Governor Cuomo's Executive Order 38 and Final Regulations Affecting New York State-Funded Service Providers

June 19, 2013

Executive Order 38, issued by New York Governor Andrew M. Cuomo on January 18, 2012, directed the commissioner of each Executive State Agency that provides State funds or State-authorized payments to providers of services to promulgate regulations requiring that: (i) at least 75% (with such percentage increasing annually by 5% to at least 85% in 2015) of State funds or State-authorized payments be directed to provide direct care or services, rather than to administrative costs, and (ii) no State funds or State-authorized payments be provided for executive compensation in excess of $199,000 per year.

On May 16, 2012, Governor Cuomo announced the release by thirteen New York State agencies of proposed regulations (the "Proposed Regulations") intended to implement Executive Order 38.[1]

The Proposed Regulations were subject to a public review process, and their original January 1, 2013 effective date was extended. Final regulations (the "Final Regulations") have now been formally promulgated by the relevant agencies and will be effective as of July 1, 2013.

Like the Proposed Regulations, the Final Regulations serve to (i) limit the amount of State funds or State-authorized payments that may be spent for administrative costs and executive compensation, subject to the availability of certain waivers, and (ii) impose reporting obligations on certain State-funded nonprofit and for-profit service providers. The Final Regulations include helpful clarifications regarding the applicability of the restrictions on administrative costs and executive compensation. Like the Proposed Regulations, the Final Regulations adopted by each agency generally follow the same template.

- Applicability. The Final Regulations apply to any "covered provider." A covered provider is defined as an entity or individual: (i) that has received during the applicable annual reporting period and the prior year an average annual amount of greater than $500,000 in State funds or State-authorized payments to render services for the benefit of members of the public ("program services") pursuant to an agreement with the applicable agency, another governmental entity, or an entity contracting on its behalf and (ii) at least 30% of whose annual New York State revenues during the applicable annual reporting period and the prior year were from State funds or State-authorized

[1] For further information regarding the Proposed Regulations, please see our previously issued client memorandum, which can be found here.

payments. Unlike the Proposed Regulations, the Final Regulations do not consolidate parent and subsidiary revenues. The Final Regulations clarify that the 30% threshold will be calculated based on total annual revenues derived from and in connection with the provider's activities in New York State, regardless of whether the provider derives additional revenues from activities in another state, and will include revenues from sources outside of New York State if they are derived from or in connection with activities in New York State. The types of entities and individuals that are expressly excluded from the definition of covered provider have been expanded since the Proposed Regulations. Under the Final Regulations, the following are excluded from the term covered provider: (i) State, county, local, and tribal governmental units in New York State and their subdivisions or subsidiaries; (ii) certain individuals providing child care services; (iii) individual professionals, partnerships, S corporations, or other entities whose program services paid for by State funds or State-authorized payments are provided by the individuals, partners, or owners of the corporation and not by employees or independent contractors; (iv) individuals or entities providing primarily or exclusively products, rather than services; and (v) entities within the same corporate family as a covered provider, except where any such entity would otherwise qualify as a covered provider but for the fact that it has received State funds or State-authorized payments from a covered provider rather than directly from a governmental agency.

The Final Regulations define "State funds" as funds appropriated by law in the annual State budget. The Final Regulations define "State-authorized payments" as payments of funds that are not State funds, but that are distributed or disbursed upon a State agency's approval, or by another governmental unit within New York State upon a State agency's approval, such as Medicaid program payments approved by a State agency. A list of the government programs whose funds will be considered State funds or State-authorized payments will be published by each agency prior to the effective date of the Final Regulations. The types of funds that are expressly excluded from the definitions of State funds and State-authorized payments have been expanded since the Proposed Regulations. Under the Final Regulations, the following are not considered either State funds or State-authorized payments: (i) procurement contracts awarded on a "lowest price" basis; (ii) awards to State or local governmental units, except where used to pay covered providers through a contract or other agreement; (iii) capital expenses, including for the purchase, development, installation, and maintenance of real estate or other real property, or equipment; (iv) direct payments or the provision of vouchers used to secure specific services selected by the individual, or health insurance premiums; (v) wage or salary subsidies paid to employers to support the hiring or retention of their employees; (vi) awards to entities engaged exclusively in commercial or manufacturing activities; (vii) policy development or research; or (viii) funds expressly intended to pay exclusively for administrative expenses.

- Limits on Executive Compensation. Pursuant to the Final Regulations, unless a covered provider has obtained a waiver, it may not use State funds or State-authorized payments for executive compensation in excess of $199,000 per year. This amount will be subject to annual review and adjustment by each agency based on "appropriate factors" and subject to approval by the Director of the Division of the Budget. This limit will be

effective and applicable to each covered provider as of the first day of such covered provider's annual reporting period occurring on or after July 1, 2013. However, the Final Regulations provide that an existing contract between a covered provider and a covered executive entered into prior to July 1, 2012 will not be subject to the executive compensation limits during the term of the contract, except that: (i) covered providers must apply for a waiver with respect to any contract for executive compensation that exceeds or fails to comply with the Final Regulations and extends beyond April 1, 2015; and (ii) renewals of any such contract after the end of its term must comply with the Final Regulations.

"Executive compensation" includes all forms of cash and noncash payments or benefits given directly or indirectly to a covered executive, including, for example, salary, wages, bonuses, housing, and below-market loans, reportable on a covered executive's IRS Form W-2 or IRS Form 1099, but does not include mandated benefits such as Social Security or worker's compensation, or other benefits such as health insurance premiums and retirement and deferred compensation plan contributions that are consistent with those provided to the covered provider's other employees. A "covered executive" is a compensated director, trustee, officer, or key employee (as such terms are used in Part VII of IRS Form 990) or managing partner, in each case, whose salary and benefits cannot be attributed to particular program services (such as the executive director or chief executive officer, controller or accounting personnel, and public relations personnel), and whose executive compensation during the applicable annual reporting period exceeded $199,000. Clinical and program personnel in a hospital or other entity providing program services, such as chairs of departments and chief medical officers, will not be considered covered executives.

The general restriction on the payment of executive compensation by related entities of a covered provider has been removed since the Proposed Regulations. Rather, if a covered provider pays a related organization to perform administrative or program services, a covered executive of the related organization will be considered a covered executive of the covered provider if more than 30% of such covered executive's compensation is derived from State funds or State-authorized payments received from the covered provider. The term related organization has the meaning used in Schedule R of IRS Form 990, but applies only with respect to an organization that has received or is anticipated to receive State funds or State-authorized payments from a covered provider during the applicable annual reporting period.

Pursuant to the Final Regulations, unless a covered provider has obtained a waiver, penalties will be imposed on any covered provider that provides executive compensation to a covered executive: (i) in excess of $199,000 (including all sources of funding, not restricted to State funds and State-authorized payments); and (ii) that either (a) is greater than the 75th percentile of compensation provided to comparable executives of other providers of the same size and program service sector in the same or comparable geographic area, as established by a compensation survey identified, provided, or recognized by the agency or the Director of the Division of the Budget; or (b) was not reviewed, with such review including an assessment of appropriate

comparability data, and approved by the board of directors or equivalent body including at least two independent directors or voting members (or, where a duly authorized compensation committee including at least two independent directors or voting members conducted such review on behalf of the full board, such actions were not reviewed and ratified by such board). To determine whether a covered provider or a related organization may be subject to penalties, a provider must provide contemporaneous documentation regarding compensation to the agency upon request.

Like the Proposed Regulations, the Final Regulations do not limit reimbursement with State funds or State-authorized payments for reasonable compensation to a covered executive for program services. The Final Regulations clarify that supervisory services performed to facilitate the covered provider's program services are also not limited. The Final Regulations further clarify that documentation of any such program services must be used by the covered provider to determine the percentage, if any, of the covered executive's compensation that is attributable to program services for purposes of excluding that compensation in the calculation of his or her executive compensation.

- Limits on Administrative Expenses. Pursuant to the Final Regulations, at least 75% of the covered operating expenses of a covered provider paid for with State funds or State-authorized payments must be used for program services expenses, rather than for administrative expenses. This limit will be effective and applicable to each covered provider as of the first day of such covered provider's annual reporting period occurring on or after July 1, 2013. The minimum percentage will increase by 5% each year until it reaches 85% in 2015 and for each year thereafter.

  The Final Regulations define "covered operating expenses" as the sum of program services expenses and administrative expenses of a covered provider. "Administrative expenses" are expenses authorized and allowable pursuant to applicable agency regulations, contracts, or other rules that govern reimbursement with State funds or State-authorized payments that are incurred in connection with a covered provider's overall management and necessary overhead that cannot be attributed directly to the provision of program services. Administrative expenses include, for example, those portions of: (i) salaries for staff performing administrative functions; (ii) legal expenses; and (iii) overhead expenses such as computer networks, audit services, and publicity expenses, in each case not attributable to the provision of program services. "Program services expenses" are those expenses authorized and allowable pursuant to applicable agency regulations, contracts, or other rules that govern reimbursement with State funds or State-authorized payments that are incurred by a covered provider or its agent in direct connection with the provision of program services. Program services expenses include, for example: (i) that portion of the salaries and benefits of staff providing particular program services or of quality assurance and supervisory personnel; and (ii) that portion of expenses incurred in connection with and attributable to the provision of particular program services, such as direct care supplies, public outreach or education, quality assurance expenses, and legal expenses necessary to accomplish particular program service objectives. The types of expenses that are expressly excluded from the definitions of both administrative expenses and program services expenses have been

expanded since the Proposed Regulations. Under the Final Regulations, the following are not considered either administrative expenses or program services expenses (and hence are not taken into account for purposes of the limitations in the Final Regulations): (i) capital expenses, including expenditures related to real estate; (ii) property rental, mortgage, or maintenance expenses (except, with respect to program services expenses, where such expenses are made in connection with providing housing to members of the public); (iii) taxes, payments in lieu of taxes, or assessments paid to any unit of government; (iv) equipment rental, depreciation, and interest expenses; (v) expenses (and, with respect to administrative expenses, equipment that is expensed rather than depreciated) of an amount greater than $10,000 that would otherwise be administrative, except that they are non-recurring or not anticipated, such as litigation expenses; and (vi) that portion of the salaries and benefits of staff performing policy development or research.

The Final Regulations clarify that, in determining whether an expense is a program service expense or an administrative expense, a covered provider may allocate a portion of the expense to each type, if such allocation is supported by the nature of the expense.

- Subcontractors and Agents. The restrictions on administrative expenses and executive compensation will apply to a subcontractor or agent of a covered provider if and to the extent that such subcontractor or agent (i) has received State funds or State-authorized payments from a covered provider to provide program services or administrative services during the applicable annual reporting period and (ii) would otherwise meet the definition of a covered provider but for the fact that it has received State funds or State-authorized payments from a covered provider rather than directly from a governmental agency. The Final Regulations state that a covered provider must incorporate the terms of the Final Regulations by reference into its agreement with any such subcontractor or agent. However, a covered provider will not be responsible for the failure of any subcontractor or agent to comply with the Final Regulations.

- Waivers. The Final Regulations permit the relevant agency to grant waivers on the limits on executive compensation and administrative expenses upon a showing of good cause. The Final Regulations require a covered provider seeking a waiver to submit a waiver application no later than when such covered provider submits its EO#38 Disclosure Form for the annual reporting period for which the waiver is requested (see "Reporting" below for the timing of filing of the EO#38 Disclosure Form). An agency will generally respond to a waiver request within 60 days. While the Final Regulations do not require that a covered provider obtain a waiver on the limits on executive compensation or administrative expenses in advance, a covered provider that anticipates exceeding the limits on executive compensation or administrative expenses will likely prefer to seek and obtain a waiver prior to making payments that may be in violation of the Final Regulations. As a result, it is not yet clear how covered providers will approach the waiver application process in practice. Although not addressed in the Final Regulations, we believe that covered providers that wish to obtain a waiver in advance should submit a waiver application at least 60 days prior to the commencement of the applicable annual reporting period. The Final Regulations state that, unless already publicly disclosed, the information submitted by a covered provider in

connection with a waiver application will not be subject to public disclosure under the State's Freedom of Information Law.

Pursuant to the Final Regulations, in assessing whether a waiver on the limit on executive compensation should be granted, an agency will consider: (i) the extent to which the executive compensation is comparable to that given to comparable executives of other providers of the same size and sector and the same or similar geographic area; (ii) the extent to which the covered provider would be unable to provide the program services at the same levels of quality and availability without the waiver; (iii) the nature, size, and complexity of the covered provider's operations and the program services provided; (iv) the covered provider's review and approval process for the subject executive compensation, including whether such process included a review and approval by the board or other governing body, whether such review was conducted by at least two independent directors or voting members, whether such review included an assessment of comparability data, and contemporaneous documentation of the review and approval process; (v) the qualifications and experience possessed by or required for the covered executive(s) or position(s); and (vi) the efforts of the covered provider to secure executives with the same levels of experience, expertise, and skills at lower levels of compensation. A waiver with respect to executive compensation will remain in effect for the period of time specified by the relevant agency, but will be revoked if the executive compensation increases by more than 5% in any calendar year, or otherwise upon notice provided by the relevant agency.

Pursuant to the Final Regulations, in assessing whether a waiver on the limit on administrative expenses should be granted, an agency will consider: (i) the extent to which the administrative expenses are necessary or avoidable; (ii) whether a failure to reimburse specific administrative expenses 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 programs; (iv) the covered provider's efforts to monitor and control administrative expenses and limit requests for reimbursement of such costs; and (v) the nature and extent of the covered provider's efforts, if any, to find other sources of funding to support its administrative expenses. A waiver with respect to administrative expenses will be granted only for the applicable annual reporting period, but the covered provider may request in its waiver application, and the relevant agency may grant, an extension of the effective period of the waiver.

- Reporting. The Final Regulations impose annual reporting obligations on all covered providers for annual reporting periods beginning on or after July 1, 2013. If applicable, a provider's annual reporting period will correspond to the annual Cost Report it is required to file with the State. Otherwise, a provider's annual reporting period may be, at the option of the provider, either the calendar year or the provider's fiscal year. Covered providers will be required to submit an EO#38 Disclosure Form within 180 days following the end of each annual reporting period. Neither the Proposed Regulations nor the Final Regulations indicate what information will be called for in the

EO#38 Disclosure Form. Failure to comply with the reporting obligations could result in the termination of the relevant agency contract or agreement.

- Non-Compliance and Enforcement. The Final Regulations require that an agency provide notice to any covered provider that it determines may not be in compliance with the limits on executive compensation or administrative expenses and which has not been granted a waiver. If the determination of non-compliance becomes final, the covered provider will have the opportunity to work with the agency to develop a corrective action plan. The covered provider will have at least six months to implement the corrective action plan. If a covered provider does not implement fully the corrective action plan within the time period allotted, the agency may, in its discretion: (i) modify the corrective action plan or extend the period for implementation or (ii) issue a determination of non-compliance, together with a notice of sanctions, which may include: (a) redirection of State funds or State-authorized payments; (b) suspension, modification, limitation, or revocation of the covered provider's licenses, or the contracts or other agreements with the covered provider; and (c) any other lawful actions or penalties deemed appropriate by the relevant agency. Sanctions will be subject to administrative appeal by the covered provider.

Executive Order 38 can be found at: http://www.governor.ny.gov/executiveorder/38.

Governor Cuomo's Press Release regarding Executive Order 38 can be found at: http://www.governor.ny.gov/press/1182011EO.

An example of the Final Regulations (from the New York State Department of Health) can be found at: http://www.health.ny.gov/regulations/recently_adopted/docs/2013-07-01_limits_on_executive_compensation.pdf.

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