

Part 6656 LIMITS ON ADMINISTRATIVE EXPENSES AND EXECUTIVE COMPENSATION

Section 6656.1 Applicability.

This Part shall be applicable to covered providers as defined in section 6656.2 of this Part which receive, pursuant to contract or other agreement with the Office or with another governmental agency, State funds from the Office or payments of funds that are not State funds but which are distributed or disbursed upon approval of the Office or by another governmental entity upon such approval or by virtue of the provider having an operating certificate from the Office.

Section 6656.2 Definitions:

For purposes of this Part:

(a) *Administrative expenses* are those expenses incurred in connection with the covered provider's overall management and necessary overhead that cannot be attributed directly to the provision of program services.

- (1) Such costs include but are not limited to the following:
 - (i) the salaries and benefits of staff performing administrative and coordination functions that cannot be attributed to particular program services, including for example, the executive director or chief executive officer, financial officers such as the chief financial officer or controller and accounting personnel, billing, claiming or accounts payable and receivable personnel, human resources personnel, public relations personnel, administrative office support personnel, and information technology personnel;
 - (ii) legal expenses that cannot be attributed directly to the provision of program services; and
 - (iii) expenses for office operations that cannot be attributed directly to the provision of program services, including telephones, computer systems and networks, professional and organizational dues, licenses, permits, subscriptions, publications, audit services, postage, office supplies, conference expenses, staff development, publicity and annual reports, insurance premiums, interest charges and equipment that is expensed (rather than depreciated) in cost reports.

- (2) Administrative expenses do not include:
- (i) capital expenses, including but not limited to non-personal service expenditures for the purchase, installation, and maintenance of real estate or other real property; or
 - (ii) property rental or maintenance expenses; or
 - (iii) equipment rental, depreciation and interest expenses, including expenditures for vehicles and fixed, major movable and adaptive equipment.

(b) *Covered operating expenses* shall mean program services expenses and administrative expenses authorized pursuant to applicable Office program regulations, contracts or other rules that govern reimbursement with State funds or State-authorized payments, and shall not include:

- (1) capital expenses, including but not limited to non-personal service expenditures for the purchase, installation, and maintenance of real estate or other real property; or
- (2) property rental or maintenance expenses; or
- (3) equipment rental, depreciation and interest expenses, including expenditures for vehicles and fixed, major movable and adaptive equipment.

(c) *Covered executive* is a director, trustee, managing partner, or officer whose salary and/or benefits, in whole or in part, are administrative expenses, and any employee whose salary and/or benefits, in whole or in part, are administrative expenses and whose executive compensation during the reporting period equaled or exceeded \$199,000. In the event that a covered provider contracts with a related entity for administrative or program services, the covered executives of the related entity shall also be considered “covered executives” of the covered provider.

(d) *Covered provider*

- (1) is an entity or individual that:
 - (i) has received pursuant to contract or other agreement with the Office, or with another governmental entity, State funds or State-authorized payments to render program services for at least two years prior to and during the covered reporting period and in an average annual amount greater than \$500,000 during those three years; and
 - (ii) at least thirty (30) percent of whose total annual in-state revenues for the most recent reporting period were derived from State funds or State-authorized payments. Where the covered provider is organized as a part of a corporate structure that includes a parent and a subsidiary corporation,

the total annual in-state revenues shall be measured as consolidated at the parent level.

- (2) The following providers shall not be considered covered providers:
- (i) State, county, and local governmental units in New York State, and tribal governments for the nine New York State recognized nations and any subdivisions or subsidiaries thereof, shall not be considered covered providers;
 - (ii) Individuals or entities providing child care services who are in receipt of child care subsidies pursuant to Title 5-C or Section 410 of the Social Services Law, except that such providers may be considered a covered provider if it also receives State funds or State-authorized payments that are not child care subsidies pursuant to Title 5-C or Section 410 of the Social Services Law and would otherwise satisfy the criteria in this definition; and
 - (iii) Individual professionals who provide program services and receive State funds or State-authorized payments individually rather than as an employee or officer of a corporation or other entity.

(e) *Executive compensation* shall include all forms of reportable cash and noncash payments or benefits given directly or indirectly to a covered executive, including but not limited to salary and wages, bonuses, dividends and other financial arrangements or transactions such as personal vehicles, meals, housing, personal and family educational benefits, below-market loans, payment of personal or family travel, entertainment, and personal use of the organization's property, except that mandated benefits (e.g., Social Security, worker's compensation, unemployment insurance and disability insurance), and health insurance premiums and pension contributions consistent with those provided to a covered provider's non-covered executive employees shall not be included in the calculation of executive compensation.

(f) *Office* means the New York State Office for the Aging.

(g) *Program services* are those services rendered by a covered provider or its agent directly to and for the benefit of members of the public (and not for the benefit or on behalf of the State or the Office) that are paid for in whole or in part by State funds or State-authorized funds. Program services shall not include:

- (1) policy development or research; or
- (2) staffing or other assistance to the Office or local unit of government in the Office's or government's provision of services to members of the public.

(h) *Program services expenses* are those expenses incurred by a covered provider or its agent in direct connection with the provision of program services.

- (1) Such expenses include but are not limited to the following:

- (i) the salaries and benefits of staff providing particular program services, including for example, employees or contractors providing direct care to clients, and supervisory personnel and support personnel whose work is attributable to a specific program in whole or in part and contributes directly to the quality or scope of the program services provided;
 - (ii) quality assurance and supervisory personnel whose work is attributable in whole or in part to particular programs and contributes to the quality or scope of the program services provided by other personnel; and
 - (iii) expenses incurred in connection with and attributable to the provision of particular program services, including for example, travel costs to and from client residences, direct care supplies, and legal expenses necessary to accomplish particular program service objectives.
- (2) Program services expenses do not include:
- (i) capital expenses, including but not limited to non-personal service expenditures for the purchase, installation, and maintenance of real estate or other real property; or
 - (ii) property rental or maintenance expenses; or
 - (iii) equipment rental, depreciation and interest expenses, including expenditures for vehicles and fixed, major movable and adaptive equipment and equipment that is expensed (rather than depreciated) in cost reports.

(i) *Related entity* shall mean any entity that meets one of the following tests:

- (1) three or more of the entity's officers, directors, trustees or employees are also officers, directors, trustees or employees of the covered provider;
- (2) the entity appoints twenty-five percent or more of the covered provider's officers, directors, trustees or employees, or vice versa;
- (3) the entity and the covered provider are subsidiaries owned or controlled, in whole or in part, by a common parent entity;
- (4) the entity owns (directly or through one or more entities) any interest in the capital or profits of the covered provider, or vice versa; or
- (5) the executive compensation or financial affairs of the entity are substantially controlled by the covered provider, or vice versa.

(j) *Reporting period* shall mean the calendar year or, where applicable, the fiscal year used by a provider. For those providers who file a cost report, the reporting period shall be the same for the submission of the cost report and the submission of the EO#38 Disclosure Form pursuant to section 6656.6 of this Part.

(k) *State-authorized payments* refer to those payments of funds that are not State funds but which are distributed or disbursed upon the Office's approval or by another governmental unit within New York State upon such approval or to a provider by virtue of the provider having a State license in New York State to operate the program for which such payments are being made. For purposes of this regulation, State-authorized payments shall not include any payments solely for the following purposes:

- (1) procurement contracts awarded on a "lowest price" basis pursuant to section 163 of the State Finance Law; provided that this exception shall not apply to any contracts for program services awarded on a "lowest price" basis;
- (2) awards to State or local units of government except to the extent such funds or payments are used by such government unit to pay covered providers to provide program services through a contract or other agreement;
- (3) capital expenses, including but not limited to non-personal service expenditures for the purchase, installation, and maintenance of real estate or other real property, or equipment;
- (4) direct payments of State funds or State-authorized payments, or provision of vouchers or other items of monetary value that may be used to secure specific services selected by the individual, or health insurance premiums, to or on behalf of individual members of the public;
- (5) wage or other salary subsidies paid to employers to support the hiring or retention of their employees;
- (6) awards to for-profit corporations or other entities engaged exclusively in commercial or manufacturing activities and not in the provision of program services; or
- (7) policy development or research.

(l) *State funds* are those funds appropriated by law in the annual state budget pursuant to Article VII, Section 7 of the New York State Constitution. For purposes of this Part, State funds shall not include any payments solely for the following purposes:

- (1) procurement contracts awarded on a "lowest price" basis pursuant to section 163 of the State Finance Law; provided that this exception shall not apply to any contracts for program services awarded on a "lowest price" basis;
- (2) awards to State or local units of government except to the extent such funds or payments are used by such government unit to pay covered providers to provide program services through a contract or other agreement;

- (3) capital expenses, including but not limited to non-personal service expenditures for the purchase, installation, and maintenance of real estate or other real property, or equipment;
- (4) direct payments of State funds or State-authorized payments, or provision of vouchers or other items of monetary value that may be used to secure specific services selected by the individual, or health insurance premiums, to or on behalf of individual members of the public;
- (5) wage or salary subsidies paid to employers to support the hiring or retention of their employees;
- (6) awards to for-profit corporations or other entities engaged exclusively in commercial or manufacturing activities and not in the provision of program services; or
- (7) policy development or research.

Section 6656.3 Limits on Administrative Expenses

- (a) Limits on Allowable Administrative Expenses. For the period commencing January 1, 2013, no less than seventy-five percent of the covered operating expenses paid for with State funds or State-authorized payments shall be program services expenses rather than administrative expenses. This percentage shall increase by five percent each year until it shall be no less than eighty-five percent for the calendar year 2015 and for each calendar year thereafter.

Subcontractors and Agents of Covered Providers. The restriction on allowable administrative expenses in subdivision (a) shall apply to subcontractors and agents of covered providers that are related entities if and to the extent that such a subcontractor or agent has received State funds or State-authorized payments from the covered provider during the reporting period. Covered providers shall promptly report to the Office the identity of such subcontractors and agents, along with any other information requested by the Office or its designee.

Covered Providers Receiving State Funds or State-Authorized Payments From County or Local Government. The restriction on allowable administrative expenses pursuant to this section shall apply to covered providers whose contract or agreement is with, or which receives State funds or State-authorized payments directly from, a county or local unit of government rather than directly from the Office. The Office or its designee, rather than the county or local unit of government, shall be responsible for obtaining the necessary reporting from and compliance by such covered providers, and shall issue guidance to affected county and local governments to set forth the procedures by which the Office or its designee shall do so.

Covered Providers with Multiple Sources of State Funds or State-Authorized Payments. If a covered provider receives State funds or State-authorized payments from multiple sources, the provider's compliance with the restriction on allowable administrative

expenses in subsection A shall be determined based upon the total amount program services expenses and administrative expenses paid for by such funding received from all of such sources. As set forth in section 6656.6, the covered provider shall report all of such State funds and State-authorized payments, and the expenses paid for by such funding, in the form and at the time specified by the Office or its designee.

Other Limits on Administrative Expenses. If the contract, grant, or other agreement is subject to more stringent limits on administrative expenses, whether through law or contract, such limits shall control and shall not be affected by the less stringent limits imposed by these regulations.

Section 6656.4 Limits on Executive Compensation

- (a) Limits on Executive Compensation. For the period commencing January 1, 2013, except if a covered provider has obtained a waiver pursuant to section 6656.5 of this Part, neither a covered provider nor a related entity shall use State funds or State-authorized payments for executive compensation given directly or indirectly to a covered executive in an amount greater than \$199,000 per annum, provided, however, that the Office shall have discretion to adjust this figure annually based on appropriate factors and subject to the approval of the Director of the Division of the Budget.
- (b) For the period commencing January 1, 2013, except if a covered provider has obtained a waiver pursuant to section 6656.5 of this Part, where a covered provider's or a related entity's executive compensation given to a covered executive is greater than \$199,000 per annum (including not only State funds and State-authorized payments but also any other sources of funding) and
- (1) greater than the 75th percentile of that compensation provided to comparable executives in other providers of the same size and within the same program service sector and the same or comparable geographic area as established by a compensation survey identified or recognized by the Office and the Director of the Division of the Budget; or
 - (2) was not reviewed and approved by the covered provider's board of directors or equivalent governing body including at least two independent directors or voting members, or such review did not include an assessment of appropriate comparability data; and
 - (3) the covered provider or related entity is unable, upon request by the Office or its designee, to substantiate the requirements found in (1) or (2) above with contemporaneous documentation in a form and level of detail sufficient to allow a determination whether such requirements have been satisfied;

then such covered provider or related entity shall be subject to the penalties set forth in section 6656.7 of this Part.

- (c) Program Services Rendered by Covered Executives. The limit on executive compensation pursuant to this Section shall not be applied to limit reimbursement with State funds or State-authorized payments for reasonable compensation paid to a covered executive for specific program services rendered by the executive outside of his or her managerial or policy-making duties. Documentation of such program services rendered shall be provided to the office or its designee upon request.
- (d) Covered Providers with Multiple Sources of State Funds or State-Authorized Payments. If a covered provider or related entity receives State funds or State-authorized payments from multiple sources, the provider's compliance with the limits on executive compensation in subdivision (a) shall be determined based upon the total amount of such funding received and the reimbursements received from all sources of State funds or State-authorized payments. As set forth in section 6656.6 of this Part, the covered provider shall report all of such State funds and State-authorized payments in the form specified by the Office or its designee.
- (e) Subcontractors and Agents of Covered Providers. The limits on executive compensation in subdivisions (a) and (b) shall apply to subcontractors and agents of covered providers that are related entities if and to the extent that such a subcontractor or agent has received State funds or State-authorized payments from the covered provider during the reporting period. Covered providers shall promptly report to the Office the identity of such subcontractors and agents, along with any other information requested by the Office or its designee.
- (f) Other Limits on Executive Compensation. If the contract, grant, or other agreement is subject to more stringent limits on executive compensation, whether through law or contract, such limits shall control and shall not be affected by the less stringent limits imposed by these regulations.

Section 6656.5 Waivers

(a) Waivers for Limit on Executive Compensation. The Office or its designee and the Director of the Division of the Budget may grant a waiver to the limits on executive compensation in section 6656.4 of this Part for executive compensation for one or more covered executives during the reporting period upon a showing of good cause. To be considered, an application for such a waiver must comply with this subsection in its entirety.

- (1) The application must be filed no later than sixty (60) days prior to the reporting period for which the waiver is sought or, where a covered provider has a contract with the Office, at least sixty (60) days prior to the date of the contract or of its renewal or extension, whichever is sooner. The application shall be transmitted in

the manner and form specified by the Office or its designee and the Director of the Division of the Budget.

- (2) The following factors, in addition to any other deemed relevant by the Office or its designee and the Director of the Division of the Budget, shall be considered in the determination of whether to grant a waiver:
 - (i) the extent to which the executive compensation that is the subject of the waiver is comparable to that given to comparable executives in other providers of the same size and within the same program service sector and the same or comparable geographic area;
 - (ii) the extent to which the covered provider would be unable to provide the program services reimbursed with State funds or State-authorized payments at the same levels of quality and availability without obtaining reimbursement for executive compensation given to a covered executive in excess of the limits in section 6656.4 of this Part;
 - (iii) the nature, size, and complexity of the covered provider's operations and the program services provided;
 - (iv) the provider's review and approval process for the executive compensation that is the subject of the waiver, including whether such process involved a review and approval by the board of directors or other governing body, whether such review was conducted by at least two independent directors or independent members of the governing body, whether such review included an assessment of comparability data including a compensation survey, and contemporaneous substantiation of the deliberation and decision to approve such executive compensation; and
 - (v) the provider's efforts, if any, to secure executives with the same levels of experience, expertise, and skills for the positions of covered executives at lower levels of compensation.
- (3) A waiver to the limits set forth in section 6656.4 shall be granted only where a covered provider has demonstrated compelling circumstances supporting such a waiver, and has provided any documentation requested by the Office or its designee or the Director of the Division of the Budget to support such a waiver.
- (4) If granted, a waiver to a covered provider shall remain in effect for the period of time specified by the Office or its designee and the Director of the Division of the Budget for the covered executive position(s) at issue, but may be deemed revoked when:

- (i) the executive compensation that is the subject of the waiver increases by more than five percent in any calendar year; or
- (ii) upon notice provided at the discretion of the Office or its designee as a result of additional relevant circumstances.

(b) Waivers for Limit on Reimbursement for Administrative Expenses. The Office or its designee and the Director of the Division of the Budget may grant a waiver to obtain reimbursement for administrative expenses incurred during the reporting period in excess of the limit set forth in section 6656.3 upon a showing of good cause. To be considered, an application for such a waiver must comply with this subsection in its entirety.

- (1) The application must be filed concurrent with the timely submission of the covered provider's cost report for the period for which the waiver is requested or, where the covered provider has a contract with the Office, at least sixty (60) days prior to the date of the contract or of its renewal or extension, whichever is sooner. At the sole discretion of the Office or its designee and the Director of the Division of the Budget, late applications may be considered in unusual and unforeseen circumstances, but such applications shall be made no later than thirty (30) days from the unusual and unforeseen circumstance supporting the late application.
- (2) The following factors, in addition to any others deemed relevant by the Office or its designee and the Director of the Division of the Budget, shall be considered in the determination of whether to grant a waiver:
 - (i) The extent to which the administrative expenses that are the subject of the waiver are necessary or avoidable;
 - (ii) Evidence that a failure to reimburse specific administrative expenses that are the subject of the waiver would negatively affect the availability or quality of program services in the covered provider's geographic area;
 - (iii) The nature, size, and complexity of the covered provider's operations and the program services provided;
 - (iv) The provider's efforts to monitor and control administrative expenses and to limit requests for reimbursement for such costs; and
 - (v) The provider's efforts, if any, to find other sources of funding to support its administrative expenses and the nature and extent of such efforts and funding sources.
- (3) A waiver to the limit set forth in section 6656.3 shall be granted only where a covered provider has demonstrated compelling circumstances supporting such a waiver, and has provided any documentation requested by the Office or its designee or the Director of the Division of the Budget to support such a waiver.

- (4) If granted, a waiver granted to a covered provider shall remain in effect only for the reporting period, except that the Office or its designee and the Director of the Division of the Budget may extend the effective period of such waiver.

(c) Denial of Waiver Request.

- (1) If the Office or its designee and the Director of the Division of the Budget propose to deny a request for waiver made pursuant to section 6656.5 of this Part, the applicant shall be given written notice of the proposed denial, stating the reason or reasons for such proposed denial. Such notice shall be sent by certified mail and shall be a final determination to be effective thirty (30) days from the date of the notice, unless reconsideration is requested;
- (2) if the Office or its designee and the Director of the Division of the Budget provide a notice of proposed denial, the applicant may request consideration of the proposed denial by submitting a written request for reconsideration within thirty (30) days of the date of the notice of proposed denial. Submission of a request for reconsideration within thirty (30) days shall stay any action to deny an applicant's request for a waiver, pending a decision regarding such request for reconsideration, and shall stay any action to enter into a contract or other agreement. Any vouchers submitted by the applicant for payment by the Office during which such reconsideration is pending shall be considered incomplete.
- (3) the written request for reconsideration shall be signed by the owner(s) or chief executive officer of the applicant, and shall include all information the applicant wishes to be considered, including any written documentation that would controvert the reason(s) for the denial or disclose that the denial was based upon a mistake of fact;
- (4) If the applicant properly seeks reconsideration of the proposed denial, the Office or its designee and the Director of the Division of the Budget shall review the proposed denial and shall issue a written determination after reconsideration. The determination after reconsideration may affirm, revoke, or modify the proposed denial. Such determination shall be a final decision.

Section 6656.6 Reporting.

(a) Reporting by Covered Providers. Beginning after the effective date of this regulation, covered providers shall submit a completed EO#38 Disclosure Form for each reporting period. Such form shall be submitted in the manner and form specified by the Office or its designee. Covered providers shall further provide the information requested in that form, and any other

information requested, upon the request of the Office or its designee at any time during the term of or prior to the execution of any contract or agreement with such provider.

(b) Covered providers receiving State funds or State-authorized payments from county or local government must report directly to the Office as required by this section. The county or local government shall advise such covered providers of their obligation to report directly to the Office under this section, but shall not be responsible for receiving or forwarding such reports to the department.

(c) Failure to Report. A covered provider's failure to submit a completed EO#38 Covered Provider Form, or to provide additional or clarifying information at the request of the Office or its designee, may result in the termination or non-renewal of a contract or agreement for State funds or State-authorized payments.

Section 6656.7 Penalties.

(a) Notice of Preliminary Determination of Non-Compliance. Whenever it is determined that a covered provider may not be in compliance with the requirements of Sections 6656.3 or 6656.4 of this Part and has not obtained a waiver, the provider shall be notified in writing of the basis for that determination. Such notice shall provide the covered provider with an opportunity and a procedure to submit additional or clarifying information within fifteen (15) days of the provider's receipt of such notice to demonstrate compliance with this Part. Failure to submit additional or clarifying information within the required time period shall result in the determination of non-compliance becoming final.

(b) Corrective Action Period. If the determination of non-compliance becomes final as set forth in subdivision (a) or if the Office or its designee determines, after reviewing and considering any information submitted by the covered provider, that such provider is not in compliance with the requirements of sections 6656.3 or 6656.4 of this regulation, the provider shall receive notice of such determination and a notice to cure. Such notice shall allow the covered provider a period of not less than six months to correct the violation(s) identified (the "corrective action period") prior to additional enforcement action or penalties being imposed, and shall require that the covered provider submit within fifteen (15) business days a corrective action plan ("CAP") for approval by the Office or its designee

(c) Corrective Action Plan (CAP). Within thirty (30) days of receipt of the covered provider's CAP, the Office or its designee shall either approve such CAP or request clarification or alterations. The covered provider shall make such alterations to the CAP as may be reasonably required by the Office or its designee. Once the CAP has been approved and the covered provider notified, and unless otherwise provided in the approved CAP, the covered provider shall have six months to complete the CAP and comply with this Part.

(d) Failure to Cure. At the conclusion of the period for implementation of an approved CAP, the Office or its designee may request information from the covered provider to determine whether the CAP has been fully and properly completed. If it has been so completed, the matter shall be considered closed and no further action on the part of the Office or the provider shall be required. If the Office or its designee determines that the CAP has not been fully and properly implemented within the designated corrective action period, the Office or its designee shall

provide written notice to the provider and may take one or more of the following actions, taking into account the seriousness of the violations, the nature of the provider's services, and the provider's efforts to correct the violations, if any:

- (1) At its sole discretion, modify the CAP and/or extend the time for the provider to complete implementation.
- (2) Issue a final determination of non-compliance, together with a notice of the sanctions which the Office seeks to impose. Such sanctions may include:
 - (a) Redirection of State funds or State-authorized payments to be used to provide program services, where possible and consistent with federal and state laws;
 - (b) Suspension, modification, limitation, or revocation of the provider's license(s) to operate program(s) for the delivery of program services;
 - (c) Suspension, modification or termination of contracts or other agreements with the covered provider; and
 - (d) Any other lawful actions or penalties deemed appropriate by the Office or its designee.

(e) Opportunity for Appeal. Within ten (10) days of receipt of a final determination of noncompliance and notice of proposed sanctions, a covered provider may request an administrative appeal by submitting a written request to the name and address set forth in the notice. The request must include a detailed explanation of the legal and factual bases for the provider's challenge to the determination and all documentation in support of the provider's position. If a request for an administrative appeal is not made within the required ten days, the determination of noncompliance shall become final and the proposed sanction shall be imposed. Unless the Office seeks to impose a sanction for which an administrative hearing is otherwise required by statute or regulation, covered the provider's appeal shall be limited to an administrative review of the record. Following the review, the covered provider shall be provided with a final written determination setting forth the findings of fact and conclusions of law that support the determination. If the provider is found to be non-compliant, the proposed sanction may be imposed forthwith.