

PART 513
LIMITS ON ADMINISTRATIVE EXPENSES
AND EXECUTIVE COMPENSATION

(Statutory Authority: Mental Hygiene Law §§ 7.09, 7.15[a], 7.15[b], 31.04, 31.05[a], 41.03, 41.15, 41.18, 41.44, 43.02, 43.02[b], Not-For-Profit Corporation Law §508)

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513.1 Background and intent.

The purpose of this Part is to implement Executive Order No. 38, issued by Governor Andrew Cuomo on January 18, 2012, by exercising the authority of the Commissioner of the Office of Mental Health to issue regulations governing the use of State funds and State-authorized payments in connection with providing program services to members of the public. E.O. 38 provides for a limit on administrative expenses and executive compensation of providers of program services in order to meet the State's ongoing obligation to ensure the proper use of taxpayer dollars and the most effective provision of such services to the public.

513.2 Legal base.

(a) Sections 7.09 and 31.04 of the Mental Hygiene Law grant the Commissioner of the Office of Mental Health the power and responsibility to adopt regulations that are necessary and proper to implement matters under his or her jurisdiction, and to set standards of quality and adequacy of facilities, equipment, personnel, services, records and programs for the rendition of services for adults diagnosed with mental illness or children diagnosed with emotional disturbance, pursuant to an operating certificate.

- (b) Section 7.15(a) of the Mental Hygiene Law charges the Commissioner of Mental Health with the responsibility for promoting, establishing, developing, coordinating and conducting programs and services for the benefit of persons with mental illness within the funding available for such purposes.
- (c) Section 7.15(b) of the Mental Hygiene Law provides the Commissioner of Mental Health with the authority to cooperate and enter into agreements with other state, local and federal departments or agencies in fulfilling his or her responsibilities.
- (d) Section 31.05(a) of the Mental Hygiene Law establishes the criteria for the issuance of an operating certificate, including that the premises, equipment, personnel, records, and program are adequate and appropriate to provide services for persons with mental illness.
- (e) Section 41.03 of the Mental Hygiene Law provides that the meaning of operating costs shall be in accordance with and subject to the regulations of the Commissioner of Mental Health.
- (f) Sections 41.15 and 41.18 of the Mental Hygiene Law provide that the Commissioner of Mental Health has the authority to approve the net operating costs of programs incurred pursuant to an approved local services plan that are eligible for state aid.
- (g) Section 41.44 provides that the Commissioner of Mental Health may provide state aid to local governments and to voluntary agencies within amounts available therefor and subject to regulations established by him or her.
- (h) Section 43.02 of the Mental Hygiene Law provides that the Commissioner of Mental Health has the power to establish standards and methods for determining rates of payment made by government agencies pursuant to Title 11 of Article 5 of the Social Services Law for services, other than inpatient services, provided by facilities, including hospitals, licensed by the Office of Mental Health.
- (i) Section 43.02(b) of the Mental Hygiene Law requires operators of facilities licensed by the Office of Mental Health to furnish such financial, statistical and program information as the Commissioner may determine to be necessary.
- (j) Executive Order No. 38 directs the Commissioner of each Executive State Agency that provides State financial assistance or State-authorized payments to providers of services, including the Office of Mental Health, to promulgate regulations and take any other actions within the agency's authority, including amending agreements with such providers, to address the extent and nature of a provider's administrative costs and executive compensation that shall be eligible to be reimbursed with State financial assistance or State-authorized payments for operating expenses. Executive Order No. 43 extends the time for agencies to comply with Executive Order No. 38.
- (k) Section 508 of the Not-For-Profit Corporation Law provides that a corporation whose lawful activities involve among other things the charging of fees or prices for its services or products shall have the right to receive such income and, in so doing, may make an incidental profit but that all such incidental profits must be applied to the maintenance, expansion or operation of the lawful activities of the corporation, and in no case shall be divided

or distributed in any manner whatsoever among the members, directors, or officers of the corporation.

513.3 Definitions.

For purposes of this Part:

(a) *Administrative 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 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 expenses include but are not limited to the following expenses, if otherwise authorized and allowable pursuant to applicable agency regulations, contracts or other rules that govern reimbursement with State funds or State-authorized payments:

- (i) that portion of the salaries and benefits of staff performing administrative and coordination functions that cannot be attributed to particular program services, including but not limited to 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, where such expenses cannot be attributed directly to the provision of program services;
- (ii) that portion of legal expenses that cannot be attributed directly to the provision of program services; and
- (iii) that portion of 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, publicity and annual reports, insurance premiums, interest charges and equipment that is expensed (rather than depreciated) in cost reports, where such expenses cannot be attributed directly to the provision of program services.

(2) Administrative expenses do not include:

- (i) capital expenses, including but not limited to non-personal service expenditures for the purchase, development, installation, and maintenance of real estate or other real property; or
- (ii) property rental, mortgage or maintenance expenses; or

- (iii) taxes, payments in lieu of taxes, or assessments paid to any unit of government; or
- (iv) 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; or
- (v) expenses of an amount greater than \$10,000 that would otherwise be administrative, except that they are either non-recurring (no more frequent than once every five years) or not anticipated by a covered provider (e.g., litigation-related expenses). Such expenses shall not be considered administrative expenses or program expenses for purposes of this regulation; or
- (vi) that portion of the salaries and benefits of staff performing policy development or research.

(b) *Covered executive* is a compensated director, trustee, managing partner, or officer whose salary and/or benefits, in whole or in part, are administrative expenses, and any key employee whose salary and/or benefits, in whole or in part, are administrative expenses and whose executive compensation during the reporting period exceeded \$199,000. For the purposes of this definition, the terms “director,” “trustee,” “officer,” and “key employee” shall have the same meaning as such terms in the Internal Revenue Service’s instructions accompanying Form 990, Part VII. If the number of key employees employed by the covered provider who meet this definition exceeds ten, then the covered provider shall report only those ten key employees whose executive compensation is the greatest during the reporting period and no other key employees shall be considered covered executives. Clinical and program personnel in a hospital or other entity providing program services, including chairs of departments, heads of service, chief medical officers, directors of nursing, or similar types of personnel fulfilling administrative functions that are nevertheless directly attributable to and comprise program services shall not be considered covered executives for purposes of limiting the use of State funds or State-authorized payments to compensate them. In the event that a covered provider pays a related organization to perform administrative or program services, the covered executives of the related organization shall also be considered “covered executives” of the covered provider for purposes of reporting and compliance with these regulations if more than thirty (30) percent of such a covered executive’s compensation is derived from State funds or State-authorized payments received from the covered provider. In such a circumstance, the related organization shall not be subject to the limitations on the use of State funds or State-authorized payments for administrative expenses in Section 513.4 of this Part solely as a result of having covered executives.

(c) *Covered operating expenses* shall mean the sum of program services expenses and administrative expenses of a covered provider as defined in subdivision (d) of this section. .

(d) *Covered provider*

- (1) A “covered provider” is an entity or individual that:

- (i) has received pursuant to contract or other agreement with the Office, or with another governmental entity, including county and local governments, or an entity contracting on its behalf, to render program services, State funds or State-authorized payments during the covered reporting period and the year prior to the covered reporting period, and in an average annual amount greater than \$500,000 during those two years; and
 - (ii) at least thirty (30) percent of whose total annual in-state revenues for the covered reporting period and for the year prior to the covered reporting period were derived from State funds or State-authorized payments. This percentage shall be calculated as a percentage of the total annual revenues derived from and in connection with the provider's activities within New York State, irrespective of whether the provider derives additional revenues from activities in another state. The source of such revenues shall include those from sources outside New York State if such revenues were derived from or in connection with activities inside New York State, including, for example, contributions by out-of-state individuals or entities for in-state activities. Where applicable, a provider's method of calculating in-state revenues for purposes of determining tax liability or in connection with completion of its financial statements shall be deemed acceptable by the Office for the purpose of applying this subparagraph.
- (2) For purposes of this Part:
- (i) An entity or individual that receives State funds or State-authorized payments directly from a managed care organization that is subject to the oversight of the Office or another governmental entity shall be deemed to receive State funds or State-authorized payments pursuant to contract or other agreement with the Office, or with another governmental entity, to render program services, and
 - (ii) The method of accounting used by the entity or individual in the preparation of its annual financial statements shall be used, except that an entity or individual that otherwise reports to the Office using a different method of accounting shall use such method.
- (3) 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 of the foregoing entities;
 - (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 covered providers if they also receive 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;

- (iii) Individual professional(s), partnerships, S Corporations, or other entities, at least seventy-five percent of whose program services paid for by State funds or State-authorized payments are provided by the individual professional(s), by the partner(s), or by the owner(s) of the corporation or entity, rather than by employees or independent contractors employed or retained by the entity, as determined by the amounts obtained in State funds or State-authorized payments for such program services;
- (iv) Individuals or entities providing primarily or exclusively products, rather than services, in exchange for State funds or State-authorized payments, including but not limited to pharmacies and medical equipment suppliers. For the purpose of applying this exception, the percentage of revenues derived from products rather than from services shall be used; and
- (v) Entities within the same corporate family as a covered provider, including parent or subsidiary corporations or entities, except where such a corporation or entity would otherwise qualify as a covered provider but for the fact that it has received its State funds or State-authorized payments from a covered provider rather than directly from a governmental agency.

(e) *Covered reporting period* shall mean the provider's most recently completed annual reporting period, as defined herein, commencing on or after July 1, 2013.

(f) *Executive compensation* shall include all forms of cash and noncash payments or benefits given directly or indirectly to a covered executive, including but not limited to salary and wages, bonuses, dividends, distributions to a shareholder/partner from the current reporting period's earnings where such distributions represent compensatory or guaranteed payments or compensatory partnership profits allocation or compensatory partnership equity interest for services rendered during such reporting period, and other financial arrangements or transactions such as personal vehicles, housing, below-market loans, payment for personal or family travel, entertainment, and personal use of the organization's property, reportable on a covered executive's W-2 or 1099 form, except that mandated benefits (e.g., Social Security, worker's compensation, unemployment insurance and short-term disability insurance), and other benefits such as health and life insurance premiums and retirement and deferred compensation plan contributions that are consistent with those provided to the covered provider's other employees shall not be included in the calculation of executive compensation. For the purposes of this definition, such benefits shall be considered consistent with those provided to other employees where the intended value of the benefit is substantially equal, even where the cost to the covered provider to provide such a benefit may differ. With respect to employer contributions to retirement and deferred compensation plans that are not consistent with those provided to other employees, executive compensation shall be deemed to include only those amounts contributed or accrued during the reporting period for the benefit or intended benefit of the covered executive, even if not reported on the executive's W-2 or 1099 for that reporting period (but not

those amounts that vested during such period but were contributed or accrued prior to the period).

(g) *Office* means the New York State Office of Mental Health.

(h) *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 awarding agency) 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 a State agency or local unit of government in such agency's or government's provision of services to members of the public.

(i) *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.

- (1) Such expenses include but are not limited to the following expenses, if otherwise authorized and allowable pursuant to applicable agency regulations, contracts or other rules that govern reimbursement with State funds or State-authorized payments:
 - (i) that portion of 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) that portion of the salaries and benefits of 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 related expenses; and
 - (iii) that portion of 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, public outreach or education or personnel training to facilitate program services delivery, information technology and computer services and systems directly attributable to program services such as, for example, electronic patient records systems to facilitate improved patient care or computer systems used in program services delivery or documentation of program services provided, quality assurance and control expenses, 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, development, installation, and maintenance of real estate or other real property; or
- (ii) property rental, mortgage or maintenance expenses, except where such expenses are made in connection with providing housing to members of the public receiving program services from the covered provider; or
- (iii) taxes, payments in lieu of taxes, or assessments paid to any unit of government; or
- (iv) 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; or
- (v) expenses of an amount greater than \$10,000 that would otherwise be administrative, except that they are either non-recurring (no more frequent than once every five years) or not anticipated by a covered provider (e.g., litigation-related expenses). Such expenses shall not be considered administrative expenses or program expenses for purposes of this regulation; or
- (vi) that portion of the salaries and benefits of staff performing policy development or research.

(j) *Related organization* shall have the same meaning as the same term in Schedule R of the Internal Revenue Service’s Form 990 except that for purposes of this regulation a related organization must have received or be anticipated to receive State funds or State-authorized payments from a covered provider during the reporting period.

(k) *Reporting period* shall mean, at the provider’s option, the calendar year or, where applicable, the fiscal year used by a provider. However, where a provider is required to file an annual Cost Report with the State, *reporting period* shall mean the reporting period applicable to said Cost Report.

(l) *State-authorized payments* refer to those payments of funds that are not State funds but which are distributed or disbursed upon a New York state agency’s approval or by another governmental unit within New York State upon such approval, including but not limited to the federal and county portions of Medicaid program payments approved by the state agency. The Office shall publish a list of government programs whose funds shall be considered State-authorized payments prior to the effective date of this regulation. 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;

- (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, development, 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 including but not limited to New York State Health Insurance Program (NYSHIP) premium payments, or Supplemental Security Income (SSI) payments, 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;
- (7) policy development or research; or
- (8) funds expressly intended to pay exclusively for administrative expenses, including but not limited to Community Service Program “core” contract funding for HIV/AIDS services programs.

(m) *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. The Office shall publish a list of government programs whose funds shall be considered State funds prior to the effective date of this regulation. 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;
- (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, development, 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 including but not limited to New York State Health Insurance Program (NYSHIP) premium payments, or Supplemental Security Income (SSI) payments, 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;
- (7) policy development or research; or
- (8) funds expressly intended to pay exclusively for administrative expenses, including but not limited to Community Service Program “core” contract funding for HIV/AIDS services programs.

513.4 Limits on Administrative Expenses.

(a) **Limits on Allowable Administrative Expenses.** No less than seventy-five (75) percent of the covered operating expenses of a covered provider 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 (85) percent in 2015 and for each year thereafter. 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. Such allocation may include allocation of portions of an employee's time and compensation to administrative or program services. Commencing on July 1, 2013, the limits on allowable administrative expenses pursuant to this Part shall be effective and applicable to each covered provider on the first day of each provider's respective covered reporting period.

(b) **Subcontractors and Agents of Covered Providers.** The restriction on allowable administrative expenses in subdivision (a) of this section, and the reporting requirements in section 513.7 of this Part shall apply to subcontractors and agents of covered providers if and to the extent that such a subcontractor or agent has received State funds or State-authorized payments from the covered provider to provide program or administrative services during the reporting period and would otherwise meet the definition of a covered provider but for the fact that it has received State funds or State-authorized payments from the covered provider rather than directly from a governmental agency. A covered provider shall incorporate into its agreement with such a subcontractor or agent the terms of these regulations by reference to require and facilitate compliance. Upon request, covered providers shall promptly report to the funding or authorizing agency the identity of such subcontractors and agents, along with any other information requested by that agency or by the Office or its designee. A covered provider shall not be held responsible for a subcontractor's or agent's failure to comply with these regulations.

(c) **Covered Providers Receiving State Funds or State-Authorized Payments From County or Local Government or From an Entity Contracting on its Behalf.** The Office or its designee, rather than the county or local unit of government or an entity contracting on behalf of such 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.

(d) **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 subdivision (a) of this section shall be determined based upon the total amount of program services expenses and administrative expenses paid for by such funding received from all of such sources. As set forth in section 513.8 of this Part, 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.

(e) 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. However, the definition and interpretation of the terms in this Part shall not be affected or limited by the definition or interpretation of terms in other regulations or agreements.

513.5 Limits on Executive Compensation.

(a) Limits on Executive Compensation. Except if a covered provider has obtained a waiver pursuant to section 513.6 of this Part, a covered provider as defined in this regulation shall not 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 review this figure annually to determine whether adjustment is necessary based on appropriate factors and subject to the approval of the Director of the Division of the Budget. Commencing on July 1, 2013, the limits on executive compensation pursuant to this Part shall be effective and applicable to each covered provider on the first day of each covered provider's respective covered reporting period.

(b) Except if a covered provider has obtained a waiver pursuant to section 513.6 of this Part, where a covered provider'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 either:

- (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, provided, 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 (if such a board or body exists) 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), or such review did not include an assessment of appropriate comparability data;

then such covered provider shall be subject to the penalties set forth in section 513.8 of this Part. To determine whether a covered provider may be subject to penalties, such provider shall provide, upon request by the Office or its designee, contemporaneous documentation in a form and level of detail sufficient to allow such determination to be made.

(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 program services, including but not limited to supervisory services performed to facilitate the

covered provider's program services, rendered by the executive outside of his or her managerial or policy-making duties. Documentation of such program services rendered shall be used by the covered provider to determine that percentage, if any, of the covered executive's compensation that is attributable to program services, and that compensation shall not be considered in the calculation of his or her executive compensation. Such documentation shall be maintained and provided to the Office or its designee upon request. Clinical and program personnel in a hospital or other entity providing program services, including chairs of departments, heads of service, chief medical officers, directors of nursing, or similar types of personnel fulfilling administrative functions that are nevertheless directly attributable to and comprise program services shall not be considered covered executives for purposes of limiting the use of State funds or State-authorized payments to compensate them.

(d) **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 limits on executive compensation in subdivision (a) of this section 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 513.7 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) of this section and the reporting requirements in section 513.7 shall apply to subcontractors and agents of covered providers if and to the extent that such a subcontractor or agent has received State funds or State-authorized payments from the covered provider to provide program or administrative services during the reporting period and would otherwise meet the definition of a covered provider but for the fact that it has received State funds or State-authorized payments from the covered provider rather than directly from a governmental agency. A covered provider shall incorporate into its agreements with such a subcontractor or agent the terms of these regulations by reference to require and facilitate compliance. Upon request, covered providers shall promptly report to the funding or authorizing agency the identity of such subcontractors and agents, along with any other information requested by that agency or by the Office or its designee. A covered provider shall not be held responsible for a subcontractor's or agent's failure to comply with these regulations.

(f) **Covered Providers Receiving State Funds or State-Authorized Payments from a County or Local Government or Entity Contracting on its Behalf.** The Office or its designee, rather than the county or local unit of government or an entity contracting on behalf of such 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.

(g) **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. However, the definition and interpretation of terms in this Part shall not be affected or limited by the definition or interpretation of terms in other regulations or agreements.

(h) A covered provider's contract or other agreement with a covered executive agreed to prior to July 1, 2012, shall not be subject to the limits in this section during the term of the contract, except that:

- (1) covered providers must apply for a waiver for any contracts or agreements with covered executives for executive compensation that exceeds or otherwise fails to comply with these regulations if such contracts or agreements extend beyond April 1, 2015; and
- (2) renewals of such contracts or agreements after the completion of their term must comply with these regulations.

513.6 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 513.5 of this Part for executive compensation for one or more covered executives, or for one or more positions, during the reporting period and, where appropriate, for a longer 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 concurrent with the timely submission of the covered provider's E.O. 38 Disclosure Form required pursuant to section 513.7 of this Part for the reporting period for which the waiver is requested. 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. The Office shall consider untimely waiver applications where a reasonable cause for such delay is shown.
- (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 513.5 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 (if such a board or body exists), 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;
 - (v) the qualifications and experience possessed by or required for the covered executive(s) or position(s), respectively; and

- (vi) 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 513.5 shall be granted only where a covered provider has demonstrated good cause 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. Unless additional information has been requested but not received from the covered provider, a decision on a timely submitted waiver application shall be provided no later than sixty (60) calendar days after submission of the application.
 - (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 shall 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.
 - (5) Unless already publicly disclosed, information provided by a covered provider to the Office in connection with a waiver application regarding the limits on executive compensation shall not be subject to public disclosure under the State's Freedom of Information Law.
- (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 and thereafter in excess of the limit set forth in section 513.4 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 concurrent with the timely submission of the covered provider's E.O. 38 Disclosure Form for the period for which the waiver is requested, as required pursuant to section 513.7 of this Part. The Office shall consider untimely waiver applications where a reasonable cause for such delay is shown.
 - (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 513.4 shall be granted only where a covered provider has demonstrated good cause 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. Unless additional information has been requested but not received from the covered provider, a decision on a timely submitted waiver application shall be provided no later than sixty (60) calendar days after submission of the application.
- (4) If granted, a waiver granted to a covered provider shall remain in effect only for the reporting period, except that the covered provider may request in its waiver application and the Office or its designee and the Director of the Division of the Budget may grant an extension of the effective period of such waiver when the waiver is granted.
- (5) Unless already publicly disclosed, information provided by a covered provider to the Office in connection with a waiver application regarding the limit on administrative expenses shall not be subject to public disclosure under the State's Freedom of Information Law.

(c) Denial of Waiver Request.

- (1) If the Office or its designee or the Director of the Division of the Budget propose to deny a request for waiver made pursuant to section 513.6 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) calendar days from the date of the notice, unless reconsideration is requested.

- (2) If the Office or its designee or the Director of the Division of the Budget provides a notice of proposed denial, the applicant may request consideration of the proposed denial by submitting a written request for reconsideration within thirty (30) calendar days of the date of the notice of proposed denial. Submission of a request for reconsideration within thirty (30) calendar 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 may be considered incomplete at the Office's discretion.
- (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 or 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.

513.7 Reporting.

- (a) Reporting by Covered Providers. Beginning after the effective date of this regulation, covered providers shall submit a completed E.O. 38 Disclosure Form for each covered reporting period. Such form shall be submitted no later than one hundred eighty (180) calendar days following the reporting period, unless otherwise authorized. 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 or an entity contracting on its behalf must report directly to the Office as required by this section. The county or local government or the entity contracting on its behalf 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 Office.
- (c) Failure to Report. A covered provider's failure to submit a completed E.O. 38 Disclosure 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.

513.8 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 513.4 or 513.5 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 thirty (30) calendar 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 513.4 or 513.5 of this Part, 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 thirty (30) calendar days a corrective action plan ("CAP") for approval by the Office or its designee.

(c) **Corrective Action Plan.** Within thirty (30) calendar 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 implemented. If it has been so implemented, 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:
 - (i) Redirection of State funds or State-authorized payments to be used to provide program services, where possible and consistent with federal and state laws;
 - (ii) Suspension, modification, limitation, or revocation of the provider's license(s) to operate program(s) for the delivery of program services;
 - (iii) Suspension, modification or termination of contracts or other agreements with the covered provider; and
 - (iv) Any other lawful actions or penalties deemed appropriate by the Office or its designee.
- (e) Opportunity for Appeal. Within thirty (30) calendar 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 thirty (30) calendar days, the determination of noncompliance shall become final and the proposed sanction shall be imposed. Unless the Office or its designee seeks to impose a sanction for which an administrative hearing is otherwise required by statute or regulation, the covered 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.

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