

Pursuant to the authority vested in the Public Health and Health Planning Council and the Commissioner of Health by Section 2828 of the Public Health Law, Part 415 of Title 10 of the Official Compilation of Codes, Rules and Regulations of the State of New York (NYCRR) is hereby amended by adding a new Section 415.34, to be effective upon publication of a Notice of Adoption in the New York State Register, to read as follows:

415.34. Minimum Direct Resident Care Spending.

(a) Purpose. This Section sets forth the requirements of the minimum direct resident care spending law set forth in Section 2828 of the Public Health Law and applies to all residential health care facilities licensed pursuant to this Part, except as provided in subdivision (c) of this Section.

(b) Definitions. The definitions of this Section shall have the same meaning as those terms set forth in subdivision (2) of Section 2828 of the Public Health Law. Additionally, the following terms shall have the following meanings:

(1) “Contracted out” shall mean services provided by registered professional nurses, licensed practical nurses, or certified nurse aides who provide services in a residential health care facility through contractual or other employment agreement, whether such agreement is entered into by the individual practitioner or by an employment agency on behalf of the individual practitioner. Such agreement may be oral or in writing.

(2) “Direct resident care” shall mean the following cost centers in the residential health care facility cost report:

(i) Nonrevenue Support Services - Plant Operation & Maintenance, Laundry and Linen, Housekeeping, Patient Food Service, Nursing Administration, Activities Program,

Nonphysician Education, Medical Education, Medical Director's Office, Housing, Social Service, Transportation;

(ii) Ancillary Services - Laboratory Services, Electrocardiology, Electroencephalogy, Radiology, Inhalation Therapy, Podiatry, Dental, Psychiatric, Physical Therapy, Occupational Therapy, Speech/Hearing Therapy, Pharmacy, Central Services Supply, Medical Staff Services provided by licensed or certified professionals including and without limitation Registered Nurses, Licensed Practical Nurses, and Certified Nursing Assistant; and

(iii) Program Services - Residential Health Care Facility, Pediatric, Traumatic Brain Injury (TBI), Autoimmune Deficiency Syndrome (AIDS), Long Term Ventilator, Respite, Behavioral Intervention, Neurodegenerative, Adult Care Facility, Intermediate Care Facilities, Independent Living, Outpatient Clinics, Adult Day Health Care, Home Health Care, Meals on Wheels, Barber & Beauty Shop, and Other similar program services that directly address the physical conditions of residents. Direct resident care does not include, at a minimum and without limitation, administrative costs (other than nurse administration), capital costs, debt service, taxes (other than sales taxes or payroll taxes), capital depreciation, rent and leases, and fiscal services.

(3) "Resident-facing staffing" shall mean all staffing expenses in the ancillary and program services categories on Exhibit H of the residential health care facility cost reports.

(4) "Revenue" shall mean the total operating revenue from or on behalf of residents of the residential health care facility, government payers, or third-party payers, to pay for a resident's occupancy of the residential health care facility, resident care, and the operation of the residential

health care facility as reported in the residential health care facility cost reports submitted to the Department; provided, however, that revenue shall exclude:

(i) the average increase in the capital portion of the Medicaid reimbursement rate from the prior three years;

(ii) funding received as reimbursement for the assessment under Public Health Law section 2807-d(2)(b)(vi), as reconciled pursuant to Public Health Law section 2807-d(10)(c);

(iii) the capital per diem portion of the reimbursement rate for nursing homes; provided, however, that such exclusion shall not apply:

(a) for nursing homes that have an overall one-, two-, or three-star rating assigned pursuant to the inspection rating system of the U.S. Centers for Medicare and Medicaid Services (CMS rating); or

(b) to any amount of the capital per diem portion of the reimbursement rate 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 as reported under Public Health Law section 2803-x(1); and

(iv) any grant funds from the federal government for reimbursement of COVID-19 pandemic-related expenses, including, but not limited to, funds received from the federal emergency management agency or health resources and services administration.

(c) Applicability.

(1) For the purposes of this Section, residential health care facilities shall not include:

(i) facilities that are authorized by the Department to primarily care for medically fragile children or young adults, people with HIV/AIDS, persons requiring behavioral

intervention, or persons requiring neurodegenerative services. For the purposes of this subparagraph, a facility shall be considered to primarily care for such specialized populations if at least 51 percent of certified beds are designated for persons with such specialty health care needs; or

(ii) continuing care retirement communities licensed pursuant to Article 46 or 46-A of the Public Health Law.

(iii) A facility may apply to the Commissioner for a waiver of applicability of this Section on the basis of providing specialty care services if such facility primarily provides care to a specialized population other than one listed in subparagraph (i) of this paragraph. Such application shall detail what specialty services the facility provides, the percentage of the resident population needing such specialty services, and whether any other residential health care facilities licensed by the Department provide such specialty services. The Commissioner shall have discretion to approve or reject applications submitted pursuant to this subparagraph, and shall provide the facility with the basis for the Commissioner's determination within a reasonable timeframe upon receipt of a complete application. Factors the Commissioner will assess in determining whether to grant or deny a waiver application based on provision of services to a specialty population include, but are not limited to, the following:

(a) the number of other residential health care facilities licensed by the Department that provide the services identified by the facility as specialized services;

(b) whether a majority of current facility residents have special health care needs as identified by the facility; and

(c) the unique training or licensing required of facility staff to provide services to the identified specialized population.

(iv) In the event a facility no longer provides care for a specialty population, as identified under subparagraphs (i) and (iii) of this paragraph, the facility shall comply with this Section by January first of the first year following the date on which the facility ceased operating as a specialty residential health care facility, as determined by the Commissioner.

(2) Additional Waivers. A facility may apply to the Commissioner for a waiver of applicability of this Section on the basis of unexpected or exceptional circumstances that prevented compliance. Such application shall detail the specific unexpected or exceptional circumstance experienced by the facility; when the facility first learned of such circumstances; why the facility could not have anticipated such circumstances arising; actions the facility took to address such circumstances; expenses incurred as a result of addressing such circumstances; when the facility expects such circumstances to be resolved; and what preventive steps the facility is taking to ensure that such circumstances do not unexpectedly arise in the future. The Commissioner shall have discretion to approve or reject applications submitted pursuant to this paragraph, and shall provide the facility with the basis for the Commissioner's determination within a reasonable timeframe upon receipt of a complete application. Factors the Commissioner will assess in determining whether to grant or deny a waiver application based on unexpected or exceptional circumstances include, but are not limited to, the following:

- (i) whether the facility should have anticipated such events occurring;
- (ii) whether any other residential health care facilities licensed by the Department experienced similar circumstances but have not applied for a waiver under this paragraph;

(iii) whether the facility has implemented sufficient policies and procedures to ensure such events do not recur.

(d) Minimum Spending Requirements. By January 1, 2022, residential health care facilities shall comply with the following minimum expenditures:

(1) 70 percent of revenue shall be spent on direct resident care; and

(2) 40 percent of revenue shall be spent on resident-facing staffing.

(i) All amounts spent on resident-facing staffing shall be included as a part of amounts spent on direct resident care; and

(ii) 15 percent of costs associated with resident-facing staffing that are contracted out by a facility for services provided by registered professional nurses, licensed practical nurses, or certified nurse aides shall be deducted from the calculation of the amount spent on resident-facing staffing and direct resident care.

(3) For the purposes of assessing whether a facility has met the minimum spending requirements, a facility may apply to the Commissioner to have certain revenues and expenses excluded from the calculation of the facility's total revenue and total expenditures, where the facility has satisfactorily demonstrated to the Commissioner that such revenues and expenses were incurred due to the following circumstances:

(i) a natural disaster, where a federal, State, or local declaration of emergency has been issued; or

(ii) the facility has received extraordinary, non-recurring revenue which, in the discretion of the Commissioner, does not accurately reflect operating revenue for the purposes of this rule, including but not limited to revenue received through insurance or legal settlements.

(e) Recoupment.

(1) A residential health care facility shall be subject to recoupment for excessive total operating revenue if:

- (i) the facility's total operating revenue exceeds total operating and non-operating expenses by more than five percent of total operating revenue; or
- (ii) the facility fails to spend the minimum amount necessary to comply with the minimum spending standards for resident-facing staffing or direct resident care, as set forth in subdivision (d) of this Section, as calculated on an annual basis, or for 2022, on a pro-rata basis for April 1, 2022 through December 31, 2022.

(2) Remission of excess revenue.

- (i) The Department shall issue a notice of noncompliance to a facility subject to recoupment for excessive total operating revenue, which indicates the amount to be remitted based on the amount of excess revenue or the difference between the minimum spending requirement and the actual amount of spending on resident-facing staffing or direct care staffing, as applicable, as well as acceptable forms of payment.
- (ii) Upon receipt of a notice of noncompliance pursuant to subparagraph (i), the facility shall remit the total amount indicated in the notice of noncompliance by November first in the year following the year in which the expenses are incurred.

(3) Penalties. Failure to remit the total required fee by the due date may result in adverse action by the Department, including but not limited to: bringing suit in a court of competent jurisdiction, taking deductions or offsets from payments made pursuant to the Medicaid program, and imposition of penalties pursuant to Section 12 of the Public Health Law.

(4) Recouped funds shall be deposited by the Department into the Nursing Home Quality Pool, pursuant to Section 2808(2-c)(d) of the Public Health Law.

(f) Residential Health Care Facility Cost Reports.

(1) The Department shall, no less frequently than annually, audit the residential health care facilities' cost reports for compliance in accordance with this Section.

(2) If a facility did not report data in the 2019 residential health care facility cost report, they must promptly provide the Department with data on the facility's direct resident care and resident facing staffing expenses in accordance with this Section and Section 2828 of the Public Health Law. This data must be submitted with a written certification by the operator, officer, or public official responsible for the operation of the facility, in a form and format determined acceptable by the Department, attesting that all data reported by the facility is complete and accurate. If the data is not submitted within a reasonable timeframe, as determined by the Department, the Department shall use the previous available cost report data applicable to such facility.

REGULATORY IMPACT STATEMENT

Statutory Authority:

The statutory authority is provided under section 2828 of the Public Health Law (PHL), which directs the Department of Health (Department) to promulgate regulations governing the disposition of revenue in excess of expenses permitted under PHL § 2828 for residential health care facilities. Specifically, PHL § 2828 directs that, as of January 1, 2022, every residential health care facility shall spend a minimum of 70 percent of revenue on direct resident care and 40 percent of revenue on resident-facing staffing, wherein amounts spent on resident-facing staffing are included in the amount spent on direct resident care.

Laws of 2022, Chapter 57, Part M, § 1, amended the definition of “revenue” in PHL § 2828.

In general, PHL § 2828 provides that remission of excess revenue is calculated on an annual basis. Laws of 2022, Chapter 57, Part M, § 4, provides that in 2022, the remission of excess revenue shall be on a pro-rata basis for only that portion of the year during which the failure of a residential health care facility to spend a minimum of seventy percent of revenue on direct resident care, and forty percent of revenue on resident-facing staffing, may be held to be a violation of the Public Health Law, i.e., April 1, 2022, through December 31, 2022, the portion of 2022 after Executive Order 4.4 expired. See 9 NYCRR §9.4.4, which was in effect from January 1, 2022, through March 31, 2022.

Legislative Objectives:

The legislative objective of PHL § 2828 is to ensure that residential health care facilities spend a majority of their revenue on direct resident care (70 percent), with 40 percent of such

expenses focused on paying for resident-facing staffing. The goal of these minimum spending requirements is to help ensure a high quality of resident care.

Needs and Benefits:

These regulations are necessary to implement the statutory directive of PHL § 2828. Specifically, pursuant to the statute, the regulations (1) set forth how facilities that fail to meet the statutory minimum spending requirements must pay the State, (2) provide exceptions from the minimum spending requirements for residential health care facilities that serve certain specialized populations, (3) set forth factors the Department will use to determine whether to waive the spending requirements for facilities unable to comply due to “unexpected or exceptional circumstances that prevented compliance,” and (4) provide factors the Department will use to determine whether to exclude extraordinary revenues and capital expenses from the calculations to determine whether a facility has met its minimum spending requirements.

Requiring nursing homes to spend an appropriate amount of revenue on the direct care of residents and resident-facing staffing will reduce errors, complications, and adverse resident care incidents. It will also improve the safety and quality of life for all long-term care residents in New York State.

COSTS:

Costs to Regulated Parties:

The purpose of this regulation is to implement PHL § 2828, which requires residential health care facilities to spend a certain percentage of revenue (70 percent) on direct resident care, with 40 percent of such revenue focused on resident-facing staffing. Residential health care facilities are not necessarily required to expend additional resources to meet these minimum spending requirements, but rather may appropriately manage expenditures to balance overall

expenditures to meet the minimum spending thresholds. While the Department anticipates that costs will be borne by residential health facilities, and that those costs may create financial challenges for some organizations, compliance with these minimum spending requirements is mandated by statute (PHL § 2828), and as such these regulatory amendments are necessary. Moreover, any recouped funds from residential health care facilities that fail to comply with PHL § 2828 will be deposited into the Nursing Home Quality Pool to benefit high-quality residential health care facilities, thereby helping to offset any costs for high-performing facilities while also encouraging the provision of quality resident care.

Costs to Local and State Governments:

This regulation will not impact local or State governments unless they operate a residential health care facility, in which case the costs will be the same as for privately-operated facilities. Currently, there are 21 residential health care facilities operated by local governments (counties and municipalities) and 6 residential health care facilities operated by the State.

Costs to the Department of Health:

This regulation will not result in any additional operational costs to the Department of Health.

Paperwork:

This regulation generally imposes no additional paperwork requirements. Although facilities will be required to submit revenue and expense information through an annual cost report submitted to the Department, such costs reports are current required pursuant to PHL §§

2805-e and 2808-b. If a facility has not submitted a cost report for 2019, the regulation requires the expense and revenue data to instead be submitted with a written certification by the operator, officer, or public official responsible for the operation of the facility, in a form and format determined acceptable by the Department, attesting that all data reported by the facility is complete and accurate. Although this data form would be a new requirement, because it is merely a temporary measure to substitute for a missing 2019 cost report, the Department does not anticipate that this requirement will be unduly burdensome for the residential health care facilities subject to this new paperwork requirement.

Local Government Mandates:

Residential health care facilities operated by local governments will be affected and will be subject to the same requirements as any other residential health care facility licensed under PHL Article 28.

Duplication:

These regulations do not duplicate any State or federal rules.

Alternatives:

These regulations are mandated pursuant to PHL § 2828. Accordingly, the alternative of not issuing these regulations was rejected.

Federal Standards:

No federal standards apply.

Compliance Schedule:

The regulations will become effective upon publication of a Notice of Adoption in the New York State Register.

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REGULATORY FLEXIBILITY ANALYSIS

Effect on Small Business and Local Government:

This regulation will not impact local governments or small businesses unless they operate a residential health care facility. Currently, there are 21 residential health care facilities operated by local governments (counties and municipalities) and 6 residential health care facilities operated by the State. Additionally, to date, 79 residential health care facilities in New York qualify as small businesses given that they have 100 or fewer employees.

Compliance Requirements:

This regulation seeks to implement PHL § 2828, which requires residential health care facilities to spend a certain percentage of revenue (70 percent) on direct resident care, with 40 percent of such revenue focused on resident-facing staffing. In accordance with this statute, residential health care facilities will be required to meet these aforementioned minimum spending requirements, unless they meet certain exceptions as detailed in both PHL § 2828 and these regulations, including facilities that provide care to Commissioner-designated specialty populations and facilities that are unable to comply with the minimum spending requirements due to natural disaster or other “unexpected or exceptional circumstances that prevented compliance.”

Facilities that fail to meet the minimum spending requirements of PHL § 2828 and these regulations will be required to remit a penalty payment in the amount of the facility’s excessive total operating revenue, based on the amount of excess revenue or the difference between the minimum spending requirement and the actual amount of spending on resident-facing staffing or direct care staffing, as applicable.

Professional Services:

No professional services are required by this regulation.

Compliance Costs:

This regulation seeks to implement PHL § 2828, which requires residential health care facilities to spend a certain percentage of revenue (70 percent) on direct resident care, with 40 percent of such revenue focused on resident-facing staffing. Residential health care facilities are not necessarily required to expend additional resources to meet these minimum spending requirements, but rather may appropriately manage expenditures to balance overall expenditures to meet the minimum spending thresholds. While the Department anticipates that costs will be borne by residential health facilities, and that those costs may create financial challenges for some organizations, compliance with these minimum spending requirements is mandated by statute (PHL § 2828), and as such these regulatory amendments are necessary. Moreover, any recouped funds from residential health care facilities that fail to comply with PHL § 2828 will be deposited into the Nursing Home Quality Pool to benefit high-quality residential health care facilities, thereby helping to offset any costs for high-performing facilities while also encouraging the provision of quality resident care.

Economic and Technological Feasibility:

There are no economic or technological impediments to the rule changes.

Minimizing Adverse Impact:

This regulation is mandated pursuant to PHL § 2828 and necessary to ensure that direct resident care is prioritized by setting forth minimum spending requirements for such care.

Therefore, any adverse impacts are outweighed by the regulation's health and safety benefits to residents as well as the legal mandate for promulgation.

Small Business and Local Government Participation:

Health care provider organizations, individual institutions, local health departments and the public are invited to comment during the Codes and Regulations Committee of the Public Health and Health Planning Council (PHHPC). Interested parties and members of the general public will be notified and provided in advance of the PHHPC meeting the time and place of the meeting, the text of the regulation for their review and a chance to submit oral and written comments. All written comments will be sent to PHHPC members 72 hours in advance of the meeting.

Further, the Department will engage in active discussions and dialogue with all interested parties, including industry associations directly impacted by this regulation, to inform them of their need to comply, to answer questions and listen to comments they may have on this regulation. Specifically, the Department will issue a *Dear Administrator Letter (DAL)* to each effected nursing home, either operated by a local government, or privately, which will outline the date such regulation will go into effect, the specific requirements outlined in the regulation and the penalties for non-compliance. Further, the Department will formally solicit questions from each effected party and will prepare a *Frequently Asked Questions, (FAQ)* which will be updated regularly and publicly posted on the Department's website for review and feedback.

Cure Period:

This regulation does not include a cure period given that compliance is required by January 1, 2022 per PHL § 2828.

RURAL AREA FLEXIBILITY ANALYSIS

Type and Estimated Numbers of Rural Areas:

Although this rule applies uniformly throughout the state, including rural areas, for the purposes of this Rural Area Flexibility Analysis (RAFA), “rural area” means areas of the state defined by Exec. Law § 481(7) (SAPA § 102(10)). Per Exec. Law § 481(7), rural areas are defined as “counties within the state having less than two hundred thousand population, and the municipalities, individuals, institutions, communities, and programs and such other entities or resources found therein. In counties of two hundred thousand or greater population ‘rural areas’ means towns with population densities of one hundred fifty persons or less per square mile, and the villages, individuals, institutions, communities, programs and such other entities or resources as are found therein.”

The following 43 counties have a population of less than 200,000 based upon the United States Census estimated county populations for 2010:

Allegany County	Greene County	Schoharie County
Cattaraugus County	Hamilton County	Schuyler County
Cayuga County	Herkimer County	Seneca County
Chautauqua County	Jefferson County	St. Lawrence County
Chemung County	Lewis County	Steuben County
Chenango County	Livingston County	Sullivan County
Clinton County	Madison County	Tioga County
Columbia County	Montgomery County	Tompkins County
Cortland County	Ontario County	Ulster County
Delaware County	Orleans County	Warren County
Essex County	Oswego County	Washington County
Franklin County	Otsego County	Wayne County
Fulton County	Putnam County	Wyoming County
Genesee County	Rensselaer County	Yates County
	Schenectady County	

The following counties of have population of 200,000 or greater, and towns with population densities of 150 person or fewer per square mile, based upon the United States Census estimated county populations for 2010:

Albany County
Broome County
Dutchess County
Erie County

Monroe County
Niagara County
Oneida County
Onondaga County

Orange County
Saratoga County
Suffolk County

Licensed residential health care facilities are located in these identified rural areas.

Reporting, recordkeeping, and other compliance requirements; and professional services:

This regulation generally imposes no additional paperwork requirements. Although facilities will be required to submit revenue and expense information through an annual cost report submitted to the Department, such costs reports are currently required pursuant to PHL §§ 2805-e and 2808-b. If a facility has not submitted a cost report for 2019, the regulation requires the expense and revenue data to instead be submitted with a written certification by the operator, officer, or public official responsible for the operation of the facility, in a form and format determined acceptable by the Department, attesting that all data reported by the facility is complete and accurate. Although this data form would be a new requirement, because it is merely a temporary measure to substitute for a missing 2019 cost report, the Department does not anticipate that this requirement will be unduly burdensome for the residential health care facilities subject to this new paperwork requirement.

Compliance Costs:

This regulation seeks to implement PHL § 2828, which requires residential health care facilities to spend a certain percentage of revenue (70 percent) on direct resident care, with 40 percent of such revenue focused on resident-facing staffing. Residential health care facilities are not necessarily required to expend additional resources to meet these minimum spending requirements, but rather may appropriately manage expenditures to balance overall expenditures

to meet the minimum spending thresholds. While the Department anticipates that costs will be borne by residential health facilities, and that those costs may create financial challenges for some organizations, compliance with these minimum spending requirements is mandated by statute (PHL § 2828), and as such these regulatory amendments are necessary. Moreover, any recouped funds from residential health care facilities that fail to comply with PHL § 2828 will be deposited into the Nursing Home Quality Pool to benefit high-quality residential health care facilities, thereby helping to offset any costs for high-performing facilities while also encouraging the provision of quality resident care.

Economic and Technological Feasibility:

There are no economic or technological impediments to the rule changes.

Minimizing Adverse Impact:

This regulation is mandated pursuant to PHL § 2828 and necessary to ensure that direct resident care is prioritized by setting forth minimum spending requirements for such care.

Therefore, any adverse impacts are outweighed by the regulation's health and safety benefits to residents as well as the legal mandate for promulgation.

Rural Area Participation:

The Department will notify all residential health care facilities, including those located in rural areas, of the existence of these regulations and the opportunity to submit public comments or questions to the Department.

STATEMENT IN LIEU OF JOB IMPACT STATEMENT

A Job Impact Statement for these regulations is not being submitted because it is apparent from the nature and purposes of the amendments that they will not have a substantial adverse impact on jobs and/or employment opportunities.

ASSESSMENT OF PUBLIC COMMENT

The New York State Department of Health (Department) received comments from several organizations as well as many for-profit nursing homes, non-profit nursing homes, and individuals. The comments and the Department's responses are summarized below.

Comment: Commenters indicated concern with facilities being penalized for not meeting the spending mandate when they are in compliance with the staffing mandate. They believe the spending mandate does not consider the quality of a facility and penalizes efficiently run, high quality facilities without addressing the problematic facilities.

Response: The Department has an obligation to execute and implement Public Health Law Section 2828, as amended by Laws of 2022, Chapter 57, Part M, Section 1 (2022-2023 Budget). The Legislature did add a provision in the 2022-2023 Budget amending the definition of revenue so that nursing homes that have a four- or five-star rating assigned pursuant to the inspection rating system of the U.S. Centers for Medicare and Medicaid Services (CMS rating) may exclude the capital per diem portion of the reimbursement rate for nursing homes from revenue. This exclusion is not, however, available for nursing homes that have a CMS one-, two-, or three-star rating. The Revised Rule amended the definition of revenue, which considers the quality of a facility and favors facilities with high CMS ratings. No changes have been made to the regulation in response to these comments.

Comment: Commentors indicated concern that the definition of revenue to be spent on patient care includes Medicare reimbursements for services rendered. They stated that diverting a

portion of these Medicare reimbursements to the nursing home quality pool would cross-subsidize the State's Medicaid program.

Response: Nursing homes in New York are required to comply with Public Health Law Section 2828, and when they do, Medicare reimbursement will be used, as it should be, for resident care. As provided in Public Health Law Section 2828(1)(c) and Section 415.34(e) of the regulation, nursing homes not in compliance with the requirements shall be subject to recoupment for excessive total operating revenue. No changes to the regulation have been made in response to these comments.

Comment: Commenters indicated that enforcement of the regulations retroactive to January 1, 2022, would be unfair. One commenter pointed to recent court rulings under the State Administrative Procedure Act, indicating that these rulings disallow the State from retroactively penalizing facilities.

Response: Under PHL Section 2828(1)(a), the minimum direct spending requirements began on January 1, 2022. Under Executive Order 4.4 (codified in 9 NYCRR Section 9.4.4), however, which was in effect from January 1, 2022, through March 31, 2022, compliance was not required until April 1, 2022. Since the statute has been in place since April 1, 2022, enforcement is not retroactive. No changes to the regulation have been made in response to these comments.

Comment: Commenters also indicated that the use of contracted staff has dramatically increased. They believe these mandates will result in increased costs and, coupled with the 15% discount for using contracted staff, will undermine their efforts to meet the spending requirements.

Response: Under PHL Section 2828(1)(b), 15 percent of costs associated with resident-facing staffing contracted out by a facility for services provided by registered professional nurses, licensed practical nurses, or certified nurse aides shall be deducted from the calculation of the amount spent on resident-facing staffing and direct resident care. Section 415.34(e) of the regulation implements this provision of the statute. No changes to the regulation have been made in response to these comments.

Comment: One Commentor expressed concern that the spending requirements would force high level facilities to hire additional staff, which would drain resources from other facilities.

Response: The Department is well-aware that there are healthcare staffing shortages in the State of New York. Requiring more direct care spending will increase expenditure on labor and thereby increase participation of healthcare workers in the labor market. No changes to the regulation have been made in response to this comment.

Comment: A commenter indicated concern with the extent to which the proposed regulations allow for facilities to request waivers when they provide specialized care.

Response: The Department's first Assessment of Public Comment already responded to this comment when this Revised Rule was published:

https://regs.health.ny.gov/sites/default/files/proposed-regulations/Nursing%20Home%20Minimum%20Direct%20Resident%20Care%20Spending_0.pdf. The Revised Rule did not make changes in response to this comment.

Comment: A commenter indicated that relying on annual revenues to determine compliance with the 5% spending cap may result in penalties being assessed inappropriately as annual revenues could include payments of prior year rate adjustments, which can inflate annual revenues and spending benchmarks. The commenter suggested that a balance sheet rather than a profit and loss statement is a superior indicator of a facility's financial condition.

Response: The Department will develop and make public its policies regarding the calculation of the 5% under PHL Section 2828(1)(c) and Section 415.34(e)(1)(i) of the regulation. No changes to the regulation have been made in response to this comment.

Comment: A commenter suggested that the regulatory definition of "contracted out" be revised to explicitly exclude payments to individual per diem employees, and these payments should not be subject to the 15 percent discount under Section 415.34(d)(2)(ii) of the regulation.

Response: The regulatory definition of "contracted out" does not include staff that are paid directly as per diem staff. The definition of "contracted out" does include staff such as agency nurses that are paid by a third-party contractor. The 15 percent discount reflects the fact that a portion of what is paid to the third-party contractor is not used for staffing of the nursing home. This regulation applies the definition of "contracted out" to all employees in the same manner, regardless of whether the employees are paid an annual salary or are paid by the hour per diem. No changes to the regulation have been made in response to this comment.

Comment: Commenters stated that the regulatory definition of "direct resident care" should be revised to include security, grounds, and medical records, as these functions are required for proper resident safety and care, and the regulation would discourage spending in areas that

contribute to the stated goals of the statute, and exclusion of these costs would serve to detract from resident safety and quality of life. One commenter urged the Department to include assistive devices that promote independent performance of self-care and mobility in the definition of direct care spending.

Response: PHL Section 2828(2)(c) defines “Direct resident care.” Section 415.34(b)(2) of the regulation implements this provision of the statute. The Department will provide further guidance as needed. No changes to the regulation have been made in response to these comments.

Comment: A commenter stated that the exclusion of the average increase in the capital portion of the Medicaid reimbursement rate from the prior three years will not offer much relief as it would have no impact on debt predating three years ago, or depreciation expense on a capital asset acquisition that is more than three years old.

Response: Under PHL Section 2828(2)(a)(i), revenue excludes the average increase in the capital portion of the Medicaid reimbursement rate from the prior three years. Section 415.34(b)(4)(i) of the regulation implements this provision of the statute. No changes to the regulation have been made in response to this comment.

Comment: A commenter suggested the proposed regulation should provide information on how the exclusion of certain capital reimbursement from revenue, based on star rating, will be implemented.

Response: The Department thanks the commenter for this suggestion. The Department will develop and make public its policies regarding the point in time at which a facility’s star rating

must be 4 or 5 to qualify for the exclusion of capital reimbursement from revenue. No changes to the regulation have made in response to this comment.

Comment: A commenter stated the regulation should define “common or familial relationship” and exclude capital payments from a not-for-profit to their parent or sponsor, hospital-based nursing home to its parent, or public facility to its sponsor.

Response: Under PHL Section 2828(2)(a)(iii), revenue excludes the capital per diem portion of the reimbursement rate for nursing homes that have an overall 4 or 5-star rating assigned pursuant to the inspection rating system of the U.S. Centers for Medicare and Medicaid Services (CMS rating), provided however that such exclusion shall not apply to any amount of the capital per diem portion of the reimbursement rate 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 as reported under PHL Section 2803-x. Section 415.34(b)(4)(iii) of the regulation implements this provision of the statute. DAL NH 22-15 (June 23, 2022) provides guidance regarding PHL Section 2803-x, and the Department will provide additional guidance as needed. No changes to the regulation have been made in response to this comment.

Comment: Comments were received regarding the proposed definition of “revenue” in the regulation and suggesting that it lacks clarity regarding the inclusion of certain non-patient care revenue, such as investment income, grants, and charitable donations. Another commenter stated that Statewide Health Care Facility Transformation program and Vital Access Provider program money is excluded from the definition of “revenue.” Another commenter stated that nursing home quality pool distributions should be excluded from the definition of “revenue.” Another

commenter stated that payments from successful Medicaid rate appeals should be excluded from the definition of “revenue.” These non-patient care revenues should be excluded from the definition of “revenue” and not require any application or demonstration.

Response: PHL Section 2828(2)(a) defines “revenue” and specifies that the definition is “as reported in the residential health care facility cost reports submitted to the department.” Section 415.34(b)(4) of the regulation implements this provision of the statute. The Department will provide additional guidance as needed. No changes to the regulation have been made in response to these comments.

Comment: A commenter stated that facilities should not be required to remit revenues in excess of five percent of total operating revenue for the duration of the federal Public Health Emergency in light of the proposed Section 415.34(d)(3), which allows facilities to apply individually for exclusions of expenses due to natural disasters and other reasons.

Response: Under PHL Section 2828(4), “The commissioner may also exclude from revenues and expenses, on a case-by-case basis, extraordinary revenues and capital expenses, incurred due to a natural disaster or other circumstances set forth by the commissioner in regulation.” Section 415.34(d)(3) of the regulation implements this provision of the statute. The Department will provide additional guidance as needed. No changes to the regulation have been made in response to this comment.

Comment: A commenter stated the proposed regulation, and as necessary, the statute, should be revised so that the 15 percent discount of the reported costs of nurse and aide services obtained under contract, as proposed in Section 415.34(d)(2)(ii) of the regulation, only apply to services

obtained under related-party staffing contracts. The commenter noted that, with non-related party contracts, the facility's operator does profit from the transaction, and the regulation would penalize nursing homes for following New York State Labor Law, which under Section 167 requires nursing homes to first attempt to call in agency staff before mandating nurse overtime.

Response: The Department believes that the statute was not only intended to discourage self-dealing but also to encourage nursing homes to provide adequate staffing by hiring staff directly and not to depend on agency nurses working under contract. No changes to the regulation were made in response to this comment.

Comment: A comment was received stating that section 415.34(e)(2)(ii), which requires remittance of excess revenue prior to November 1st, should be amended to require remittance within 30 days from the date of the notice of noncompliance. The commenter stated that a delay in the cost reporting deadline or other associated delays could prevent the Department from issuing a notice of noncompliance in time to allow adequate notice to a facility.

Response: Under PHL Section 2828(1)(c), "such excess revenue... shall be payable, in a manner to be determined by... regulations, by November first in the year following the year in which the expenses are incurred." Section 415.34(e)(2)(ii) of the regulation implements this provision of the statute. The Department will provide additional guidance as needed. No changes to the regulation have been made in response to this comment.

Comment: A commenter suggested the Department clarify how additional funds will be distributed, noting a lack of clarity because the State has not submitted a State Plan Amendment to authorize changes to the quality pool.

Response: The Department’s first Assessment of Public Comment already responded to this comment when this Revised Rule was published:

https://regs.health.ny.gov/sites/default/files/proposed-regulations/Nursing%20Home%20Minimum%20Direct%20Resident%20Care%20Spending_0.p

[df](#). No changes to the regulation have been made in response to this comment.

Comment: A commenter asked how direct resident care and resident facing staffing expenses will be calculated for hospital-based nursing homes, as hospital-based nursing homes do not file the RHCF-4 Medicaid cost report.

Response: The Department’s first Assessment of Public Comment already responded to this comment when this Revised Rule was published:

https://regs.health.ny.gov/sites/default/files/proposed-regulations/Nursing%20Home%20Minimum%20Direct%20Resident%20Care%20Spending_0.p

[df](#). No changes to the regulation have been made in response to this comment.