STATE OF NEW YORK
SUPREME COURT COUNTY OF ALBANY

In the Matter of the Application of

LEADINGAGE NEW YORK, INC.; NEW YORK STATE HEALTH FACILITIES ASSOCIATION, INC.; SOUTHERN NEW YORK ASSOCIATION, INC.; GREATER NEW YORK HEALTH CARE FACILITIES ASSOCIATION, INC.; HEALTHCARE ASSOCIATION OF NEW YORK STATE, INC.; CONTINUING CARE LEADERSHIP COALITION, INC.; BETHEL NURSING & REHABILITATION CENTER; CLOVE LAKES HEALTH AND REHABILITATION CENTER; BETHEL NURSING HOME COMPANY INC.; DAUGHTERS OF SARAH NURSING CENTER; EGER HEALTH CARE AND REHABILITATION CENTER; ISLAND NURSING AND REHAB CENTER; VICTORIA HOME; KIRKHAVEN; ISABELLA GERIATRIC CENTER; JEWISH HOME OF ROCHESTER; THE NEW JEWISH HOME, MANHATTAN; THE NEW JEWISH HOME, SARAH NEUMAN; PARKER JEWISH INSTITUTE FOR HEALTH CARE & REHAB; GURWIN JEWISH NURSING & REHABILITATION CENTER; RIVERLEDGE HEALTH CARE AND REHABILITATION CENTER; MAPLEWOOD HEALTH CARE AND REHABILITATION CENTER; ST. ANNS COMMUNITY; ST. CABRINI NURSING HOME; SAINTS JOACHIM & ANNE NURSING AND REHABILITATION CENTER; ST JOHNS HEALTH CARE CORPORATION; THE FRIENDLY HOME; THE VALLEY VIEW CENTER FOR NURSING CARE AND REHABILITATION; GLENDALE HOME-SCHDY CNTY DEPT SOCIAL SERVICES; WYOMING COUNTY COMMUNITY HOSPITAL SNF; BETHANY NURSING HOME & HEALTH RELATED FACILITY INC.; HILLSIDE MANOR REHABILITATION AND EXTENDED CARE CENTER; WINGATE AT ULSTER; CREST MANOR LIVING AND REHABILITATION CENTER; MIDDLETOWN PARK REHABILITATION AND HEALTH CARE CENTER; PUTNAM NURSING AND REHABILITATION CENTER; SKY VIEW REHABILITATION AND HEALTH CARE CENTER; WATERVIEW HILLS REHABILITATION AND NURSING CENTER; SALEM HILLS NURSING AND REHABILITATION CENTER; DIAMOND HILL NURSING AND REHABILITATION CENTER; SEAGATE NURSING AND REHABILITATION CENTER; THE NEW FRANKLIN REHABILITATION AND HEALTH CARE FACILITY;

DECISION AND ORDER/JUDGMENT
Index No.: 907319-19
RJI No.: 01-19-ST0658

SPLIT ROCK REHABILITATION AND HEALTH CARE CENTER; FORT TRYON REHABILITATION AND HEALTH CARE FACILITY; THE MAPLEWOOD NURSING HOME; WEDGEWOOD CARE CENTER, INC., d/b/a HIGHFIELD GARDENS CARE CENTER; THE CHATEAU AT BROOKLYN REHABILITATION AND NURSING CENTER; CORTLANDT HEALTH CARE; THE ENCLAVE AT PORT CHESTER REHABILITATION AND NURSING CENTER; THE GLENGARIFF HEALTH CARE CENTER; THE GRAND PAVILLION FOR REHABILITATION AND NURSING AT ROCKVILLE CENTRE; THE GROVE AT VALHALLA REHAB AND NURSING CENTER; THE HAMMOND REHABILITATION AND HEALTH CARE CENTER AT NESCONSET; THE PHOENIX NURSING AND REHABILITATION CENTER; THE RIVERSIDE; THE ROCKVILLE SKILL NURSING AND REHABILITATION CENTRE; THE SANS SOUCI REHABILITATION AND NURSING CENTER; ST. JAMES REHABILITATION AND HEALTH CARE CENTER; WATERS EDGE AT PORT JEFFERSON; SILVER LAKE SPECIALIZED REHABILITATION AND CARE CENTER; FOREST HILLS CARE CENTER; NEW EAST SIDE NURSING HOME; BERKSHIRE NURSING HOME; NEWFANE REHABILITATION AND HEALTH CARE CENTER; WINGATE AT DUTCHESS; BEDFORD CENTER FOR NURSING AND REHABILITATION; CROWN HEIGHTS CENTER FOR NURSING AND REHABILITATION; GREATER HARLEM/HARLEM CENTER; HAMILTON PARK NURSING AND REHABILITATION CENTER; LINDEN CENTER FOR NURSING AND REHABILITATION; BEACH GARDEN REHABILITATION AND NURSING CENTER; BROOKLYN GARDENS NURSING AND REHABILITATION CENTER; CATON PARK NURSING AND REHABILITATION CENTER; HEMPSTEAD PARK NURSING HOME; PARK NURSING HOME; TARRYTOWN HEALTH CARE CENTER; ALPINE REHABILITATION AND NURSING CENTER; NORWICH REHABILITATION AND NURSING CENTER; HIGHLAND REHABILITATION AND NURSING CENTER; UTICA REHABILITATION AND NURSING CENTER; SODUS REHABILITATION AND NURSING CENTER; AUBURN REHABILITATION AND NURSING CENTER; ORCHARD REHABILIATION AND NURSING CENTER; GOWANDA REHABILITATIO AND NURSING CENTER; EDEN REHABILITATION AND NURSING CENTER; DUNKIRK REHABILIATION AND NURSING CENTER; HOUGHTON REHABILITATION AND NURSING CENTER;

YORKTOWN REHABILITATION AND NURSING CENTER; COSDEN LLC d/b/a PALATINE NURSING HOME; BROOKHAVEN REHABILITATION AND HEALTH CARE CENTER; NORTHERN MANHATTAN REHABILITATION AND NURSING CENTER; REGENCY EXTENDED CARE CENTER; ROCKAWAY CARE CENTER; YONKERS GARDENS CENTER FOR NURSING & REHABILITATION; SCHOFIELD RESIDENCE; PONTIAC NURSING HOME; BLOSSOM CENTER FOR NURSING AND REHABILITION; FISHKILL CENTER FOR NURSING AND REHABILITATION; SAPPHIRE NURSING AND REHABILITATION CENTER AT GOSHEN; SAPPHIRE NURSING AT MEADOWHILL; SAPPHIRE REHABILITATION OF NORTHTOWNS; PARK GARDENS REHABILITATION AND NURSING CENTER; SAPPHIRE CENTER FOR NURSING AND REHABILITATION OF CENTRAL QUEENS; SAPPHIRE REHABILITATION OF SMITHTOWNS; SAPPHIRE NURSING OF WAPPINGER FALLS; WILLIAMSVILLE SUBURBAN SAPPHIRE NURSING AND REHABILITATION CENTER; CEDAR MANOR NURSING AND REHABILITATION CENTER; BETSY ROSS NURSING AND REHABILITATION CENTER; DUMONT CENTER FOR NURSING AND REHABILITATION; FRIEDWALD CENTER FOR REHABILITATION AND NURSING; KINGS HARBOR MULTICARE CENTER; HORIZON CARE CENTER; NEW SURFSIDE NURSING HOME d/b/a CORNING FAMILY NURSING AND REHABILITATION CENTER; NORTHWOODS REHABILITATION AND NURSING CARE CENTER AT MORAVIA; MEDFORD MULTI-CARE CENTER; MANHATTANVILLE HEALTH CARE CENTER; RESORT NURSING HOME; DRY HARBOR NURSING HOME; FOREST VIEW CENTER FOR REHABILITATION AND NURSING; WOODCREST REHABILITATION AND RESIDENTIAL HEALTH CARE FACILITY; WEST LAWRENCE CARE CENTER, LLC; AVON NURSING HOME; THE BRIGHTONIAN NURSING HOME; HAMILTON MANOR NURSING HOME; HORNELL GARDENS, LLC; THE HURLBUT NURSING HOME; THE LATTA ROAD NURSING HOME EAST; LATTA ROAD NURSING HOME WEST; NEWARK MANOR NURSING HOME; PENFIELD PLACE NURSING HOME; SENECA NURSING AND REHABILITATION CENTER; THE SHORE WINDS NURSING HOME; BAINBRIDGE NURSING & REHABILITATION CENTER; EAST HAVEN NURSING & REHABILITATION CENTER; MOSHOLU PARKWAY NURSING AND REHABILITATION CENTER; WAYNE

CENTER FOR NURSING AND REHABILITATION; THE GRAND REHABILITATION AND NURSING AT BARNWELL; THE GRAND REHABILITATION AND NURSING AT GUILDERLAND; THE GRAND REHABILITATION AND NURSING AT UTICA; THE GRAND REHABILITATION AND NURSING AT PAWLING; THE GRAND REHABILITATION AND NURSING AT QUEENS; THE GRAND REHABILITATION AND NURSING AT ROME; CHESTNUT PARK REHABILITATION AND NURSING CENTER; BUFFALO COMMUNITY HEALTHCARE CENTER; THE GRAND REHABILITATION AND NURSING AT SOUTH POINT; PARK TERRACE CARE CENTER; QUEENS NASSAU NURSING HOME; ADIRA AT RIVERSIDE REHAB & NURSING; BENSONHURST CENTER FOR REHABILITATION & HEALTHCARE; HILAIRE REHAB & NURSING; SMITHTOWN CENTER FOR REHAB & NURSING CARE; SPRAIN BROOK MANOR REHAB; GREENE MEADOWS NURSING & REHABILITATION CENTER; PREMIER GENESEE; LEROY VILLAGE GREEN RESIDENTIAL HEALTH CF INC.; PINE HAVEN HOME; BELLHAVEN CENTER FOR REHAB. & NURSING; WHITTIER REHAB. & SKILLED NURSING CENTER; BEACH GARDENS REHABILITATION AND NURSING CENTER; BRONX GARDEN REHABILITATION AND NURSING CENTER; THE PLAZA REHABILITATION AND NURSING CENTER; GRANDELL REHABILITATION AND NURSING CENTER; OCEANSIDE CARE CENTER; BEACH TERRACE CARE CENTER; ABSOLUT CARE AT ORCHARD PARK; ABSOLUT CARE OF WESTFIELD; ABSOLUT CARE OF ALLEGANY; ABSOLUT CARE OF AURORA PARK; ABSOLUT CARE OF GASPORT; MEADOWBROOK CARE CENTER; MEADOWBROOK HEALTHCARE; NEW YORK CENTER FOR REHABILITATION AND NURSING; EAST ROCKAWAY CARE CENTER D/B/A LYNBROOK RESTORATIVE THERAPY AND NURSING; EXCEL AT WOODBURY FOR REHABILITATION AND NURSING; FOREST MANOR CARE CENTER D/B/A GLEN COVE CENTER FOR NURSING AND REHABILITATION; LONG ISLAND CARE CENTER; MONTCLAIR CARE CENTER D/B/A EMERGE NURSING AND REHABILITATION CENTER; OASIS REHABILITATION AND CARE CENTER; QUANTUM REHABILITATION AND NURSING CENTER; SUFFOLK RESTORATIVE CARE AND NURSING CENTER D/B/A MOMENTUM AT SOUTH BAY; HAYM SOLOMON HOME FOR THE AGED; HIGHLAND CARE CENTER; OXFORD

NURSING HOME INC.; NEW CARLTON REHAB NURSING CENTER; LACONIA NURSING HOME; SCHERVIER NURSING CARE CENTER; BROOKSIDE MULTICARE CENTER; LITTLE NECK CARE CENTER; WHITE PLAINS CENTER FOR NURSING; ELCOR NURSING AND REHABILITATION CENTER; HUDSON VALLEY REHABILITATION AND EXTENDED CARE FACILITY; REGEIS CARE CENTER; WESTCHESTER CENTER FOR REHABILITATION AND NURSING; SPRING CREEK REHABILITATION & NURSING CARE CENTER; BUENA VIDA CONTINUING CARE AND REHABILITATION CENTER; BEZALEL REHABILITATION & NURSING CENTER; BEACON REHABILITATION AND NURSING CENTER; PELHAM PARKWAY NURSING CARE AND REHABILITATION FACILITY LLC; LAWRENCE NURSING CARE CENTER, INC.; WESTHAMPTON CARE CENTER; and ST. LUKE RESIDENTIAL HEALTH CARE FACILITY INC.,

Petitioners-Plaintiffs,

for a Judgment Pursuant to Article 78 of the CPLR, and for Declaratory and Injunctive Relief

-against-

HOWARD A. ZUCKER, M.D., J.D., as COMMISSIONER OF HEALTH OF THE STATE OF NEW YORK; and THE NEW YORK STATE DEPARTMENT OF HEALTH,

Respondents-Defendants.

AUTUMN VIEW HEALTH CARE FACILITY, LLC; AARON MANOR REHABILITATION AND NURSING CENTER; AFFINITY SKILLED LIVING AND REHABILITATION CENTER; BETHANY GARDENS SKILLEDLIVING CENTER; BRIGHTON MANOR INC.; BROOKHAVEN HEALTH CARE FACILITY, LLC; CAMPBELL HALL REHABILITATION CENTER, INC.; CLIFTON SPRINGS NURSING HOME; EDNA TINA WILSON LIVING CENTER; FATHER BAKER MANOR; FIELDSTONE LODGE CARE CENTER; GARDEN GATE HEALTH CARE FACILITY, LLC; GOLD CREST CARE CENTER; HARRIS HILL

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NURSING FACILITY, LLC; HIGHLAND NURSING HOME, INC.; HILL HAVEN NURSING HOME; HOLLIS PARK MANOR NURSING HOME; MCAULEY RESIDENCE; MERCY HOSPITAL SKILLED NURSING FACILITY; MORNINGSTAR RESIDENTAL CARE CENTER; NORTH GATE HEALTH CARE FACILITY, LLC; ST CATHERINE LABOURE HEALTH CARE CENTER; SUNNYSIDE CARE CENTER; SUNRISE MANOR CENTER FOR NURSING AND REHABILITATION; THE ELEANOR NURSING CARE CENTER; UNITY LIVING CENTER; VALLEY VIEW MANOR NURSING HOME; WATERVILLE RESDENTIAL CARE CENTER; WELLSVILLE MANOR CARE CENTER; AND WINDSOR PARK NURSING HOME,

Plaintiffs-Petitioners,

v.

HOWARD ZUCKER, M.D., AS COMMISSIONER OF HEALTH OF THE STATE OF NEW YORK, OR HIS SUCCESSOR IN OFFICE,

Defendant-Respondent.

MAYFAIR CARE CENTER INC.; MIDWAYNURSING HOME, INC.; FULTON COMMONS CARE CENTER, INC.; BRIDGE VIEW NURSING HOME, INC.,

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Petitioners,

-against-

HOWARD ZUCKER, M.D. as COMMISSIONER OF HEALTH OF THE STATE OF NEW YORK; THE NEW YORKS STATE DEPARTMENT OF HEALTH; AND DIRECTOR OF BUDGET OF THE STATE OF NEW YORK,

Respondents.

For a Judgment pursuant to Article 78 of the CPLR

(Supreme Court, Albany County, Special Term)

(Justice Kimberly A. O'Connor, Presiding)

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O'CONNOR, J.:

Before the Court are three hybrid Article 78 proceedings and plenary actions for declaratory and injunctive relief, challenging the legality, and in one case the constitutionality, of

a change in the method for adjusting nursing home Medicaid reimbursement rates, commonly known as the "case mix adjustment," which was announced by respondent-defendant The New York State Department of Health ("Department" or "DOH") on October 9, 2019 and effective July 1, 2019. Following an application brought by Order to Show Cause (O'Connor, J.), dated October 24, 2019, in the *LeadingAge New York, Inc., et al. v. Zucker, et al.* proceeding and action ("*LeadingAge*"), this Court issued a Decision and Order, dated November 7, 2019, enjoining respondents-defendants Howard A. Zucker, M.D., J.D., as Commissioner of Health of the State of New York ("Commissioner Zucker" or "DOH Commissioner"), and the DOH from implementing the new methodology for calculating the case mix adjustment they adopted effective as of July 1, 2019, and directing the DOH Commissioner and Department to continue using the method for calculating petitioners-plaintiffs' Medicaid reimbursement rates that was in effect as of June 30, 2019, pending a final determination of that proceeding and action.

Before the Order to Show Cause in *LeadingAge* was decided, the *Autumn View Health Care Facility, LLC, et al. v. Zucker* proceeding and action ("*Autumn View*") was commenced as related litigation, and by Order, dated January 13, 2020, the Court granted plaintiffs-petitioners' motion to, among other things, consolidate *Autumn View* with *LeadingAge* to the extent of having both cases proceed under a unified briefing schedule and toward a joint trial. On November 7, 2019, the *Mayfair Care Center, Inc., et al. v. Zucker, et al.* proceeding and action ("*Mayfair*") was commenced as litigation also related to *LeadingAge*. Although no formal application was made, *Mayfair* has proceeded under a unified briefing schedule and toward a joint trial with *LeadingAge* and *Autumn View* at the parties' direction.

Commissioner Zucker and the DOH (collectively "respondents-defendants"), and the Director of Budget of the State of New York ("DOB Director") in *Mayfair*, have answered the verified petitions and complaints, and oppose the requested relief. Respondents-defendants, and

the DOB Director in *Mayfair*, also move, pursuant to CPLR 3212, for an order granting summary judgment in their favor and dismissing the claims for declaratory relief set forth in the verified petitions and complaints. Petitioners-plaintiffs in *LeadingAge*, *Autumn View*, and *Mayfair* have separately replied to the opposition, and oppose the respective summary judgment motions. The respondents-defendants, and the DOB Director in *Mayfair*, replied to the opposition to their summary judgment motions. Oral argument was held on July 27, 2020. All three cases have been briefed, are fully submitted, and stand ready for decision.

BACKGROUND

Petitioners-plaintiffs LeadingAge New York, Inc., New York State Health Facilities Association, Inc., Southern New York Association, Inc., Greater New York Health Care Facilities Association, Inc., Healthcare Association of New York State, Inc., and Continuing Care Leadership Coalition, Inc. are associations that represent the interests of a substantial number of the approximately 600 residential health care facilities (commonly known as "nursing homes") in New York State. Petitioners-plaintiffs Bethel Nursing and Rehabilitation Center, Clove Lakes Health and Rehabilitation Center, Bethel Nursing Home Company Inc., Daughters of Sarah Nursing Center, Eger Health Care and Rehabilitation, et al.; plaintiffs-petitioners Autumn View Health Care Facility, LLC, Aaron Manor Rehabilitation and Nursing Center, Affinity Skilled Living and Rehabilitation Center, Bethany Gardens Skilled Living Center, Brighton Manor Inc., et al.; and petitioners Mayfair Care Center Inc., Midway Nursing Home, Inc., Fulton Commons Care Center, Inc., and Bridgeview Nursing Home, Inc. comprise over 140 not-for-profit and for-profit nursing homes that participate in New York State's Medicaid Program and receive Medicaid reimbursement to cover the cost of care and services for eligible individuals who reside in their facilities (collectively "petitioners-plaintiffs," unless otherwise noted).

Medicaid is "a joint federal-state program established pursuant to [T]itle XIX of the Social Security Act (42 USC § 1396 *et seq.*), [which] pays for medical care for those otherwise unable to afford it, including nursing home care for older people with low incomes and limited assets" (*Matter of Nazareth Home of the Franciscan Sisters v. Novello*, 7 N.Y.3d 538, 542 [2006]). Under the program, "[t]he federal government normally covers 50% of New York's Medicaid costs, while the [S]tate and local governments share responsibility for the rest" (*Matter of Nazareth Home of the Franciscan Sisters v. Novello*, 7 N.Y.3d at 542). "New York operates its own Medicaid program, setting its own guidelines for eligibility and services in conformity with federal statutes and rules" (*Matter of Nazareth Home of the Franciscan Sisters v. Novello*, *supra* at 542). To that end, the DOH is the single State agency responsible for administering New York's Medicaid Program and promulgating regulations to implement the Program (*see* Social Services Law § 363-a[1],[2]).

Pursuant to Article 28 of the Public Health Law, Commissioner Zucker is charged with "determin[ing]" the Medicaid reimbursement rates for nursing homes participating in the State's Medicaid Program, and "certify[ing] to [the DOB Director]" that the Medicaid reimbursement rates for nursing homes "are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities" (Public Health Law § 2807[3]; *see* Public Health Law § 2808[3]). In accordance with Public Health Law § 2807, the DOB Director "is responsible for approving the Medicaid reimbursement rates determined and certified by the Commissioner of Health" (*Matter of Cabrini of Westchester v. Daines*, 23 Misc.3d 855, 856 [Sup. Ct., Westchester County 2009]).

Rate-Setting Methodology

A nursing home's Medicaid reimbursement rate – the daily rate at which the facility can bill Medicaid for every Medicaid-eligible resident – is comprised of two components: (1) an

operating cost component, *i.e.*, non-capital component; and (2) a capital cost component (*see* 10 NY.C.R.R. § 86-2.10[a][7], [b][1][ii]). The operating cost component represents the sum of direct,[1] indirect,[2] and noncomparable[3] costs, as well as other non-capital add-ons and adjustments (*see* 10 N.Y.C.R.R. § 86-2.10[b][2]; Affidavit of Michael Ogborn, ¶ 6). The capital cost component includes, among other costs, interest on current and capital indebtedness and depreciation on the plant and moveable and non-moveable equipment (*see* 10 N.Y.C.R.R. § 86.2.10[g], 86-2.19, § 86-2.20, § 86-2.21, § 86-2.22). The operating cost component, specifically the direct costs, of a nursing home's Medicaid rate is subject to a periodic adjustment by the DOH to reflect the facility's "case mix" (*see* Public Health Law § 2808[2-b][b][ii]).

"Case mix" is defined as "the patient population of a facility as classified and aggregated into patient classification groups" based on the varying levels of care that the facility's patient population requires and receives, commonly referred to as patients' acuity (10 N.Y.C.R.R. § 86-2.1[c]). "Patient classification groups" are "the patient categories contained in the [Resource Utilization Groups-III (RUG-III)] classification system . . . which identifies the relative resource consumption required by different types of long-term care patients" (10 N.Y.C.R.R. § 86-2.1[b]). "There are 53 different patient classification groups within the current . . . 'RUG-III' category system" (*LeadingAge* Ver. Pet. & Compl., ¶ 259).

[1] Direct costs consist of the costs of "direct," hands-on patient care such as salaries for nurses and nurse's aides, and physical, occupational, and speech therapy, as well as social services, pharmacy, and transportation, among other things (*see* 10 N.Y.C.R.R. § 86-2.10[c][1]).

[2] Indirect costs include, among others, the costs incurred for administrative services, fiscal services, plant operations and maintenance (other than utilities and real estate and occupancy taxes), grounds, security, food, housekeeping, and laundry services, nonphysician and medical education, and medical records (*see* 10 N.Y.C.R.R. § 86-2.10[d][1]).

[3] Noncomparable costs are those specific to a particular facility, and consist of laboratory services, radiology, podiatry, dental, and psychiatric services, medical staff services, utilities, and real estate and occupancy taxes, among other costs (*see* 10 N.Y.C.R.R. § 86-2.10[f]).

"Each RUG category is assigned a numerical value based upon the resources necessary to care for that type of patient" (*Matter of Elcor Health Servs. v. Novello*, 100 N.Y.2d 273, 276-277 [2003]). "The weighted average of a facility's patients in each category is its case mix index (CMI)" (*id.* at 277; *see* 10 N.Y.C.R.R. § 86-2.10[c]). "Generally, the higher the CMI, the more intensive and costly the care required" (*Matter of Blossom View Nursing Home v. Novello*, 4 N.Y.3d 581, 586 [2005]). As such, "[t]he number of a nursing home's residents classified in the various RUG[ ]categories determines the facility's overall CMI and[,] thus[,] significantly influences its per diem Medicaid reimbursement rate" (*id.* at 586). Therefore, "if a facility's case mix index increases, so does its reimbursement rate" (*Matter of Nazareth Home of the Franciscan Sisters v. Novello*, 7 N.Y.3d at 544; *accord Matter of Adirondack Health-Uihlein Living Ctr. v. Shah*, 125 A.D.3d 1366, 1367 [4th Dep't 2015]; *see Matter of Elcor Health Servs. v. Novello*, 100 N.Y.2d at 277).

To assist the DOH Commissioner in setting Medicaid reimbursement rates, nursing homes "are required to assess all patients to determine case mix intensity using a federally mandated process for clinical assessment and defined patient review criteria" (Ogborn Aff. at ¶ 18]). In that regard, the DOH's regulations require nursing homes to "submit . . . the data contained in the comprehensive assessment and review of assessments (quarterly reviews) required to be completed by facilities in accordance with section 415.11 of . . . [10 N.Y.C.R.R.] and section 483.20 of 42 [C.F.R.]," referred to and known as the "minimum data set" ("MDS") (10 N.Y.C.R.R. § 86-2.37[a]). This assessment data is used to calculate each nursing home's case mix adjustment (*see* Ogborn Aff. at ¶¶ 18-19).

Case Mix Adjustment

Under the provisions of Public Health Law § 2808(2-b)(b)(ii), the DOH is required to make semi-annual case mix adjustments to a nursing home's Medicaid reimbursement rates as follows:

> The operating component of rates shall be subject to case mix adjustment through application of the relative resource utilization groups system of patient classification (RUG-III) employed by the federal government with regard to payments to skilled nursing facilities pursuant to [T]itle XVIII of the federal [S]ocial [S]ecurity [A]ct (Medicare), as revised by regulation to reflect New York state wages and fringe benefits, provided, however, that such RUG-III classification system weights shall be increased in the following amounts for the following categories of residents: (A) thirty minutes for the impaired cognition A category, (B) forty minutes for the impaired cognition B category, and (C) twenty-five minutes for the reduced physical functions B category. Such adjustments shall be made in January and July of each calendar year. Such adjustments and related patient classifications in each facility shall be subject to audit review in accordance with regulations promulgated by the [C]ommissioner.

Consistent with the statute, 10 N.Y.C.R.R. § 86-2.40(m), the Department's implementing regulation, sets forth the methodology for case mix adjustments and provides in relevant part, that

> [t]he direct component of the price shall be subject to a case mix adjustment in accordance with the following:
>
> (1) The application of the relative Resource Utilization Groups System (RUGS-III) as published by the Centers for Medicare and Medicaid Services and revised to reflect New York State wage and fringe benefits, and based on Medicaid[-]only patient data.
>
> (3) The case mix adjustment for the direct component of the price effective January 1, 2012 shall be calculated by dividing the Medicaid[-]only case mix calculated using data for January 2011 by the all-payer case mix for the base year 2007.
>
> (6) Subsequent case mix adjustments to the direct component of the price for rate periods effective after January 1, 2012 shall be made in July and January of each calendar year and shall use Medicaid-only case mix data applicable to the previous case mix period.
>
> (8) The adjustments and related patient classifications for each facility shall be subject to audit review by the Office of the Medicaid Inspector General.
>
> (9) The operator of a proprietary facility, an officer of a voluntary facility, or the public official responsible for the operation of a public facility shall submit to the Department a written certification, in a form as determined by the Department, attesting that all of the "minimum data set" ("MDS") data reported by the facility for each census roster submitted to the Department is complete and accurate.
>
> (10) In the event the MDS data reported by a facility results in a percentage change in the facility's case mix index of more than five percent, then the impact of the payment of the Medicaid rate adjustment attributable to such a change in the

> reported case mix may be limited to reflect no more than a five percent change in such reported data, pending a prepayment audit of such reported MDS data, provided, however, that nothing in this paragraph shall prevent or restrict post-payment audits of such data as otherwise provided for in this subdivision.

Prior to July 1, 2019, the DOH based its semi-annual case mix adjustment on patient acuity assessment data from a single day "snapshot" of patient care, i.e., the last Wednesday of January or July (*see* Ogborn Aff. at ¶ 22). That "[data] was then extrapolated out for the entire six-month period in order to derive the six-month case mix adjustment for a given [nursing home]" (*id.*). If a patient did not have an acuity assessment reported on the date of the "snapshot," the DOH would conduct a look back of 92 days and a look forward of 13 days to locate acuity information for that patient, and use the acuity assessment information closest in time to the "snapshot" day for the facility's case mix adjustment (*id.* at ¶ 23).[4]

Rate-Setting Calculation Change

Between 2015 and 2018, the DOH saw a 52% increase (from $701 million to $1.07 billion) in case mix reimbursements to nursing homes, resulting in a cumulative increase of $365 million in Medicaid spending (*see* Ogborn Aff. at ¶ 29). The DOH found significant variations in nursing home acuity depending on the month used for the "snapshot" calculation, noting dramatic increases in patient acuity in January and July, the months used for the "snapshot" extrapolation as compared to a month not utilized for the "snapshot" (*id.* at ¶ 25). Among other things, the DOH found that "[t]he percentage of patients receiving higher acuity rehabilitation services as reported by nursing homes more than tripled from 17 percent in April 2018 to 60 percent in July 2018" (*id.*).[5] Finding that "[t]he only logical explanation for this drastic statistical increase [was] that

[4] According to the DOH respondents-defendants, "[n]ursing homes are required to submit patient acuity assessments within 13 days of a patient's admission and every 92 days thereafter" (Ogborn Aff. at ¶ 23; *see* 10 N.Y.C.R.R. § 415.11; 42 C.F.R. § 483.20).

[5] The DOH presented these findings to the Legislature during a legislative briefing in February 2019, explaining that the "use of one assessment for each adjustment does not accurately represent and/or measure the acuity of a [nursing

[nursing] homes were backloading patient acuity services to correspond with the data review months to artificially manipulate their [case mix] adjustment," the Department "made a decision to adjust the [case mix] calculation," effective for nursing homes' July 1, 2019 rates, using "an average of all available acuity assessments, rather than a single day 'snapshot' that calculated the rate using only one assessment per resident" (*id.* at ¶¶ 26, 29-30).

2019 Public Notice

On March 27, 2019, the DOH published a public notice in the New York State Register proposing to amend the State's Medicaid Plan as follows:

> Effective on or after April 1, 2019[,] nursing home reimbursement case mix collections which impact the direct price component of nursing home Medicaid reimbursement. The direct statewide price shall be adjusted by a Medicaid-only case mix in January and July of each year, using the case mix data applicable to the previous period.
>
> The estimated annual net aggregate decrease in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2019-2020 is ($191 million) (N.Y. Reg., March 27, 2019 at 89) (*see LeadingAge* Ver. Pet. & Compl., Ex. D).

Case Mix Adjustment Workgroup

Thereafter, as part of the 2019-2020 State Budget, enacted on April 12, 2019, the Legislature established the "[r]esidential health care facilities case mix adjustment workgroup" (hereinafter "workgroup"), and directed "[t]he [C]ommissioner of [H]ealth or [the Commissioner's] designee [to] convene and chair [the] workgroup on the implementation of the change in case mix adjustments to Medicaid rates of payment of residential health care facilities that will take effect on July 1, 2019" (L. 2019, ch. 57, pt. G, § 9). "[C]omprised of residential health care facilities or

home's] residents" and noting that "[t]he SFY 2019-20 Executive Budget proposes to use all available assessments during a 6 month period to adjust [nursing home] rates and more appropriately account for acuity" (*see* Ogborn Aff. at ¶ 28, Ex. C).

representatives from such facilities, representatives from the statewide associations and other such experts on case mix as required by the [C]ommissioner or [the Commissioner's] designee," the workgroup was charged with "review[ing] recent case mix data and recent analyses conducted by the [D]epartment with respect to the [D]epartment's implementation of the July 1, 2019 change in methodology, the [D]epartment's minimum data set collection process, and case mix adjustments authorized under [Public Health Law § 2808(2-b)(b)(ii)]" (*id.*). "Such review" was intended "to promote a higher degree of accuracy in the minimum data set, and target abuses" (*id.*).

The 2019-2020 Budget legislation authorized the workgroup to "offer recommendations on how to improve future practice regarding accuracy in the minimum data set collection process and how to reduce or eliminate abusive practices" (L. 2019, ch. 57, pt. G, § 9), and "[i]n developing such recommendations," the workgroup was required to "ensure that the collection process and case mix adjustment recognizes the appropriate acuity for residential health care residents" (*id.*). The workgroup was also authorized to "make recommendations regarding the proposed patient driven payment model and the administrative complexity in revising the minimum data set collection and rate promulgation process" (*id.*). The workgroup's recommendations were to be reported "no later than June 30, 2019," and the legislation prohibited the DOH Commissioner from "modify[ing] the method used to determine the case mix adjustment for periods prior to June 30, 2019" (*id.*).

Pursuant to this legislative mandate, the DOH respondents-defendants convened, and the Commissioner's designee chaired, the residential health care facilities case mix adjustment workgroup, which operated under the working title "Nursing Home Acuity Workgroup" (*LeadingAge* Ver. Pet & Compl. at ¶ 280). Three workgroup meetings were held on May 22, 2019, June 13, 2019, and June 27, 2019, respectively, and on June 28, 2019, the workgroup delivered its recommendations to the DOH (*Autumn View* Am. Ver. Pet. & Compl., ¶ 47; Ogborn Aff. at ¶¶ 49-

50). In delivering its recommendations, the workgroup "express[ed] grave concerns with the impending change in acuity adjustments to the July 1, 2019 Medicaid rates," contending that the Department's proposed methodology is "at odds with recently enacted state law and if implemented, would negate recent efforts to address compensation of essential front-line caregivers, exacerbate the State's healthcare workforce crisis, and seriously disrupt access to high quality nursing home care throughout New York State" (*LeadingAge* Ver. Pet. & Compl., Ex. C at 1).

Among other things, the workgroup asserted that "[b]ased on the clear language of Chapter 57 of the Laws of 2019, stakeholders understood that the [w]orkgroup would provide recommendations and advice to the Department on the methodology utilized to calculate case[] mix adjustments to nursing home reimbursement rates," before implementation of the rate change, but that the DOH nevertheless "indicated . . . it[s] plans to implement the cut on July 1st, using unrepresentative resident data from the period August 8, 2018 through March 31, 2019" (*id.*, Ex. C at 1). The workgroup further noted that the DOH had indicated "plans not to invoke the current 5 percent constraint on case[ ]mix changes during each six-month period pending completion of an OMIG [Office of Medical Inspector General] audit" (*id.*, Ex. C at 2).

Concluding that the Department's new methodology does not accomplish the Legislature's intent of "promot[ing] a higher degree of accuracy in the minimum data set" and "essentially ignores the requirement for 'the [C]ommissioner not to modify the method used to determine the case mix adjustment for periods prior to June 30, 2019,'" the workgroup proposed "freez[ing] and apply[ing] the July 2018 CMI (utilized in the . . . January 1, 2019 rates) for the six-month rate periods commencing July 1, 2019 and January 1, 2020," and transitioning to a "quarterly calculation (average) of all Medicaid MDSs as a temporary methodology" for the July 2020 rate period, using "the quarterly average of all MDSs for the six-month period from July 1, 2019

through December 31, 2019," and "[a]pply[ing] the 5 percent constraint for each six-month period" (*id.*, Ex. C at 3-4). The workgroup also recommended moving to the RUG-IV 48-Group model and continuing the 5 percent constraint for the January 2021 rate period, and proposed having the workgroup "continue to analyze, advise, and collaborate with the Department on improving current and future practices regarding the minimum data set collection accuracy and rate promulgation processes" (*id.*, Ex. C at 4-5).

State Plan Amendment

On June 28, 2019, the DOH submitted a State Plan Amendment ("SPA" or "SPA #19-0033") to the federal Centers for Medicaid and Medicare Services ("CMS") "propos[ing] to establish a new methodology for the Minimum Data Set (MDS) data in the calculation of the case mix index" which, "[e]ffective April 1, 2019 . . . will be base[d] on all MDS data submitted by NYS nursing facilities for a six-month period preceding the effective date of the Medicaid reimbursement rates" (*LeadingAge* Ver. Pet. & Compl., Ex. D). SPA #19-003 provides that "[t]he case mix adjustment to the direct component of the price for the rate period effective on July, 1, 2019, will use all Medicaid-only case mix data submitted to CMS applicable to the August 2018 – March 2019 period," and that "[t]he case mix adjustment to the direct component of the price for the rate periods effective after July, 1, 2019, will be made in January and July of each calendar year and will use all Medicaid-only case mix data submitted to CMS applicable to the previous six-month period (e.g., April – September for the January case mix adjustment; October – March for the July case mix adjustment)" (*id.*).

Industry/Legislative Concerns

By letter, dated July 16, 2019, petitioners-plaintiffs trade associations collectively wrote to the Acting Regional Administrator for the United States Department of Health and Human Services, CMS New York Regional Office, "express[ing] grave concerns about the change in

acuity adjustments to the July 1, 2019 Medicaid rates for nursing homes proposed by New York under . . . (SPA) #19-0033," and urging CMS to disapprove the SPA "[b]ased on the potential for th[e] proposed retroactive change in methodology to destabilize nursing home finances and endanger beneficiary access to quality care." In their letter, petitioners-plaintiffs associations asserted that the State's public notice did not include sufficient information to ensure that interested parties could provide meaningful input prior to the SPA's submission; that the proposed methodology is at odds with the New York State 2019-2020 Budget legislation that references the change; and that there is no evidence the State properly undertook and documented public input processes related to access to care prior to submitting the SPA. Petitioners-plaintiffs associations also expressed substantive concerns about the impact the proposed SPA could have on beneficiary access to quality care (Affidavit of Stephen B. Hanse, Ex. G).

Thereafter, in a letter to Governor Andrew M. Cuomo, dated August 19, 2019 and copied to Commissioner Zucker and the DOB Director, among others, "on behalf of all nursing homes in New York State," the New York State Assembly Minority Leader "encouraged [the Governor] to suspend the current efforts of the New York State Department of Health (NYSDOH) to implement a devastating quarter-billion dollar rate cut" that "retroactively chang[es] the calculation of resident acuity adjustments to facilities' July 1, 2019 Medicaid rates." The Assembly Minority Leader noted that "the retroactive rate cut [was] being proposed by NYSDOH, despite the strong objection from the Nursing Home Acuity Workgroup," and "formally requested that [the Governor] suspend the proposed cut and work with the long-term care community to devise a more feasible alternative to this model that is consistent with the recommendations of the Nursing Home Acuity Workgroup" (Hanse Aff., Ex. J).

On or about September 9, 2019, the Chair of the New York State Assembly Committee on Health wrote to the Deputy Secretary of Health and the DOB Director, expressing "concern[ ] . . .

that efforts of the [w]orkgroup have been ignored," and noting that "the [w]orkgroup ha[d] offered useful suggestions for modernizing the case mix method" (*LeadingAge* Ver. Pet. & Compl., Ex. E). Subsequently, by September 11, 2019 letter to the DOB Director and copied to Commissioner Zucker, the Chairs of the New York State Senate Health and Finance Committees, and 23 other New York State Senators, "express[ed] [their] concern about the impact of administrative rate changes to residential health care facilities" (*id.*, Ex. F at 1). Noting, among other things, that "[r]ecommendations were issued by the [w]orkgroup in late June without the benefit of having first received and reviewed the data and related analyses from the Department, as required by law," and that "even without the required information, the [w]orkgroup's recommendations raised alarms about the magnitude of the rate cut and the Department's failure to follow the letter and intent of the law," the Senators asked that the "implementation of th[e] cuts" be delayed "pending further review in conformity with the Legislature's intent in reviewing and implementing th[e] changes" (*id.*, Ex. F at 1-2).

Application of New Calculation

By "Dear Administrator Letter" ("DAL"), dated October 9, 2019, the DOH notified nursing homes participating in the State's Medicaid Program, including petitioners-plaintiffs, that their "July 1, 2019 rates have been updated to include a case mix adjustment which was calculated using all assessment data submitted to [the] Centers for Medicare and Medicaid Services for the time period August 8, 2018 through March 31, 2019," and that "[t]he payment for July 1, 2019 rates will be made in cycle 2200 with a check release date of 11/6/2019" (*id.*, Ex. G). As of the date of the DAL, SPA # 19-0033 had not been approved by CMS.

Current Litiation

LeadingAge petitioners-plaintiffs subsequently commenced a proceeding and action on October 24, 2019, seeking a judgment under CPLR Article 78: (1) annulling the respondents-

defendants' methodology for the July 1, 2019 semi-annual case mix adjustment and for future semi-annual case mix adjustments as arbitrary and capricious, and contrary to law; (2) directing the respondents-defendants to recalculate their July 1, 2019 case mix adjustments and subsequent case mix adjustments during the pendency of this proceeding and action, in compliance with the methodology required by the Public Health Law and 10 N.Y.C.R.R. § 86-2.40(m); and (3) directing the respondents-defendants to reimburse them for any underpayments made pursuant to their "erroneous methodology." By their proceeding and action, the *LeadingAge* petitioners-plaintiffs also seek a judgment, pursuant to CPLR § 3001, declaring that the respondents-defendants must rely upon assessment data for the six-month period before the semi-annual case mix adjustment and utilize the 5% pre-audit limit on adjustments contained within their regulations to calculate the semi-annual case mix adjustments, and a permanent injunction, pursuant to CPLR Article 63 and CPLR § 7805, enjoining the respondents-defendants from utilizing the methodology they adopted effective for the July 1, 2019 rate period for the semi-annual case mix adjustment, unless and until such methodology is explicitly permitted by a duly enacted statute and/or regulation, and an approved SPA.

Thereafter on October 29, 2019, *Autumn View* plaintiffs-petitioners commenced a related proceeding and action seeking an order and judgment of the Court: (1) barring Commissioner Zucker from enforcing the "recently released" CMI adjustments on the ground that they are arbitrary and capricious, and affected by an error of law; (2) enjoining the Commissioner's recent CMI adjustments as violative of the New York State Constitution and the State Administrative Procedure Act; (3) declaring Commissioner Zucker's recent CMI adjustments to be violative of 10 N.Y.C.R.R. § 86-2.40(m)(6); (4) enjoining the recent CMI adjustments as violative of plaintiffs-petitioners' rights to procedural and substantive due process under the New York State and United

States Constitutions and their civil rights under 42 U.S.C. § 1983; and (4) awarding plaintiffs-petitioners reasonable attorneys' fees, pursuant to 42 U.S.C. § 1988.

Mayfair petitioners commenced a related proceeding and action on November 7, 2019, seeking, among other relief, a judgment of the Court: (1) permanently enjoining the DOH from implementing the July 1 2019 Medicaid rates as currently calculated; (2) declaring respondent-defendants actions in retroactively modifying the July 1, 2019 Medicaid reimbursement rates based on case mix changes to be arbitrary and capricious, illegal retroactive rate setting and in violation of the Public Health Law and associated regulations "as well as the edicts of the New York State Legislature expressly creating a work[ ]group for coordination of such changes and [f]ederal standards associated with appropriate pre-approval of changes to the State Medicaid [P]lan"; and (3) directing the DOH to continue reimbursing petitioners based on the methodology for computing the case mix adjustment that was in effect up until July 1, 2019.[6]

2020 Notice of Proposed Rulemaking

On January 29, 2020, the DOH published notice in the New York State Register, pursuant to the State Administrative Procedure Act, proposing "[a]mendment of section 86-2.40(m) of Title 10 NYCCR." Among other changes, the proposed rule adds new subparagraphs (i) and (ii) to paragraph (6), which state:

> (i) For the case mix period beginning July 1, 2019, the case mix adjustment to the direct component of the price for the July 1, 2019 rate period shall use all Medicaid-only case mix data submitted to CMS applicable to the August 2018 – March 2019 period.
>
> (ii) For the case mix periods beginning on and after January 1, 2020, the case mix adjustment to the direct component of the process shall be made in January and July of each calendar year and shall use all Medicaid-only case mix data

[6] Although the *Mayfair* petition requests a "judgment pursuant to Article78 of the Civil Practice Law and Rules," the *Mayfair* petitioners caption their pleading as a "Verified Petition and Complaint," signaling their intent to bring a hybrid proceeding and action. While the *Mayfair* petition does not assert a cause of action for declaratory judgment, petitioners seek a declaration that respondents-defendant have acted in violation of federal and state statutes and regulations.

> submitted to CMS applicable to the previous six-month period (e.g., April – September for the January case mix adjustment; October – March for the July case mix adjustment) (N.Y. Reg, Jan. 29, 2020 at 22).

The proposed rule also eliminates paragraph (10) of the rule (*id.*).

ARGUMENTS

Collectively, petitioners-plaintiffs argue that the DOH's new methodology for calculating nursing homes' case mix adjustments is arbitrary and capricious, and contrary to law. More particularly, petitioners-plaintiffs contend that the respondents-defendants acted in violation of, and failed to comply with, the Legislature's specific instructions in the 2019-2020 enacted State Budget regarding the workgroup and the implementation of the methodology change proposed to take effect July 1, 2019. According to petitioners-plaintiffs, the express language of the statute, as well as the accelerated timeframe for the workgroup to report its findings, make clear that the Legislature intended for the workgroup to review the change in the case mix adjustment methodology and provide recommendations before the change was implemented.

Additionally, petitioners-plaintiffs assert that the respondents-defendants failed to provide the workgroup with "recent case mix data and recent analyses conducted by the [D]epartment with respect to the [DOH's] implementation of the July 1, 2019 change in methodology," or give the workgroup an opportunity to review "the [D]epartment's minimum data set collection process, and case mix adjustments authorized under [Public Health Law § 2808(2-b)(b)(ii)]," as the Legislature instructed (L. 2019, ch. 57, pt. G, § 9). Furthermore, petitioners-plaintiffs contend that it was the Legislature's intention that the methodology change be implemented "to promote a higher degree of accuracy in the minimum data set" and "target abuses," while also "ensur[ing] that the collection process and case mix adjustment recognizes the appropriate acuity for residential health care residents" (*id.*). However, they submit that the respondents-defendants' new methodology is not targeted toward any particular abuses, as it uses preselected data to achieve a planned rate cut, and

does not promote accuracy or recognize the appropriate acuity for nursing home residents because it simply aggregates data, without regard to accuracy, from a stale review window.

Next, petitioners-plaintiffs argue that the new case mix adjustment methodology is contrary to the Public Health Law and the Department's own regulations. Citing Public Health Law § 2808(2-b)(b)(ii), petitioners-plaintiffs contend that the respondents-defendants are required to make case mix adjustments "in January and July of each calendar year," and that 10 N.Y.C.R.R. § 86-2.40(m)(6) mandates such semi-annual case mix adjustment to be based on "Medicaid-only case mix data applicable to the previous case mix period," that is, data from the preceding six-month period (specifically, July 1 through December 31 for the January 1 rate and January 1 through June 30 for the July 1 rate). Petitioners-plaintiffs maintain that before the July 1, 2019 case mix adjustment and consistent with 10 N.Y.C.R.R. § 86-2.40(m)(6), respondents-defendants used data from within the immediately preceding six-month period to make case mix adjustments.

Petitioners-plaintiffs claim that the respondents-defendants have departed from their own regulations by using an initial eight-month look back period, i.e., August 2018 to March 2019, for the July 1, 2019 case mix adjustment, and using a six-month look back period for future case mix adjustments that is not within the regulatory period and is based on "stale" data from as far back as the preceding April for the January case mix adjustment and the preceding October for the July case mix adjustment. They also assert that the respondents-defendants have departed from their regulations by disregarding the 5% "cap," or "circuit breaker" provided for in 10 N.Y.C.R.R. § 86-2.40(m)(10), which the DOH Commissioner consistently applied in the past, to all cases, positive or negative, to limit the impact of case mix adjustments "to reflect no more than a five percent change . . . pending [an OMIG] prepayment audit."

Petitioners-plaintiffs further submit that the respondents-defendants' new case mix adjustment methodology violates Public Health Law § 2807(3) because it has been adopted

without regard to whether the adjusted rates are "reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities." *LeadingAge* petitioners-plaintiffs maintain that a $246 million Medicaid rate cut will more than double the size of nursing homes' operating losses, placing certain facilities at risk of reduction in service, curtailment of programs, or ultimately, closure if they cannot adequately fund their operations. Additionally, they contend that the dramatic rate reduction will not improve the quality of care and will place Medicaid beneficiaries at risk of adverse impacts on their ability to access nursing home care, as well as threaten nursing homes' ability to meet recently negotiated wage increases in collective bargaining agreements. According to petitioners-plaintiffs, respondents-defendants implemented the new methodology solely to reduce Medicaid reimbursement rates by a significant, pre-determined amount, and not, as the Department claims, to "rationalize" case mix reimbursement.

Furthermore, petitioners-plaintiffs assert that the respondents-defendants acted to implement their new case mix adjustment methodology without obtaining prior SPA approval from CMS in violation of federal law. Moreover, the *Autumn View* and *Mayfair* petitioners-plaintiffs complain that the respondents-defendants' unilateral change to the case mix adjustment methodology, effective July 1, 2019, constitutes an unpromulgated rule in violation of the State Administrative Procedure Act ("SAPA") and the New York State Constitution. And the *Autumn View* plaintiffs-petitioners contend that that the respondents-defendants' implementation of a new case mix adjustment methodology is violative of their procedural and substantive due process rights as guaranteed by the New York State and United States Constitutions, and their civil rights under 42 U.S.C. § 1983.

In opposition to the verified petitions and complaints and support of their motions for summary judgment dismissing petitioners-plaintiffs' claims for declaratory judgment relief, respondents-defendants maintain that the DOH's implementation of the new "average calculation"

to determine nursing homes' case mix adjustments is consistent with the Department's mandate under the Public Health Law and the implementing regulations, and the DOH's overall obligation to promote accuracy and decrease abuses in the State's Medicaid Program. As such, respondents-defendants argue that the Department's implementation of the "average calculation" should not be disturbed.

Initially, respondents-defendants argue that the gravamen of petitioners-plaintiffs' complaint is that "they prefer the 'snapshot' calculation to the average formula[ ] because it is fiscally advantageous to them." Citing *Matter of Ellis Ctr. for Long Term Care v. DeBuono* (261 A.D.2d 791 [3d Dep't 1999]), respondents-defendants assert that petitioners-plaintiffs must show more than the existence or availability of an alternate methodology more favorable to them to challenge a DOH rate-setting methodology; they must demonstrate that the "average calculation" itself is irrational, unreasonable, or inconsistent with the statute's purpose.

Further, respondents-defendants contend that each of petitioners-plaintiffs' arguments supporting their claim that the new "average calculation" is arbitrary and capricious, and contrary to law, is based on a fundamentally flawed reading and application of the controlling law. Initially, respondents-defendants assert that the "mandate" in the 2019 Budget Law upon which the petitioners-plaintiffs rely is *per se* invalid. Citing *Darweger v. Staats* (267 N.Y. 290, 311 [1935]), *Huron Group, Inc. v. Pataki* (5 Misc.3d 648, 680-681 [Sup. Ct., Erie County 2004]), and *De Agostina v. Parkshire Ridge Amusements, Inc.* (155 Misc. 518, 524 [Sup. Ct., Kings Co. 1935]), respondents-defendants submit that "[t]he law is clear that the Legislature cannot delegate its own lawmaking authority or executive branch executive powers to a third party," and thus "the Legislature has no authority to condition an executive agency action on the approval of a non-governmental public workgroup." As such, respondents-defendants maintain that "[p]etitioner[s-plaintiffs'] inaccurate reading of the 2019 Budget Law as vesting [the workgroup] with some

power, authority or conditional right of approval over DOH's actions would create an unconstitutional delegation of authority to an industry workgroup," and "[t]he Court cannot adopt a proposed statutory construction of the 2019 Budget Law that would render the [L]aw unconstitutional."

Respondents-defendants next argue that the petitioners-plaintiffs misinterpret the workgroup's role with respect to the implementation of the "average calculation." They submit that "[n]owhere in the [Budget] [L]aw does the Legislature compel [the] DOH to 'consider' the workgroup's recommendations prior to implementation of the average calculation on July 1, 2019," or "direct the DOH to 'convene a workgroup and implement their recommendations' before the change is [made]." According to respondents-defendants, "the [L]aw merely states that the workgroup 'may' offer recommendations," and "says absolutely nothing about what DOH must do with those recommendations." Respondents-defendants contend that if the Legislature wanted to mandate the Department to accept or even "consider" the workgroup's recommendations, it would have stated so, and thus, its silence in that regard must be construed as intentional. Additionally, respondents-defendants assert that "a logical reading" and "reasonable interpretation" of the 2019 Budget Law is that the Legislature intended for the workgroup to convene and provide ongoing recommendations and review after the July 1, 2019 implementation, to smooth out unintended consequences or issues – not to restrict DOH to implement recommendations beforehand.

Furthermore, respondents-defendants maintain that Commissioner Zucker and the Department fully complied with the Legislature's workgroup mandate, and that the DOH's actions concerning the workgroup were fully consistent with the 2019 Budget Law and "actually went above the legislative requirements." Respondents-defendants submit that the DOH convened the workgroup and held three workgroup meetings prior to implementing the "average calculation,"

producing PowerPoint presentations in advance of each meeting that set out the agendas and substantively addressed the issues. Respondents-defendants assert that contrary to petitioners-plaintiffs' claims that the DOH did not "consider" or "ignored" the workgroup's recommendations, the PowerPoint slides demonstrate that the DOH directly addressed the recommendations and solicited further comments and discussion on each.

According to respondents-defendants, petitioners-plaintiffs' claim that the DOH's "average calculation" violates Public Health Law § 2808(2-b)(b)(ii) and 10 N.Y.C.R.R. § 86-2.40(m) is founded upon a misleading interpretation of the statute and regulatory provisions. Respondents-defendants contend that Public Health Law § 2808(2-b)(b)(ii) does not specify the data that the Department is to rely on for case mix adjustments, but states only that the DOH must make case mix adjustments "in January and July of each calendar year," and vests the Department with the responsibility to promulgate regulations to effect such adjustments. They further submit that 10 N.Y.C.R.R. § 86-2.40(m)(6), which requires case mix adjustments to be based on "Medicaid-only case mix data applicable to the previous case mix period," does not define what the "data applicable to the previous case mix period" is, leaving that to the discretion of the DOH.

Respondents-defendants assert that although petitioners-plaintiffs interpret "'data applicable to the previous case mix period' to mean that the DOH can only use case mix adjustment data from the immediately preceding six-month period," the "DOH has never interpreted that [language] to mean only the data from the prior six months" because even under the "snapshot" calculation, the Department used data from a defined date six months back plus an additional 92 days (a total of 9 months and two days), when acuity information was not available on the day of the "snapshot." They argue that petitioners-plaintiffs are conflating "previous case mix period" with "'data applicable to' the previous case mix period," and claim that the regulation does not say that the DOH must calculate the case mix adjustment on data "from the case mix period only," but

rather says that the case mix adjustment "is to be calculated based on data that was applicable to that previous period." Respondents-defendants contend that the Department has determined in its discretion that, for purposes of the "average calculation," the "data applicable to" the previous case mix period picks up from where DOH left off in the prior case mix adjustment.

Respondents-defendants submit that petitioners-plaintiffs' interpretation of 10 N.Y.C.R.R. § 86-2.40(m), as limiting the Department to the prior six months' worth of data does not harmonize with other provisions of the Public Health Law, and creates a number of "absurd outcomes." They maintain that if the DOH had to rely exclusively on data from the prior six-month period, then the Department could not comply with the requirement in Public Health Law § 2807(7) to provide sixty-days' notice to nursing homes of approved rates before the rates take effect. Respondents-defendants also contend that the petitioners-plaintiffs' reading of the regulation "does not consider the fact that rate computation takes time." They explain, as an example, that applying petitioners-plaintiffs' interpretation of the regulation, in order for the Department to promulgate a new rate on January 1, 2020, the DOH would have to factor, in its average, all data from July 1, 2019 through December 31, 2019 at 11:59 p.m., but "could not practically obtain and compute data from minutes and hours before issuing its rate on January 1st." Respondents-defendants assert that "[t]his creates an absurd result that was not intended by the language 'data applicable to the previous case mix period.'" Moreover, respondents-defendants note that petitioners-plaintiffs' interpretation of 10 N.Y.C.R.R. § 86-2.40(m)(6) as applying only to the preceding six-months of data is inconsistent with its own workgroup's recommendation to use data from as far back as 12 months to calculate the average for the July 1, 2020 case mix adjustment.

As to petitioners-plaintiffs' contention that the "average calculation" is inconsistent with 10 N.Y.C.R.R. § 86-2.40(m)(10), respondents-defendants argue that there is no mandatory 5% "cap," "threshold," or "circuit breaker" on the DOH's computation of case mix adjustments, as

conceded by the *Autumn View* plaintiffs-petitioners. Respondents-defendants assert that 10 N.Y.C.R.R. § 86-2.40(m)(10) is permissive in nature, and, thus, under the plain language of the regulation, application of the 5% rule is left solely to the DOH's sound discretion. They submit that it would be error for the Court to substitute its own judgment and find that the "average calculation" is arbitrary and capricious because it permits more than a 5% swing in nursing homes' case mix adjustments. According to respondents-defendants, petitioners-plaintiffs' claim that the "average calculation" will result in an "existential threat" and industry-wide downward rate adjustment of more than 5% "is a misstatement." They maintain that only those nursing homes that abused or manipulated the "snapshot" calculation should experience rate adjustments in excess of 5%, as the rule was not promulgated to protect fraudulent or abusive Medicaid practices, and that any nursing home that followed their legal obligations under the Public Health Law will experience either rate increases or the same rates as a result of the "average calculation."[7]

Respondents-defendants argue that the exclusive impetus for the DOH's implementation of the "average calculation" was to address an "unprecedented 52% . . . increase" in case mix adjustments from 2015 through 2018 and derive a more accurate rate adjustment. They assert that that "[t]he very purpose of the new average calculation was to promote accuracy and avoid fraud/abuse that was commonplace under the prior 'snapshot' calculation," and that petitioners-plaintiffs' "contention that the average calculation did not 'target any particular abuses' is plain error[,] as targeting the variations in acuity was the central abuse DOH looked to remedy." Respondents-defendants point out that both the 2019 Budget Law and Public Health Law prioritize the Department promoting "a higher degree of accuracy" and targeting "abuses."

[7] According to respondents-defendants, the DOH found at least 68 nursing homes that saw increases in their case mix adjustments or saw their adjustments stay the same after the implementation of the "average calculation."

Further, respondents-defendants contend that petitioners-plaintiffs' argument that the "average calculation" violates Public Health Law § 2807(3) does not consider the DOH's overall statutory obligation to administer Medicaid funds properly, protect the public fisc, and avoid fraud and waste. In that regard, respondents-defendants aver that the Legislature's underlying intent in passing Article 28 of the Public Health Law "was to control spiraling costs of Medicaid services consuming taxpayer dollars at a rate that was burgeoning and mind-boggling." Moreover, respondents-defendants assert that Public Health Law § 2807(3) does not require rates to cover a facility's actual cost, and submit that "rates are considered reasonable and adequate so long as they reimburse the necessary costs of efficiently and economically operated facilities." Moreover, respondents-defendants maintain that petitioners-plaintiffs' assertion that the estimated Medicaid savings of $246 million[8] from the "average calculation" is just a rate cut in disguise is speculative and fails to acknowledge the DOH's well-documented basis for the calculation change, which is to create a more accurate case mix measurement that better address fraud and abuse.

Citing *Matter of Adirondack Health-Uihlein Living Ctr. v. Shah*, respondents-defendants contend that the petitioners-plaintiffs do not have standing to challenge the new "average calculation" based on the failure of the Department to obtain federal CMS approval of the SPA before implementing the calculation change (125 A.D.3d 1366, 1369 [4th Dep't 2015]). Respondents-defendants argue that, in any event, there is no requirement that the DOH obtain SPA approval before implementing the "average calculation" change. According to respondents-defendants, only "material changes" need to be reported to and approved by CMS, and because

[8] Respondents-defendants note that once implemented, the actual savings from the "average calculation" were projected by Department to be $144 million.

DOH's alteration to the calculation of the case mix adjustment is not a "material change" to the State Medicaid Plan that requires a SPA, the change does not require federal CMS approval.[9]

Respondents-defendants submit that even if the new "average calculation" was deemed a "material change," the DOH does not need SPA approval from CMS to implement the change. In that regard, they maintain that it would be untenable for the DOH to await approval from CMS before making any changes to its Medicaid Program, as CMS routinely takes upwards of a year to approve SPAs. Respondents-defendants assert that the DOH is free to implement Medicaid changes prior to CMS approval, operating at its own risk, and if CMS later declines to approve a SPA, the Department would be fiscally responsible for making the appropriate rate adjustments.

Respondents-defendants contend that the *Autumn View* and *Mayfair* petitioners-plaintiffs' SAPA claims fail because the Department's application of the "average calculation" is not a "rule," and therefore, the DOH was not required to engage in administrative rulemaking. According to respondents-defendants, SAPA applies only to an agency's adoption of a "rule," and a "rule" is defined under SAPA § 102(2)(a), in pertinent part, as "the whole or part of an agency statement, regulation or code of general applicability that implements or applies law." They submit that a "rule or regulation is a fixed, general principle to be applied by an administrative agency without regard to the other facts and circumstances relevant to the regulatory scheme of the statute it administers," while "an administrative determination is an interpretative statement when it relies on and constitutes a reasonable interpretation of existing regulations or statutes" (*Matter of Entergy Nuclear Indian Point 2, LLC v. New York State Dep't of* State, 983 N.Y.S.2d 202, 202 [Sup. Ct., Albany County 2013]).

[9] Respondents-defendants claim that the DOH is not changing anything beyond the way the agency itself reviews and analyzes acuity data, and is merely applying a more accurate and fraud proof way to compute case mix adjustments.

Respondents-defendants argue that the Department's implementation of a new method of calculating the case mix adjustment is not a rule change because "it merely interprets existing statutory and regulatory authority that vests the DOH with discretion over the manner in which [case mix] adjustments are undertaken." They claim that neither Public Health Law § 2808 nor 10 N.Y.C.R.R. §86-2.40(m) set forth a specific calculation or formula by which the DOH is to calculate case mix adjustments, or define the specific data to be used by the DOH in the calculation. As such, respondents-defendants contend that "the DOH's implementation of the 'average calculation' is just an interpretive statement." Respondents-defendants also submit that the "general policy" exception also insulates the "average calculation" from a SAPA challenge because "a statement of general policy" which "has no legal effect [and] is merely explanatory," "is not considered a rule" under SAPA. On both points, they maintain that the "average calculation" draws from the same acuity data pool as the "snapshot" method, changes nothing on the nursing homes' side, as facilities continue to bear the same legal and regulatory responsibilities to provide acuity services to patients, as needed, and to periodically document and report assessments for rate adjustment purposes, and only changes the manner in which the DOH reviews and calculates the data to establish a rate adjustment.

Respondents-defendants argue that the *Autumn View* plaintiffs-petitioners' claims based on violations of their procedural and substantive due process rights are meritless for the same reasons respondents-defendants articulated in opposition to their claim for Article 78 relief. Furthermore, respondents-defendants assert that to succeed on a substantive due process claim, the *Autumn View* petitioners-plaintiffs were required to show that there is no reasonable relationship to be perceived between the new "average calculation" and the achievement of a legitimate governmental purpose. Again citing *Matter of Adirondack Health-Uihlein Living Ctr. v. Shah*, respondents-defendants maintain that the DOH "has a legitimate governmental purpose of assuring

that Medicaid funds will not be fraudulently diverted into the hands of an untrustworthy provider of services" (125 A.D.3d at 1369-1370).

Contending that the basis for petitioners-plaintiffs' requests for declaratory relief are substantively identical to their CPLR Article 78 claims, defendants-respondents argue that those causes of action should be dismissed for the same reasons articulated in their opposition to the petitioners-plaintiffs' CPLR Article 78 petitions. Moreover, respondents-defendants submit that to the extent that the petitioners-plaintiffs are seeking application of a permanent injunction, those applications should be denied for all of the reasons stated in their opposition to the petitions and for the reasons set forth in their opposition to the petitioners-plaintiffs' prior application for a preliminary injunction. Finally, respondents-defendants argue that the *Mayfair* verified petition and complaint must be dismissed as against the DOB Director because outside of naming the DOB Director by title in the case caption, the *Mayfair* petitioners do not assert any substantive allegations against the DOB Director or set forth a basis upon which the Director is in this case, and specifically, have not alleged any involvement of the DOB Director in the implementation of the "average calculation."

In reply and opposition to defendants-respondents' motion for summary judgment, *LeadingAge* petitioners-plaintiffs clarify that their arguments concerning the 2019 Budget mandate is not that the workgroup had "a conditional right of approval over the DOH's actions," but rather that the respondents-defendants failed to consult the workgroup and consider its recommendations. According to the *LeadingAge* petitioners-plaintiffs, the workgroup was tasked in the 2019 Budget legislation with reviewing data and making recommendations before Commissioner Zucker and the DOH implemented their new methodology, and all that was required of the respondents-defendants was that they provide the workgroup with information and consider its recommendations. *LeadingAge* petitioners-plaintiffs contend that despite the claim that their

actions were fully consistent with the budget mandate and even went beyond the legislative requirements, respondents-defendants did not share required information with the workgroup or permit its analysis and input, as the Legislature intended, but instead pressed forward with their methodological change without participating in a meaningful way with the workgroup.[10] As such, *LeadingAge* petitioners-plaintiffs argue that respondents-defendants clearly violated the Legislature's specific statutory directives.

LeadingAge petitioners-plaintiffs claim that the Legislature's clear intent in requiring case mix adjustments to be made "in January and July of each calendar year" (Public Health Law § 280[2-b][b][ii]) was to require the DOH to use the most recent available data so that nursing homes' reimbursements would more closely reflect their costs from the six months prior to the adjustment, rather than their expenditures from earlier periods. Consequently, they submit that the DOH's regulations provide for those adjustments to be based on "Medicaid-only case mix data applicable to the previous case mix period" (10 N.Y.C.R.R. § 86-2.40[m][6]), noting that in the approved State Medicaid Plan, the Department explained the language "use Medicaid-only case mix data applicable to the previous case mix period" as follows: "e.g., July 1, 2012, case mix adjustment will use January 2012 case mix data, and January 1, 2013, case mix adjustment will use July 2012 case mix data."

LeadingAge petitioners-plaintiffs assert that despite the clear statutory time frame, confirmed by respondents-defendants' own statements and prior practice, respondents-defendants now claim that 10 N.Y.C.R.R. § 86-2.40(m) does not define what the "data applicable to the

[10] Petitioners-plaintiffs point to the letters from the Senate Majority, Assembly Health Committee, and Assembly Minority Leader to the Governor, DOB Director, and Deputy Secretary for Health, which they contend make clear that the 2019 Budget legislation required the workgroup to provide "analysis and input" before "the administration moved forward." They also submit that the Legislature's delayed implementation of the methodological change until the workgroup delivered its recommendations was "[p]lainly . . . to provide an opportunity for meaningful input and consultation."

previous case mix period" is, and maintain that the Legislature left that to their discretion. *LeadingAge* petitioners-plaintiffs argue that such an interpretation would render the Legislature's requirement that case mix adjustments be made every six months meaningless. They also submit that using lengthier data from a stale time frame more than six months before an adjustment frustrates the legislative intent, which is to provide reimbursements that are reflective of their more recent acuity data, i.e., costs of care.

Additionally, *LeadingAge* petitioners-plaintiffs argue that the requirement in 10 N.Y.C.R.R. § 86-2.40(m)(6) that the case mix adjustment "use Medicaid-only case mix data applicable to the previous case mix period" prohibits the use of the stale data respondents intend to utilize to calculate the case mix adjustment. Furthermore, they maintain that the "disharmony with the other provisions of the [Public Health Law] and regulations" and the "absurd results" would only occur through the implementation of respondents-defendants' new methodology relying on a six-month average, rather than a "snapshot." Moreover, as to respondents-defendants' claim that it would not be feasible to implement the new "average calculation" using data from days immediately prior to the date the rate goes into effect, petitioners-plaintiffs contend that such fact merely demonstrates that the new methodology is at odds with other applicable law. And petitioners-plaintiffs question why the Department specifically requested to amend the State's Medicaid Plan with respect to the calculation of the case mix adjustment for July 1, 2019 to include data outside of the immediately preceding six months, if respondents-defendants have always been permitted to do so.

Next, *LeadingAge* petitioners-plaintiffs contend that respondents-defendants' claim that they are not changing their methodology is belied by their admissions in SPA #19-0033 that the "State Plan Amendment proposed to establish a new methodology for the MDS data in the calculation of the case mix index," and their January 29, 2020 notice of proposed rulemaking,

wherein the DOH stated that "the proposed regulations will amend section 86-2.40 . . . and codify the Department's revised methodology for establishing nursing home Medicaid reimbursement rate[s] of payment for patient acuity." They also argue that the fact that the DOH may have used data from 92 days before and 13 days after the "snapshot" date is of no moment because the look back and look forward were merely used to obtain relevant data for a particular resident on "snapshot" date; the "snapshot" date itself was within the six months prior to the case mix adjustment. Moreover, *LeadingAge* petitioners-plaintiffs submit that the workgroup did not endorse the practice of using stale data, and assert that the workgroup's proposal to use data from periods outside the six months immediately preceding the adjustment date as part of the temporary methodology for July 2019, January 2020, and July 2020 adjustments, while the parties worked to transition to the RUG-IV 48-Group model for measuring patient acuity, does not demonstrate support for the respondents-defendants' position that such practices are an appropriate component of a permanent methodology.

Reiterating their argument that the new methodology does not satisfy the Legislature's mandate in Public Health Law § 2807(3) that reimbursement rates must be adequate to cover the costs of efficiently and economically operated facilities, *LeadingAge* petitioners-plaintiffs maintain that they have "supplied voluminous evidence" that cutting nursing home reimbursement rates by $246 million will reduce rates below what is adequate to cover nursing homes' costs. They dispute respondents-defendants' assertion that the "average calculation" is an "indisputably more accurate measure" of patient acuity, contending that the DOH has not offered any proof that the new methodology adequately compensates New York's nursing homes and does not even attempt to explain how a cut that they concede affects 90% of New York's nursing homes leaves Medicaid rates adequate under the Public Health Law.

Because they make no claims under 42 U.S.C. § 1983 or any federal statute, and are challenging the DOH respondents-defendants determination to implement the new methodology without CMS approval under CPLR Article 78 on the ground, among others, that it is contrary to federal regulation, *LeadingAge* petitioners-plaintiffs assert that they have standing under Article 78. *LeadingAge* petitioners-plaintiffs also argue that CMS approval is clearly required prior to DOH respondents-defendants' implementation of the methodology change. According to petitioners-plaintiffs, federal law requires "material" alterations to the State's approved Medicaid Plan to be submitted to CMS. They submit that the decrease in Medicaid reimbursement rates here, an approximate 22% cut to 90% of the State's nursing homes by respondents-defendants own admission, is "material."

Further, *LeadingAge* petitioners-plaintiffs contend that CMS has unequivocally told respondents-defendants that "[f]ederal statute and regulations require CMS to review and approve SPAs for consistency with the requirements of [§] 1902(a) of the Social Security Act . . . before a State may implement Medicaid program modifications," and that courts have stated that when a rate change constitutes a change to the Medicaid State Plan, federal regulations require federal approval before the change may be enforced. *LeadingAge* petitioner-plaintiffs maintain that respondents-defendants position that CMS approval is not required is contradicted by their prior admissions regarding the "new methodology, and their actions in preparing a SPA, providing public notice of the SPA, and submitting it to CMS for approval."

As to the 5% cap on changes to the case mix adjustments provided for in 10 N.Y.C.R.R. §86-2.40(m)(10), *LeadingAge* petitioners-plaintiffs point out that when the DOH defendants-respondents promulgated the rule, they did not claim that the 5% limit was "wholly permissive" and within the Department's "sound discretion," but instead created a "safeguard" to limit rate changes pending an audit. They submit that until the recent change in the methodology for case

mix adjustments, the DOH had always limited any case mix adjustment, plus or minus, to 5%, and contend that bypassing the 5% cap in the calculation of nursing homes' July 1, 2019 case mix adjustment is inconsistent with the Department's prior practice since 10 N.Y.C.R.R. § 86-2.40(m) was adopted in 2014.

Moreover, *LeadingAge* petitioners-plaintiffs argue that respondents-defendants' own submissions demonstrate that their new methodology was the product of financial engineering designed to arrive at a predetermined outcome. According to the *LeadingAg*e petitioners-plaintiffs, defendants-respondents' claim that the use of the "snapshot" calculation" was not "an accurate measure of acuity for rate adjustment purposes" and assertion that the "only logical explanation" for the "unprecedent 52% increase in CMI rate adjustments" is that nursing homes were "backloading patient acuity services to correspond with the data review months to artificially manipulate their CMI adjustment" are conclusory, and have not been supported with underlying data. They contend that the more logical explanation for the "fraud and abuse" perceived by the respondents-defendants is that the case mix naturally fluctuated due to "patient deterioration, increased resource utilization, and patient care." *LeadingAge* petitioners-plaintiffs assert that respondents-defendants "may not resort to an indiscriminate, across-the-board policy change that penalizes all [nursing homes] for the alleged bad actions of a few," and submit and that "if there are issues with a nursing home's reporting of resident acuity, the solution in the Public Health Law is an OMIG audit," not industry-wide rate cuts.

Autumn View plaintiffs-petitioners, in reply and opposition to Commissioner Zucker's motion for summary judgment, assert that summary judgment must be denied because the Commissioner failed to make a prima facie showing of entitlement to summary judgment, dismissing their causes of action alleging a SAPA violation, for a declaration that the Commissioner violated 10 N.Y.C.R.R. § 86-2.40(m)(6) and Public Health Law § 2808(2-b), and

claiming procedural and substantive due process rights violations. They contend that even if Commissioner Zucker's initial burden had been met, there are facts material to their claims that are in dispute.

Preliminarily, *Autumn View* plaintiffs-petitioners assert that Commissioner Zucker has failed to demonstrate, in the first instance, that his changes to the case mix adjustment methodology were not an unpromulgated rule. Citing SAPA § 102(2)(a) and *Plainview-Old Bethpage Congress of* Teachers (140 A.D.3d 1329, 1331 [3d Dep't 2016]), *Autumn View* plaintiffs-petitioners contend that a "'rule' is an agency stance, methodology, policy or action of general applicability applied without respect to individual circumstances, and specifically includes changes in methodology in relation to long-term care rates." According to *Autumn View* plaintiffs-petitioners, Commissioner Zucker's own submissions show that his changes to the case mix adjustment methodology will be generally applicable to all nursing homes and will apply without regard to individual facts and circumstances, i.e., the Commissioner is not limiting the methodology to only those nursing homes allegedly suspected of abuse.

Autumn View plaintiffs-petitioner further submit that there are issues of fact as to whether Commissioners Zucker's changes to the case mix adjustment methodology constituted an unpromulgated rule. In that regard, they maintain that in March 2019, the DOH announced in the State Register its plan to cut case mix adjustment reimbursements statewide to achieve a budget savings of $191 million; claim that the Department attempted to include the methodology change in the 2019-2020 State Budget legislation and when that effort failed, the DOH, unilaterally and ignoring the workgroup's input, included the change in a proposed SPA submitted to CMS; and note that the Department published notice in the State Register in January 2020 proposing to formalize the new methodology for case mix adjustments as a regulation, retroactive to July 2019.

Autumn View plaintiffs-petitioners assert that DOH, by its own actions, has created a question as to whether its changes to the case mix adjustment are subject to SAPA and formal rulemaking.

In addition, *Autumn View* plaintiffs-petitioners contend that by Commissioner Zucker's own admissions, the DOH ignored the data gathering periods set forth in 10 N.Y.C.R.R. § 86-2.40(m)(6) and imposed a new initial gathering period of eight months and subsequent gathering periods outside the prior six-month case mix period, departing from its previous, decade-old application of § 86-2.40(m)(6) and, effectively, conceding that the DOH's actions violate the regulation. They maintain that Commissioner Zucker "makes no real effort to conceal his motivation for this methodology, dressing it up as a measure to address alleged fraud and abuse, but failing to offer any proof in that regard." *Autumn View* plaintiffs-petitioners also aver that the DOH instructed nursing homes for years to maximize CMI and now, at the Department's whim, no longer wishes to abide by the very 5% cap that had been in place as a safety valve, protecting both the public fisc and nursing homes in the case of large swings in case mix adjustments. And *Autumn View* plaintiffs-petitioners assert that they are entitled to discovery, pursuant to CPLR 3212(f), of any alleged proof to support Commissioner Zucker's claim that case mix adjustment changes are to target fraud and abuse.

Moreover, *Autumn View* plaintiffs-petitioners contend that Commissioner Zucker made no attempt to address their procedural and substantive due process claims on the merits, arguing instead that those claims are duplicative of plaintiffs-petitioners' other claims. *Autumn View* plaintiffs-petitioners assert that their due process claims are not duplicative as they seek vindication of rights conferred by the state and federal constitutions, and further that they are entitled to assert claims in the alternative. *Autumn View* plaintiffs-petitioners also submit that Commissioner Zucker's speculation that they will be unable to prove their due process claims is not a basis upon which the Court can grant him summary judgment.

As to their Article 78 claims, *Autumn View* plaintiffs-petitioners argue that if the Court is inclined to defer to the DOH at all, it should defer to the Department's prior methodology for case mix adjustments, which were applied for a decade, rather than the new methodology "adopted by fiat" to achieve a pre-determined budget cut of $246 million. Additionally, they contend that the Legislature directed the DOH Commissioner to make case mix adjustment changes, if at all, in conjunction with the workgroup, not despite it as Commissioner Zucker did here. Furthermore, *Autumn View* plaintiffs-petitioners submit that they are not challenging the DOH's failure to obtain CMS approval of its proposed SPA, but instead are asserting, among other things, that Commissioner Zucker's failure to obtain CMS approval establishes that the DOH acted arbitrarily and capriciously in implementing its novel case mix adjustment methodology. Thus, they maintain that Commissioner Zucker's reliance on *Matter of Adirondack Health-Uihlein Living Ctr. v. Shah* is misplaced.

In reply and opposition to respondents-defendants and the DOB Director's motion for summary judgment, *Mayfair* petitioners do not dispute that the DOH has broad discretionary authority to interpret both regulations and statutes within the Department's expertise. They argue, however, that "[g]iven the lack of compliance with the [w]ork[]group requirements of the [2019 Budget] [L]aw, the Commissioner's interpretations of statute or regulation are not entitled to deference." *Mayfair* petitioners also assert that respondents-defendants have not articulated a basis for their conclusion that nursing homes have somehow "gamed" the system or that the use of older, stale patient acuity data in the calculation will somehow improve the accuracy of the case mix adjustment.

Furthermore, *Mayfair* petitioners contend that the revised methodology has not been justified as a reasonable interpretation of the existing statutory mandates, and is not in accord with the clear language of the current regulations, which mandate the use of semi-annual MDS

submissions and direct respondents-defendants to limit changes in the adjustment to 5% pending audit. As such, they claim that the actions of respondents-defendants in creating, adopting, and implementing rates using the new methodology are arbitrary, capricious, and affected by an error of law.

Moreover, *Mayfair* petitioners argue that respondents-defendants incorrectly conclude that implementation of the new methodology is not a violation of SAPA. *Mayfair* petitioners contend that use of the multiperiod "average" as opposed to the "snapshot" is a "regulatory revision" because it is violative of the regulatory requirements to use the prior period data and limit changes to no greater than 5%, and as such, the DOH is required to promulgate a revised regulation. Lastly, *Mayfair* petitioners aver that they properly pleaded the DOB Director as a party to their proceeding and action based on his authority under the Public Health to approve rates, and because they assert a claim under Public Health Law § 2807(3) related to the sufficiency of reduced rates resulting from the DOH's new case mix adjustment methodology.

In reply to the oppositions to their motions, respondents-defendants argue that petitioners-plaintiffs fail to raise anything new with respect to their claims, and that "[t]he only noteworthy characteristics of their oppositions are, among other things, "their forced concessions throughout and the extent to which they backpedal from their initial . . . arguments to a weaker stance as a result of these concessions." Further, respondents-defendants contend that the petitioners-plaintiffs' opposition does not "establish anything more compelling than a preference for one alternate calculation method."

As to the claim that Commissioner Zucker and the DOH violated the Legislature's mandate by acting before receiving the workgroup's input, respondents-defendants contend that the "[p]etitioners[-plaintiffs] now argue that it is not 'consideration' of the workgroup's recommendations they were looking for, but, instead, 'real engagement' with the workgroup and

a 'substantive process.'" Respondents-defendants argue that such argument holds no merit as "[t]he terms 'real engagement' and 'substantive process' were not contemplated by the Legislature in creating the workgroup and appear nowhere in the 2019 Budget Law." They also assert that those "vague" concepts go far beyond the Legislature's mandate to "convene and chair a workgroup" that "may" offer recommendations," and submit that the Legislature does not posses power under the State Constitution to impose an ambiguous obligation on an executive agency to submit to "real engagement" or a "substantive process" with an industry workgroup.

With respect to petitioners-plaintiffs' claim that data from eight months back would be "stale" and "outdated," respondents-defendants again point out that the petitioners-plaintiffs' "own workgroup was prepared to use data from an even more antiquated look back period." Thus, respondents-defendants assert that petitioners-plaintiffs "cannot be heard to argue the ills of DOH's using eight-month old data." Respondents-defendants further submit that petitioners-plaintiffs "cannot plausibly argue that the DOH 'is required by law' to use only data from the immediately preceding six-months – while simultaneously conceding that the DOH has long used data from more than 9-months to calculate the 'snapshot.'"

As to petitioners-plaintiffs' arguments concerning the 5% "cap" or "circuit breaker," respondents-defendants aver that "[a]n agency's use of its regulatory discretion is not *per se* indicative of its arbitrariness, capriciousness or irrationality," and maintain that such discretion is vested with the DOH, to be applied when the Department deems necessary. Respondents-defendants submit that the DOH determined, based upon review of reimbursement data, that unexplained and significant increases to nursing home acuity in reporting months was likely the result of fraudulent backloading, and that using the average of all data was the more accurate tool to calculate the case mix reimbursement. Therefore, they contend that it was within the

Department's discretion whether to apply the 5% rule, and maintain that the DOH is entitled to a high degree of deference, as it was acting in the area of its particular expertise.

Respondents-defendants assert that they have provided ample data, showing significant variations in acuity services that occurred during the "snapshot" reporting months, which was explained as "systemic provider fraud from the back[loading] of acuity services during reporting months" in order to "manipulate the 'snapshot' calculation." Respondents-defendants submit that the "[o]pposition cannot account for these significant variations, which alone provide a rational basis for the DOH's decision to move on from 'snapshot' and adopt the new average formula." They maintain that the petitioners-plaintiffs now change their argument from a claim that the DOH has no evidence of abuse to a claim that the evidence is "unsubstantiated and speculative," and now argue that by addressing perceived fraud, the DOH is "seeking to usurp" the OMIG's role, and "should leave evidence of fraud exclusively to [the] OMIG." Respondents-defendants argue that these contentions lack merit.

Respondents-defendants aver that the DOH's determination to adopt the "average calculation" was based on a detailed study of case mix adjustment increases between 2015 and 2018, and that the Department determined, in its judgment and expertise, that the only logical explanation for such increases only in reported months was some nursing homes were thumbing the scale by backloading acuity services. They further assert that even assuming the increase in acuity services during the reporting month is a coincidence, "the use of more data for the average calculation is still a more accurate and fair representation of a [nursing home's] case mix in a given period" than looking at a single day's worth of information.

Moreover, Respondents-defendants maintain that the DOH is not usurping the OMIG's authority by altering the case mix adjustment calculation to root out Medicaid fraud. Respondents-defendants contend that by the express terms of the OMIG's statutory mandate, the OMIG is tasked

with working collectively with the DOH, and vice versa, to prevent Medicaid fraud and protect public funds, and that the DOH, as the single State agency responsible for administering the State's Medicaid Program, is obligated to oversee and administer Medicaid funds properly, protect the public fisc, and avoid fraud and waste. According to respondents-defendants, the Department responded to strong evidence of systemic fraud by adopting a "more accurate calculation," thus, "[t]o say that DOH cannot make a change until the OMIG finds and prosecutes system-wide fraud is illogical, contrary to law and does not protect Medicaid funds."

With respect to petitioners-plaintiffs' challenge to the "average calculation" on the grounds that it violates federal law because DOH did not obtain CMS approval of a SPA before implementing the change, respondents-defendants argue that CPLR Article 78 does not operate here to create a private right of action and standing that does not otherwise exist. In that regard, they note that *Matter of Adirondack Health-Uihlein Living Ctr. v. Shah* was also a CPLR Article 78 proceeding, and submit that the Fourth Department did not find anything about the Article 78 mechanism that conferred standing to enforce the requirement of federal approval of a SPA.

Furthermore, respondents-defendants claim that their "underlying papers demonstrate that SAPA is inapplicable because DOH's adoption of a new internal calculation model is not a formal rulemaking, but an interpretive statement. As to *Mayfair* petitioner's assertion that the "average calculation" is a "regulatory revision" because it violates, among other things, the 5% requirement, respondents-defendants argue that "the 5% rule is plainly permissive and not a 'requirement' that DOH can violate." With respect to *Autumn View* plaintiffs-petitioners contention that the "average calculation" must constitute a regulatory change because it results in a large reduction to Medicaid reimbursement, respondents-defendants submit that whether something is a "regulatory change" or "interpretive statement" under SAPA is not based on the ultimate impact of the change, and that

"[c]hanging the technique that an agency uses to internally analyze data does not trigger compulsory rulemaking under SAPA."

Moreover, respondents-defendants aver that the DOH's "adoption of the new average calculation is not a methodological change for purposes of SAPA or CPLR Article 78; it is not rulemaking" and "does not change anything but the manner that the DOH internally interprets the same CMI data." As such, they contend that reference to the adoption of the "average calculation" as a "formula," a "calculation," a "methodology," a "technique," a "model," or any other synonymous term "is purely semantics" because "all of these terms are being used to describe the same thing; DOH's internal process to calculate CMI data." Respondents-defendant claim that their use of the terms "method" or "methodology" in prior briefings as a descriptor for the "average calculation" is not a concession as to the legal use of the terms under SAPA or CPLR Article 78.

Regarding *Autumn View* plaintiffs-petitioners assertion that the respondents-defendants failed to meaningfully address their procedural and substantive due process arguments, respondents-defendants contend that plaintiffs-petitioners' due process claims are premised on the exact same facts and allegations as their CPLR Article 78 claims, and do not set forth anything new. Respondents-defendants submit that by stating "as set forth above" to make out these claims, *Autumn View* plaintiffs-petitioners acknowledged that their due process claims turn on the same allegations as their CPLR Article 78 claims. In the interest of avoiding redundancy, respondents-defendants maintain that their underlying papers do not repeat in the due process sections each and every argument covered in the Article 78 sections of their brief.

According to respondents-defendants, *Autumn View* plaintiffs-petitioners "seem to confuse [their] reliance on prior arguments as a claim that [plaintiffs-p]etitioners are not permitted to assert . . . [d]ue [p]rocess arguments." Respondents-defendants contend that *Autumn View* plaintiffs-petitioners are entitled to assert whichever claims they deem cognizable, and explain that "if the

alternative claims are founded on the exact same factual and legal grounds as the primary grounds, then failure for one means failure for all."

Lastly, respondents-defendants argue that the *Mayfair* petitioners' attempt to cure their pleading deficiency with respect to the DOB Director in their summary judgment opposition papers is "an unsanctioned attempt to amend a pleading in the eleventh hour to fix a dispositive failure."

DISCUSSION

As an initial matter, the Court declines to dismiss the *Mayfair* proceeding and action as against the DOB Director. While the verified petition and complaint in *Mayfair* does not include any substantive allegations against the DOB Director or articulate any involvement of the Director in the implementation of the Department's new "average calculation," it does allege that the DOB Director "is responsible for approval of the Medicaid rates of payment for services rendered to Medicaid recipients by residential health care facilities pursuant to [the] Public Health Law," and asserts, as a cause of action, a violation of Public Health Law § 2807(3) based on "revenue reductions to [p]etitioners[ ] due to the case mix adjustments in excess of 5%," which they claim "will overwhelm the ability [to] efficiently and economically operate their facilities." Thus, the DOB Director has been properly included as a party (*see e.g., Leeman v. O'Connell,* 115 N.Y.S.2d 163, 164 [Sup. Ct., Albany County 1952]).

Turning to the merits of petitioners-plaintiffs' claims, "[t]he standard of review applicable to an administrative action such as that taken here by respondents[-defendants] is whether [the action] had a rational basis in the record, and was not unreasonable, arbitrary or capricious" (*Matter of St. James Nursing Home v. De Buono*, 12 A.D.3d 921, 923 [3d Dep't 2004]; *see* CPLR § 7803; *Kuppersmith v. Dowling*, 93 N.Y.2d 90, 96 [1999]; *Matter of County of Monroe v. Kaladjian*, 83 N.Y.2d 185, 189 [1994]). "An action is arbitrary and capricious when it is taken

without sound basis in reason or regard to the facts "(*Matter of Murphy v. New York State Div. of Hous. & Community Renewal*, 21 N.Y.3d 649, 652 [2013][internal quotation marks and citation omitted]; *see Matter of Pell v. Bd. of Educ. of Union Free Sch. Dist. No. 1 of Towns of Scarsdale & Mamaroneck, Westchester County*, 34 N.Y.2d 222, 231 [1974]; *Matter of Heintz v. Brown*, 80 N.Y.2d 998, 1001 [1992]; *Matter of Grella v. Hevesi*, 38 A.D.3d 113, 116 [3d Dep't 2007]). A rational basis will be found where the action is supported "by proof sufficient to satisfy a reasonable [person], of all the facts necessary to be proved in order to authorize the action" (*Matter of Pell v. Bd. of Educ. of Union Free Sch. Dist. No. 1 of Towns of Scarsdale & Mamaroneck, Westchester County*, 34 N.Y.2d at 231 [internal quotation marks and citation omitted]).

In an Article78 proceeding, "a court may not substitute its judgment for that of the [administrative official or agency] . . . unless the [action] under review is arbitrary and unreasonable" (*Matter of Perez v. Rhea*, 20 N.Y.3d 399, 405 [2013]; *accord Matter of Pell*, 34 N.Y.2d at 230-231). Further, if "the judgment of the agency involves factual evaluations in the area of the agency's expertise and is supported by the record, such judgment must be accorded great weight and judicial deference" (*Matter of Flacke v. Onondaga Landfill Sys.*, 69 N.Y.2d 355, 363 [1987]). Moreover, "[w]here . . . the 'interpretation of a statute or *its application* involves knowledge and understanding of the underlying operational practices or entails an evaluation of factual data and inferences to be drawn therefrom, the courts regularly defer to the government agency charged with the responsibility for administration of the statute'" (*Town of Lysander v. Hafner*, 96 N.Y.2d 558, 564-565 [2001], quoting *Kurcsics v. Merchants Mut. Ins. Co.*, 49 N.Y.2d 451, 459 [1980][emphasis in original]).

"Generally[,] the construction given statutes and regulations by the agency responsible for their administration will be upheld if not irrational or unreasonable" (*Matter of St. James Nursing Home v. Axelrod*, 135 A.D.2d 26, 29 [3d Dep't 1988]). To that end, the "DOH is entitled to a

'high degree of judicial deference, especially when . . . act[ing] in the area of its particular expertise'" (*Matter of Nazareth Home of the Franciscan Sisters v. Novello,* 7 N.Y.3d 538 544 [2006], quoting *Matter of Consolidation Nursing Home v. Comm'r of New York State*, 85 N.Y.2d 326, 331-332 [1995]). As such, "rate-setting actions of the [DOH] Commissioner, being quasi-legislative in nature, may not be annulled except upon a compelling showing that the calculations from which they were derived were unreasonable" (*Matter of Nazareth Home of the Franciscan Sisters v. Novello*, 7 N.Y.3d at 544 [internal quotation marks, brackets, and citation omitted]; *see New York Ass'n of Counties v. Axelrod*, 78 N.Y.2d 158, 166 [199]; *Matter of St. James Nursing Home v. De Buono,* 12 A.D.3d at 923).

Moreover, summary judgment is a drastic remedy which should only be granted when it is clear that there are no triable issues of fact (*see Andre v. Pomeroy*, 35 N.Y.2d 361, 364 [1974]). "[T]he proponent of a summary judgment motion must make a prima facie showing of entitlement to judgment as a matter of law, tendering sufficient evidence to demonstrate the absence of any material issues of fact" (*Alvarez v. Prospect Hosp.,* 68 N.Y.2d 320, 324 [1986]; *see Deleon v. New York City Sanitation Dep't*, 25 N.Y.3d 1102, 1106 [2015]; *Vega v. Restani Const. Corp.*, 18 N.Y.3d 499, 503 [2012]; *Winegrad v. New York Univ. Med. Ctr.*, 64 N.Y.2d 851, 853 [1985]; *see also* CPLR 3212[b]). The "[f]ailure to make such a prima facie showing requires denial of the motion, regardless of the sufficiency of the opposing papers" (*Alvarez v. Prospect Hosp.,* 68 N.Y.2d at 324; *see Vega v. Restani Const. Corp.*, 18 N.Y.3d at 503; *Winegrad v. New York Univ. Med. Ctr.*, 64 N.Y.2d at 853).

It is only when the moving party has demonstrated a right to judgment as a matter of law that the burden shifts to the party opposing the motion to establish, by admissible proof, the existence of a genuine issue of material fact requiring trial of the action, or to demonstrate an acceptable excuse for the failure to do so (*see Zuckerman v. City of New York*, 49 N.Y.2d 557, 562

[1980]; CPLR 3212[b]). The Court's "function on a summary judgment motion is to view the evidence in the light most favorable to the party opposing the motion, giving that party the benefit of every reasonable inference" (*Barra v. Norfolk S. Ry. Co.*, 75 A.D.3d 821, 822-823 [3d Dep't 2010], quoting *Boyce v. Vasquez*, 249 A.D.2d 724, 726 [3d Dep't 1998]), and "decide only whether [any] triable issues have been raised" (*Barlow v. Spaziani*, 63 A.D.3d 1225, 1226 [3d Dep't 2009]; *see Boston v. Dunham*, 274 A.D.2d 708, 709 [3d Dep't 2000]).

Because the Court finds, upon a review of the record, that respondents-defendants' "average calculation" is an unpromulgated rule, nursing homes' Medicaid reimbursements rates based on that calculation announced by the DOH in the October 9, 2019 DAL are invalid and cannot be applied until the calculation is adopted as a rule through the State Administrative Procedure Act (*see Matter of Plainview-Old Bethpage Congress of Teachers v. New York State Health Ins. Plan*, 140 A.D.3d 1329, 1332 [3d Dep't 2016]; *Matter of Aurelia Osborn Fox Mem. Hosp. v. Axelrod*, 103 A.D.2d 509, 510-511 [3d Dep't 1984]).

"A 'rule' is defined by the State Administrative Procedure Act to include 'the whole or part of each agency statement, regulation or code of general applicability that implements or applies law, or prescribes . . . the procedure or practice requirements of any agency, including the amendment, suspension or repeal thereof'" (*Cubas v. Martinez*, 8 N.Y.3d 611, 621 [2007], quoting State Administrative Procedure Act § 102[2][a]; *accord Matter of Bd. of Educ. of the Kiryas Joel Vil. Union Free Sch. Dist. v. State of New York*, 110 A.D.3d 1231, 1233 [3d Dep't 2013]). However, "[s]pecifically exempted from the definition of rule under [SAPA] are 'forms and instructions, interpretive statements and statements of general policy which in themselves have no legal effect but are merely explanatory'" (*Matter of Elcor Health Servs. v. Novello*, 100 N.Y.2d 273, 279 [2003], quoting State Administrative Procedure Act § 102[2][b][iv]; *accord Matter of*

Bd. of Educ. of the Kiryas Joel Vil. Union Free Sch. Dist. v. State of New York, 110 A.D.3d at 1233).

Courts have said that a "rule or regulation" is a "'fixed, general principle to be applied by an administrative agency without regard to other facts and circumstances of the regulatory scheme of the statute it administers'" (*Cubas v. Martinez*, 8 N.Y.3d at 621, quoting *Matter of Roman Catholic Diocese of Albany v. New York State Dep't of Health*, 66 N.Y.2d 948, 951 [1985]); *see Matter of Connell v. Regan*, 114 A.D.2d 273, 275 [3d Dep't 1986]). "In contrast, interpretive statements and guidelines assist agency officials in exercising some aspect of their discretionary authority granted by existing statutes and regulations" (*Matter of Plainview-Old Bethpage Congress of Teachers v. New York State Health Ins. Plan*, 140 A.D.3d at 1331). In *Matter of Plainview-Old Bethpage Congress of Teachers v. New York State Health Ins. Plan*, the Third Department observed that

> [t]he primary difference between a rule or regulation and an interpretive statement or guideline is that the former set standards that substantially alter or, in fact can determine the result of future agency adjudications while the latter simply provide additional detail and clarification as to how such standards are met by the public and upheld by the agency (*id.*[internal quotation marks, brackets, and further citations omitted).

The Court rejects respondents-defendants argument that the DOH's implementation of the "average calculation" is not a rule change insofar as it merely interprets existing statutory and regulatory authority that vests the DOH with discretion over the manner in which CMI adjustments are undertaken. Even crediting respondents-defendants' assertion that neither the Public Health Law § 2808(2-b)(b)(ii) nor 10 N.Y.C.R.R. § 86-2.40(m) set forth a specific calculation or formula by which the DOH is to calculate the case mix adjustment or define the specific data DOH must use in making the calculation, the Court finds that the DOH's "average calculation" establishes a fixed, general principle for calculating case mix adjustments for all nursing homes, moving

forward, that substantially alters their Medicaid reimbursement rates without regard to their individual facts and circumstances (*see Matter of Morningside House Nursing Home Co. v. Comm'r of New York State Dep't of Health*, 206 A.D.2d 617 [3d Dep't 1994]; *Matter of Sunrise Manor Nursing Home v. Axelrod*, 135 A.D.2d 293, 298 [3d Dep't 1988]).

Moreover, even if the "average calculation" "effectively changes nothing on the providers' side" because they bear "the same legal and regulatory responsibilities to provide acuity services to patients and to periodically document and report assessments for rate adjustments" as respondents-defendants assert, the Court is simply not persuaded that the "average calculation" is "a statement of general policy that has no legal effect," and merely provides "additional details" and "clarification" regarding the case mix adjustment. It is a wholesale change in how such adjustments are made. Additionally, respondents-defendants' reliance on *Matter of Roman Catholic Diocese of Albany v. New York State Dep't of Health* to support its argument that the "guidelines" exception insulates the "average calculation" from SAPA is misplaced because the "50% guideline" in that case was one of several factors considered in approving applications to provide abortion services; it was not universally applied as the Department's new method for calculating the case mix adjustment is here.

Finally, it is worth noting that in implementing the recent changes in the Department's method for calculating the case mix adjustment, Commissioner Zucker and the DOH did not comply with the intent and spirit of the Legislature's mandate establishing the "Nursing Home Acuity Workgroup." While there is no question that the workgroup had no authority to control the Commissioner's or Department's actions, or overrule their determinations, with respect to the adoption of their new "average calculation" for case mix adjustments, a reading of the 2019 Budget legislation and the record in these matters make clear to this Court that the Legislature intended the workgroup's participation in the implementation of this new methodology to be substantive

and meaningful both leading up to the July 1, 2019 change and moving forward. By failing to engage the Workgroup in the process as the Legislature plainly intended, the Commissioner and Department wholly failed to comply with their statutory obligation, and that, in the Court's opinion, is inappropriate and disregards the mandate of the Legislature.

For these reasons, respondents-defendants' motions for summary judgment are denied, and the Court grants the petitions in *LeadingAge, Autumn View*, and *Mayfair, **only*** to the extent of annulling the Department's case mix adjustments effective July 1, 2019 rate; **and** enjoining the respondents-defendants from using the "average calculation" method they adopted effective for July 1, 2019 for the case mix adjustment and directing respondents-defendants to continue using the method for calculating the case mix adjustment in effect as of June 30, 2020, until the "average calculation" method is adopted as a rule in accordance with the State Administrative Procedure Act. Given this determination, the remaining arguments in the petitions and defendants-respondents' opposition and motions for summary judgment are denied as moot and/or academic.

Accordingly, it is hereby

ORDERED AND ADJUDGED, that respondents-defendants' motions for summary judgment are denied for the reasons stated herein; and it further

ORDERED AND ADJUDGED, that the petitions in *LeadingAge*, *Autumn View*, and *Mayfair,* are granted ***only*** to the extent of annulling the Department's case mix adjustments effective July 1, 2019; **and** enjoining the respondents-defendants from using the "average calculation" method they adopted effective July 1, 2019 for the case mix adjustment **and** directing respondents-defendants to continue using the method for calculating the case mix adjustment in effect as of June 30, 2020, until the "average calculation" method is adopted as a rule in accordance with the State Administrative Procedure Act; and is further

ORDERED AND ADJUDGED, that the remaining arguments in the petitions and defendants-respondents' opposition and motions for summary judgment are denied as moot and/or have been rendered academic by this determination.

This memorandum constitutes the Decision and Order/Judgment of the Court. The original Decision and Order/Judgment is being uploaded to the NYSCEF system for filing and entry by the Albany County Clerk. The signing of this Decision and Order/Judgment and uploading to the NYSCEF system shall not constitute filing, entry, service, or notice of entry under CPLR 2220 and § 202.5-b(h)(2) of the Uniform Rules for the New York State Trial Courts. Counsel is not relieved from the applicable provisions of those Rules with respect to filing, entry, service, and notice of entry of the original Decision and Order/Judgment.

SO ORDERED.

ENTER.

Dated: January 19, 2021
Albany, New York

Kimberly A. O'Connor

HON. KIMBERLY A. O'CONNOR
Acting Supreme Court Justice

Papers Considered:

1. (*LeadingAge*) Order to Show Cause (O'Connor, J.), October 24, 2019; Summons and Notice of Petition, dated October 24, 2019; Verified Petition and Complaint, dated October 24, 2019, with Exhibits A-G annexed; Affidavit in Support of Order to Show Cause of Stephen B. Hanse, sworn to October 24, 2019, with Exhibits A-J annexed; Affidavit of Carl Pucci, sworn to October 23, 2019, with Exhibits A-B annexed; Affidavit of Neil Heyman, sworn to October 22, 2019; Affidavit of Michael Balboni, sworn to October 23, 2019; Affidavit of Anastasios Markopoulos on behalf of Petitioner-Plaintiff Bethel Nursing & Rehabilitation Center, sworn to October 22, 2019, with Exhibits A-H annexed; Affidavit of Anastasios Markopoulos on behalf of

Petitioner-Plaintiff Bethel Nursing Home Company, sworn to October 22, 2019, with Exhibits A-H annexed; Affidavit of Mark L. Koblenz on behalf of Petitioner-Plaintiff Daughters of Sara Nursing Center, sworn to October 22, 2019, with Exhibits A-B annexed; Affidavit/Affirmation of David Rose on behalf of Petitioner-Plaintiff Eger Health Care and Rehabilitation Center, sworn to October 22, 2019, with Exhibits A-H annexed; Affidavit of David Fridkin on behalf of Petitioner-Plaintiff Island Nursing and Rehabilitation Center, sworn to October 22, 2019, with Exhibits A-H annexed; Affidavit of Anne R. Gallese on behalf of Petitioner-Plaintiff Kirkhaven, sworn to October 21, 2019, with Exhibits A-H annexed; Affidavit/Affirmation of Alexander Balko on behalf of Petitioner-Plaintiff Isabella Geriatric Center, sworn to October 23, 2019, with Exhibits A-H annexed; Affidavit of Michael S. King on behalf of Petitioner-Plaintiff Jewish Home of Rochester, sworn to October 21, 2019, with Exhibits A-H annexed; Affidavit/Affirmation of Marie Rosenthal on behalf of Petitioner-Plaintiff Jewish Home Lifecare, Manhattan, sworn to October 23, 2019, with Exhibits A-H annexed; Affidavit/Affirmation of Sandra Mundy on behalf of Petitioner-Plaintiff Jewish Home Lifecare Sara Neuman Center, Westchester, sworn to October 23, 2019, with Exhibits A-H annexed; Affidavit/Affirmation of Michael N. Rosenblut on behalf of Plaintiff Parker Jewish Institute for Health Care and Rehabilitation, sworn to October 21, 2019, with Exhibits A-H annexed; Affidavit/Affirmation of Stuart B. Almer on behalf of Petitioner-Plaintiff Gurwin Jewish Nursing & Rehabilitation Center, sworn to October 22, 2019, with Exhibits A-H annexed; Affidavit/Affirmation of Bonita Burke on behalf of Petitioner-Plaintiff Cabrini of Westchester d/b/a St. Cabrini Nursing Home, sworn to October 23, 2019, with Exhibits A-H annexed; Affidavit of Charles K. Runyon on behalf of Petitioner-Plaintiff St. John's Health Care Corporation, sworn to October 22, 2019, with Exhibits A-H annexed; Affidavit/Affirmation of Laurence LaDue on behalf of Petitioner-Plaintiff The Valley View Center for Nursing and Rehabilitation, sworn to October 23, 2019, with Exhibits A-H annexed; Affidavit of Terrence Gorman on behalf of Petitioner-Plaintiff St. Luke Residential Health Care Facility Inc., sworn to October 21, 2019, with Exhibits A-E annexed; Affidavit/Affirmation of CEO Stephen E. Knight on behalf of Petitioner-Plaintiff United Helpers Canton Nursing Home Inc. (Maplewood Health Care and Rehabilitation Center), sworn to October 21, 2019, with Exhibits A-H annexed; Affidavit/Affirmation of CEO Stephen E. Knight on behalf of Petitioner-Plaintiff United Helpers Nursing Home Inc. (Riverledge Health Care and Rehabilitation Center), sworn to October 21, 2019, with Exhibits A-H annexed; Memorandum of Law in Support of Motion for Preliminary Injunction and in Support of Verified Petition and Complaint, dated October 24, 2019;

2. Affirmation of C. Harris Dague, Esq., dated October 30, 2019, with Exhibit 1 annexed; Memorandum of Law in Opposition to Motion for Preliminary Injunction, dated October 30, 2019, with Exhibit 1 annexed; *and*
3. Reply Memorandum of Law in Further Support of Motion for Preliminary Injunction, dated October 31, 2019;
4. Correspondence from Cornelius D. Murray, Esq., dated February 14, 2020;
5. Verified Answer (*LeadingAge*), dated February 18, 2020;
6. Notice of Motion for Summary Judgment on the Declaratory Judgment Claims, dated February 18, 2020; Affidavit of Michael Ogborn, sworn to February 18, 2020, with Exhibits A-G annexed; Affirmation of C. Harris Dague, Esq., dated February 18, 2020,

with Exhibit 1 annexed; Combined Memorandum of Law in Opposition to the Article 78 Petitions and in Support of Respondents' Motion for Summary Judgment on Petitioners' Declaratory Judgment Claims, dated February 18, 2020, with Appendix A annexed;

7. Correspondence from C. Harris Dague, Esq., dated February 21, 2020;
8. Affidavit of Carl Pucci, sworn to May 27, 2020, with Exhibits A-G annexed; Reply Memorandum of Law in Further Support of Petition and in Opposition to Respondents-Defendants' Motion for Summary Judgment, dated May 29, 2020, with Appendix A and B annexed;
9. Respondents'/Defendants' Combined Reply Memorandum of Law in Further Support of their Motion Pursuant to CPLR 3212 for Summary Judgment on Petitioners'/Petitioners' Declaratory Judgment Claims, dated June 26, 2020;
10. Correspondence from C. Harris Dague, Esq., dated July 27, 2020;
11. (*Autumn View*) Notice of Petition, dated October 29, 2019; Summons, dated October 29, 2019; Amended Verified Petition and Complaint, dated January 30, 2020, with Exhibit A annexed; Affirmation of F. Paul Greene in Support of Verified Petition and Complaint, dated October 29, 2019, with Exhibit A (Affidavit in Support of Order to Show Cause of Stephen B. Hanse, sworn to October 24, 2019) annexed; Memorandum of Law in Support of Verified Petition (First Cause of Action for Article 78 Relief), dated January 13, 2020;
12. Verified Answer (*Autumn View*), dated February 18, 2019;
13. Notice of Motion for Summary Judgment on the Declaratory Judgment Claims, dated February 18, 2020; Affidavit of Michael Ogborn, sworn to February 18, 2020, with Exhibits A-G annexed; Affirmation of C. Harris Dague, Esq., dated February 18, 2020, with Exhibits 1 and 2 annexed; Combined Memorandum of Law in Opposition to the Article 78 Petitions and in Support of Respondents' Motion for Summary Judgment on Petitioners' Declaratory Judgment Claims, dated February 18, 2020, with Appendix A annexed;
14. Correspondence from C. Harris Dague, Esq., dated February 21, 2020;
15. Affidavit of Stephen M. Mercurio, RNMS, LNHA, CAS, in Opposition to Motion for Summary Judgment, sworn to May 27, 2020, with Exhibit A annexed; Affirmation in Opposition to Defendant-Respondent's Motion for Summary Judgment of F. Paul Greene, Esq., dated May 29, 2020, with Exhibits A-I annexed; Memorandum of Law in Opposition to Defendant-Respondent's Motion for Summary Judgment Concerning Petitioners' Declaratory Judgment Claims, dated May 29, 2020;
16. Respondents'/Defendants' Combined Reply Memorandum of Law in Further Support of their Motion Pursuant to CPLR 3212 for Summary Judgment on Petitioners'/Petitioners' Declaratory Judgment Claims, dated June 26, 2020;
17. Correspondence from C. Harris Dague, Esq., dated July 27, 2020;
18. (*Mayfair*) Notice of Petition, dated November 7, 2019; Verified Petition and Complaint, dated November 7, 2019;
19. Verified Answer (*Mayfair*), dated February 18, 2019;
20. Notice of Motion for Summary Judgment on the Declaratory Judgment Claims, dated February 18, 2020; Affidavit of Michael Ogborn, sworn to February 18, 2020, with Exhibits A-G annexed; Affirmation of C. Harris Dague, Esq., dated February 18, 2020, with Exhibit 1 annexed; Combined Memorandum of Law in Opposition to the Article 78 Petitions and in Support of Respondents' Motion for Summary Judgment on

Petitioners' Declaratory Judgment Claims, dated February 18, 2020, with Appendix A annexed;

21. Correspondence from C. Harris Dague, Esq., dated February 21, 2020;
22. Petitioners' Memorandum of Law in Reply, dated May 29, 2020;
23. Respondents'/Defendants' Combined Reply Memorandum of Law in Further Support of their Motion Pursuant to CPLR 3212 for Summary Judgment on Petitioners'/Petitioners' Declaratory Judgment Claims, dated June 26, 2020; *and*
24. Correspondence from C. Harris Dague, Esq., dated July 27, 2020.