40 standard and avoid rewarding under-investment in direct care**.

If conditioning eligibility on compliance with the 70/40 standard is the Department's intent, as this proposed staffing regulation suggests and as we recommend, the SPA must be modified to accomplish this. In addition, as currently drafted, the proposed staffing regulation appears to require compliance with all three PHL § 2828 spending requirements (at least 70% on direct care and 40% on resident-facing staffing, and a 5% limit on operating revenue in excess of operation and non-operating expenses), rather than just the 70/40 requirements set forth in the appropriation legislation. The regulation should be revised to clarify these conditions of eligibility.

- *Eligibility of Pediatric, HIV and Other Specialty Facilities*

Proposed §415.13(g) appears to allow pediatric, HIV and other specialty facilities to qualify for funds. It provides that "[a]ny such nursing home that the Department finds will be required to spend additional funds to comply with this Section shall be eligible to receive from the Department additional funds . . .."

In context, the phrase "such nursing home" appears to refer to any nursing home "anticipated to be in compliance with Section 2828 of the Public Health Law" that "must expend additional funds to comply with this Section [the minimum staffing section]." There are no exclusions based on type of nursing home. This approach is also consistent with the appropriation legislation which similarly does not exclude pediatric, HIV or other specialty facilities from eligibility.

We support the proposed regulation's apparent authorization of staffing funds for pediatric, HIV and other specialty nursing facilities. They are subject to the same staffing requirements as other facilities, and the appropriation legislation would also allow them to qualify.

Unfortunately, while this aspect of the eligibility provision is consistent with the law, it is inconsistent with the proposed SPA which explicitly excludes all pediatric, HIV and other specialty facilities from supplemental payments for staffing. Given the confusion generated by the SPA, the eligibility of these facilities should be clarified in the notice of final adoption. The associated SPA must also be modified to align with the appropriation legislation and the regulation by making pediatric and other specialty facilities eligible for financial support.

- *Need for "Additional Funds" as a Condition of Eligibility*

The proposed regulation would authorize payments to facilities that "must expend additional funds to comply" or "will be required to expend additional funds to comply." This 'need' criterion for the funding appears to be a product of the Department's administrative discretion; it does not appear in PHL §2895-b nor in the appropriation legislation. The method for determining "need" is not set forth in the regulation, and the regulation's characterization of need is inconsistent with methodology set forth in the SPA. We support an approach, implied by the proposed regulation, that would allow facilities to qualify for funding even if they managed to attain the required staffing levels.

Although not clearly spelled out in the regulation, the determination of need set forth in the regulation appears to be based on a current ("must expend") or prospective ("will be required to expend") need for funds, not a retrospective examination of whether funds were needed in the distant past to reach the required staffing levels. The SPA, by contrast, would provide supplemental payments only to nursing homes that were *not* in compliance with minimum staffing standards as of the *fourth quarter of the year two years prior* to the payment year, even if the facility had not complied with the 70/40 spending requirements. Thus, under the SPA's methodology, in order to qualify for funds in 2022, a nursing home must have been *out of compliance* with the minimum staffing levels in the fourth quarter of 2020. The SPA would deny funding in 2022 to facilities that managed to attain the statutory staffing levels in the fourth quarter of 2020, regardless of their need for funding or staffing levels in 2021 or 2022.

For example, under the SPA's methodology, a facility that spent *more than* the 70/40 requirements and closed a unit in order to comply with staffing requirements, but operated at a deficit, dipped into its reserves, and/or failed to pay vendors or make debt service payments in a timely manner, would *not* qualify for funding. On the other hand, a facility that *failed* to meet the 70/40 requirements, diverted excess revenue to owners, and continued to fill all of its beds, while *failing* to comply with staffing levels *would* receive additional payments from the State.

Facilities that manage to comply with staffing levels by investing heavily in staff, at the risk of their future viability, should not be denied funding. The majority of non-profit facilities in the state are in financial crisis. A significant number were facing financial stress even before the pandemic, largely because they prioritized staffing, the primary expense for a nursing home. Establishing a funding methodology that ignores a facility's commitment to staffing even at the risk of its financial viability, while rewarding facilities that may have had low staffing and positive margins for years, makes little sense. Over 50 public and non-profit homes were forced to close or sell to for-profit entities since 2014. Funding policies like this only encourage that trend.

In sum, the regulation's intent regarding eligibility for funding is unclear both because it lacks detail and because it is inconsistent with the proposed SPA. We strongly recommend that the Department clarify the regulatory text, and/or the commentary accompanying it as appropriate, to create an eligibility process that: (i) requires compliance with the 70/40 requirements as set forth in the appropriation legislation, (ii) allows pediatric and specialty facilities to qualify, and (iii) allows facilities that have met staffing requirements to qualify. Facilities that have managed to meet minimum nursing staff requirements should not be penalized for their commitment to their residents and their staff. Such facilities should be eligible to receive funding to support ongoing compliance and remain financially viable. LeadingAge NY would be pleased to work with DOH on a more sensible methodology for distributing funds.

The Department should also amend the SPA to align with these recommendations and the regulations. The current methodology outlined in the SPA would prevent the majority of non-profit and government-sponsored nursing homes from qualifying for funding, without regard for their actual need, because they managed to comply with the minimum staffing requirements in late 2020 by investing heavily in staffing and limiting admissions (at the risk of financial ruin). At the same time, the SPA would provide funding to facilities that diverted revenues from resident care and failed to meet staffing requirements. This is indefensible.

Posting Requirements (PHL § 2895-b(4))

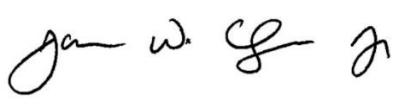
The regulations neglect to elaborate on two statutory requirements that demand DOH's instructions. First, the statute requires nursing homes to post information regarding nurse staffing that the facility is required to make available to the public under Public Health Law § 2805-t, "in a form approved by the department" and "in a manner which is visible and accessible to residents, their families and the staff, as required by the commissioner." Inexplicably, Public Health Law § 2805-t refers to posting requirements for general hospitals; however, nursing homes are not considered to be "general hospitals" under statute [see PHL § 2801(10)]. In addition, facilities are required to post a summary of the law provided by DOH, in proximity to the other postings. Nursing homes are waiting for the form and manner of these postings and the summary of the statute from the Department.

CONCLUSION

By imposing infeasible and arbitrary nurse and CNA staffing ratios, the proposed rulemaking and PHL § 2895-b represent an ill-conceived attempt to regulate away a problem that simply cannot be solved through regulations. The proposed regulation will only: (1) exacerbate existing staffing shortages by depriving nursing homes of the financial resources they need to effectively recruit and retain staff, (2) adversely affect access to local care through unit closures and resident transfers to other facilities; and (3) create ripple effects on other sectors of the health care system through unit closures, transfers of residents.

We hope to work with the Department to ensure the best possible care and quality of life for nursing home residents. This regulation will not promote our shared goals. Thank you in advance for carefully considering our comments and recommendations.

Sincerely yours,



James W. Clyne, Jr.
President and CEO

Attachment

cc: Angela Profeta
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Attachment 2

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

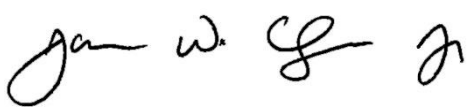
The proposed regulation fails to identify how direct resident care and resident facing staffing expenses will be calculated for hospital-based nursing homes which do not file the standard RHCF-4 Medicaid cost report. Those facilities do not accumulate or allocate costs in the same manner as a nursing 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,



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Attachment