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

VERIFIED PETITION AND COMPLAINT

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AND REHABILITATION CENTER; SEAGATE NURSING AND REHABILITATION CENTER; THE NEW FRANKLIN REHABILITATION AND HEALTH CARE FACILITY; 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.; and WESTHAMPTON CARE CENTER,

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.

The above-named Petitioners-Plaintiffs, LeadingAge New York, Inc. ("LeadingAge");

New York State Health Facilities Association, Inc. ("NYSHFA"); Southern New York Association, Inc. ("SNYA"); Greater New York Health Care Facilities Association, Inc. ("GNYHCFA"); Healthcare Association of New York State, Inc. ("HANYS"); Continuing Care Leadership Coalition, Inc. ("CCLC"; collectively with LeadingAge, NYSHFA, SNYA, GNYHCFA, and HANYS, the "Organizational Petitioners"); Bethel Nursing & Rehabilitation Center ("Bethel Croton"); Clove Lakes Health and Rehabilitation Center ("Clove Lakes"); Bethel Nursing Home Company Inc. ("Bethel Ossining"); Daughters of Sarah Nursing Center ("Daughters of Sarah"); Eger Health Care and Rehabilitation Center ("Eger"); Island Nursing and Rehab Center ("Island Nursing"); Victoria Home ("Victoria Home"); Kirkhaven ("Kirkhaven"); Isabella Geriatric Center ("Isabella"); Jewish Home of Rochester ("Jewish Home"); The New Jewish Home, Manhattan ("New Jewish Home Manhattan"); The New Jewish Home, Sarah Neuman ("New Jewish Home Sarah Neuman"); Parker Jewish Institute for Health Care & Rehab ("Parker Jewish"); Gurwin Jewish Nursing & Rehabilitation Center ("Gurwin"); Riverledge Health Care and Rehabilitation Center ("Riverledge"); Maplewood Health Care and Rehabilitation Center ("Maplewood"); St. Ann's Community ("St. Ann's"); St. Cabrini Nursing Home ("Cabrini"); Saints Joachim & Anne Nursing and Rehabilitation Center ("Saints Joachim & Anne"); Glendale Home; St. Johns Health Care Corporation ("St. Johns"); The Friendly Home ("Friendly Home"); The Valley View Center for Nursing Care and Rehabilitation ("Valley View"); Glendale Home-Schdy CNTY Dept Social Services ("Glendale Home"); Wyoming County Community Hospital SNF ("Wyoming County Skilled Nursing Facility"); Bethany Nursing Home & Health Related Facility Inc. ("Bethany"); 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; 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 Pavilion 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 Skilled 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 ("Park 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 Rehabilitation and Nursing Center; Eden

Rehabilitation and Nursing Center; Dunkirk Rehabilitation 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 Rehabilitation; 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; Cedar Manor Nursing and Rehabilitation; 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 of 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 at Barnwell"); The Grand Rehabilitation and Nursing at Guilderland ("The Grand at Guilderland"); The Grand Rehabilitation and Nursing Center at Utica ("The Grand at Utica"); The Grand Rehabilitation and Nursing at Pawling ("The Grand at Pawling"); The Grand Rehabilitation and Nursing at Queens ("The Grand at Queens"); The Grand Rehabilitation and Nursing at Rome ("The Grand at Rome"); Chestnut Park Rehabilitation and Nursing Center ("Chestnut Park"); Buffalo Community Healthcare Center ("Emerald North"); The Grand Rehabilitation and Nursing at South Point ("The Grand 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 ("Beacon Rehabilitation"); Pelham Parkway Nursing Care and Rehabilitation Facility LLC ("Pelham Parkway"); Lawrence Nursing Care Center, Inc. ("Lawrence"); and Westhampton Care Center (collectively, with the foregoing, the "Provider Petitioners"; the Organizational Petitioners and Provider Petitioners are referred to collectively as the "Petitioners"), by their attorneys, O'Connell & Aronowitz Attorneys at Law and Hinman Straub P.C., for their Verified Petition and Complaint, allege as follows:

Introduction

1. In this hybrid CPLR article 78 / Declaratory Judgment action, Petitioners are not-for-profit and for-profit residential health care facilities (commonly known as "nursing homes") and the major trade associations that represent them as well as the vast majority of nursing homes throughout the State, all of which participate in the State's Medicaid Program. They challenge and seek to enjoin, both preliminarily and permanently, a massive illegal reduction in their Medicaid reimbursement rates. Respondents-Defendants, the Commissioner of Health and the New York State Department of Health ("DOH" or "the Department"), announced this rate reduction on October 9, 2019.

2. These rate cuts are scheduled to be implemented on November 6, 2019 and made retroactive to July 1, 2019.

3. By DOH's own calculations, these cuts will amount in the aggregate to approximately a quarter of a billion dollars ($246 million, to be precise), inclusive of federal payments, that will be imposed on rates covering the period from July 1, 2019 through the end of the calendar year, and new rates which will take effect on January 1, 2020 that will also be based on the same illegalities that affect the July 1, 2019 through December 31, 2019 rates. By the end of the State's current fiscal year on March 31, 2020, DOH projects a total reduction of $246 million.

4. These enormous rate reductions affect all types of facilities: freestanding not-for-profit facilities; hospital-based not-for-profit facilities; for-profit facilities; and public facilities operated by units of government that are located in urban, suburban, and rural areas all across the State.

5. Nursing homes are paid a daily rate for each resident who is a Medicaid beneficiary. The $246 million cut works out to an overall average of $11.47 per resident per day. For an "average" facility with approximately 100 Medicaid residents (a common number), this equals a cut of over $346,000 per year.

6. However, each nursing home has a unique Medicaid rate, fixed by the Department, so the rate cut will not hit all facilities equally. The Provider Petitioners will lose, for example, between $4.00 and $51.70 per resident per day.

7. Thus, if implemented, the cuts would represent an existential threat to individual Petitioners, and many other similarly situated facilities, which care for some of the State's must

vulnerable citizens, *i.e.*, the ill, aged, infirm and impoverished residents throughout the State who desperately depend on these facilities for their care.

8. The number of individuals receiving care in nursing homes in New York State exceeds 100,000 and approximately 72% of them are Medicaid recipients. Should facilities be forced to close, it will cause an immediate crisis for the State of New York. According to the most recent data from the Department, the median nursing home occupancy rate in New York is 95%. According to the Federal Centers for Disease Control, New York has the second highest occupancy rate in the country (see Centers for Disease Control and Prevention, Nursing Homes, Beds, Residents and Occupancy Rates by State: United States, selected years 1995–2016, available at https://www.cdc.gov/nchs/data/hus/2017/092.pdf [accessed Oct. 23, 2019]). If facilities are forced to close, it begs the question as to where these patients will be placed.

9. Even if some facilities are able to remain open, in order to survive and absorb these draconian cuts, they will be forced to reduce staff and optional services, as well as, in certain areas of the State, renegotiate their collective bargaining agreements with the unions that represent the men and women (registered nurses, licensed practical nurses, and certified nurses' aides) these facilities employ and who directly care for their residents (see e.g. Crain's Health Pulse, *Nursing Homes Reach Labor Deal with 1199SEIU* [Dec. 21, 2018], *available at* https://www.1199seiu.org/media-center/daily-clips/nursing-homes-reach-labor-deal-1199seiu [noting that contracts which apply to approximately 30,000 Downstate healthcare workers, were negotiated following state assurance that "it would increase the operating component of their Medicaid reimbursement rates" and permit nursing homes to "revisit the wage increases with the union if their reimbursement changes"] [accessed Oct. 23, 2019]).

10. To say this represents an existential threat is no hyperbole. Already, twelve nursing homes have closed in New York State over the past five years, and four others were merged into other facilities.

11. Within the past year, a study commissioned by the American Health Care Association of several State Medicaid programs noted that while many state Medicaid programs woefully underfund nursing homes, New York State has the dubious distinction of being the worst. That study revealed a shortfall between costs and the daily Medicaid reimbursement rate paid for by the State that averaged $61.32 per patient day in 2015 and, based upon available data, was projected to grow to $64.18 in 2017 (see Hansen Hunter and Company, P.C., "A Report on Shortfalls of Medicaid Funding for Nursing Center Care" [Nov. 2018], available at https://www.ahcancal.org/facility_operations/medicaid/Documents/2017%20Shortfall%20Methodology%20Summary.pdf [accessed Oct. 23, 2019]). A copy is annexed hereto as Exhibit "A".

12. As will be set forth in greater detail in this Petition / Complaint, the illegality of the rate reductions are the result of a change in the Medicaid reimbursement methodology that DOH has decided to impose which, as previously stated, will be made retroactive to July 1, 2019. More specifically, the change affects the manner in which the so-called "case-mix" adjustment to the Medicaid rate is calculated. The case-mix is essentially a measure intended to predict the amount of resources needed to care for each resident of a nursing home. The case-mix for each resident is determined based on periodic assessments of those residents performed by facility staff and reported to the Department of Health and varies over time as a result of any changes in a resident's condition.

13. Each resident is assigned a numerical number that measures their acuity and the Facility's case-mix is determined by the average acuity score of all Medicaid residents in the

facility. An individual's case-mix score can be as low as 0.46 and as high as 2.38 for the heaviest care patients. In 2018, the statewide average Medicaid case-mix was 1.3. The higher an individual facility's case-mix, the greater its Medicaid reimbursement rate.

14. State law dictates that all case-mix adjustments to Medicaid rates must be made in January and July of each year, and DOH's own regulations require that case-mix adjustments for each six-month period (January through June and July through December) be based on case-mix data assembled during the immediately preceding six-month period. In other words, the January case-mix adjustment should be based on case-mix data assembled during the immediately preceding six-month period (July through December of the preceding calendar year). The July case-mix adjustment should be based on case-mix data assembled in the preceding January through June. This ensures that the facility's rate — which is the same for each resident regardless of individual need — most closely reflects the population present on July 1.

15. According to DOH, the new methodology it has embraced to calculate the case-mix adjustment, retroactively effective as of July 1, 2019, was supposedly adopted pursuant to Section 9 of Part G of Chapter 57 of the Laws of 2019. That characterization is inaccurate.

16. That law required DOH to establish a Workgroup consisting of nursing home industry representatives who were to make recommendations to the Department with respect to the changes in the methodology. However, as will be shown, the Department of Health announced the changes in methodology just as the Workgroup convened, and advised the Workgroup that the changes it intended to implement were a *fait accompli*. The Workgroup's report was statutorily due by June 30, 2019, but DOH had already submitted a so-called State

Plan Amendment ("SPA") to the Federal Government in which DOH sought Federal approval of the proposed methodology changes it had developed without the Workgroup's input.

17. Despite the Workgroup's requests to DOH and the requirements of Section 9 of Part G of Chapter 57 of the Laws of 2019 that it share the rates and supporting data that would result from the change in methodology, DOH refused to give the Workgroup any information on the rates in advance. The rates were not published until October 9, 2019.

18. Since, however, all state Medicaid programs are reimbursed, in part, by the Federal Government for the costs they incur in providing care, any SPA must first be approved by the Federal Government before it can be implemented.

19. A SPA submission allows the Federal Government to make sure that, before any changes can be implemented, they can be reviewed to ensure that any reductions in reimbursement will not be so large that they might adversely affect the population of residents that the nursing homes serve and to ensure that patients will still have access to quality care.

20. As of the date of this Petition / Complaint, the Federal Government has yet to approve the SPA. Upon information and belief, the Federal Government, via the Centers for Medicare and Medicaid Services, only recently requested more information from DOH with respect to its proposed SPA, to which DOH has yet to respond. Nevertheless, the State has decided to "damn the torpedoes" and move ahead with the cuts without Federal approval, as reflected in a so-called "DAL" (Dear Administrator Letter) sent by DOH on October 9, 2019 to all nursing homes finally advising them of the rate cuts.

21. Even if, however, the Federal Government approved the State Plan, DOH's change in methodology would violate State law and regulation.

22. The methodological change, effective July 1, 2019 as set forth in DOH's proposed SPA, which was dated June 28, 2019, stated that such case-mix adjustments will be based on case-mix data accumulated more than six months prior to the effective date. DOH has adopted a methodology that allows it to use stale outdated data to calculate rates. Indeed, the DAL advised that assessments made as far back as August 8, 2018 would be used to calculate the rate to be paid for the care of residents almost a year later, *i.e.*, July 1, 2019. The sole reason for doing so was to reduce rates regardless of the current needs of the residents.

23. DOH's SPA submission also indicated that it intended even after January 1, 2020 to use data accumulated for periods prior to the six-month period preceding the effective date of any case-mix adjustment, not just the immediately preceding six months.

24. DOH's ability to use a different period, rather than the most recent six months, gives the Department flexibility to pick and choose whatever assessment period results in lower reimbursement, regardless of the current needs of the residents.

25. DOH's new methodology also ignores the provision, embedded in its own regulations, that case-mix adjustments should be limited to a change of 5% or less in the facility's rate (see 10 NYCRR 86-2.40 [m] [10]). This "floor" on any case-mix "drop" was intended to insulate facilities from any precipitous reduction in rates that could compromise patient care. DOH has nevertheless advised Plaintiffs that they will not apply this "circuit breaker" to the July 1, 2019 rates.

26. The use of the different "collection period" for case-mix data results in less accurate data upon which to calculate Medicaid reimbursement rates. DOH nevertheless forged ahead because the use of this data set enabled the State to achieve a budgetary reduction of a quarter of a billion dollars for the nine-month period between July 1, 2019 and March 31, 2020.

27. The result is that the new rates fail to comply with Federal and State law and the Department's own regulations. More specifically, they fail to satisfy the requirement in Section 2807 (3) of the Public Health Law that requires that Medicaid rates set by DOH must be sufficient to cover the costs incurred by efficiently and economically operated facilities, and the case-mix calculation methodology written into DOH's rules.

28. In sum, DOH has failed to comply with Federal law, State law, and its own regulations. These rate reductions were motivated purely out of budgetary concerns, with no consideration for the residents in the nursing home or the facilities that have to provide the care that is necessary for these residents. Because DOH's actions were arbitrary, capricious and in violation of the law, they should be annulled.

29. Accordingly, for the foregoing reasons and others more fully set forth in the following paragraphs of this Petition / Complaint, DOH should be enjoined from implementing the July 1, 2019 rates and directed forthwith to continue to reimburse facilities based on the methodology for computing the case-mix adjustment that was in effect up until July 1, 2019.

The Parties

30. LeadingAge is a state-wide not-for-profit trade association which has operated in New York for 58 years and currently represents the interests of approximately 182 not-for-profit, mission-drive and public "residential health care facilities" under Public Health Law § 2801 (3) (commonly referred to as "nursing homes") with approximately 22,564 residents throughout New York State who are Medicaid beneficiaries. The principal office of LeadingAge is located at 13 British American Blvd., Latham, Albany County, New York 12110.

31. LeadingAge has a history of litigating on behalf of its members regarding issues of significance to its membership, and it has the capacity to assume an adversary position on the

issues involved herein. LeadingAge fairly represents nursing homes and their residents in this State, and the Respondents' unlawful conduct at issue directly affects LeadingAge's members and their residents. Accordingly, LeadingAge has standing to maintain this action on its own behalf and on behalf of its members, which would have standing in their own names to pursue this action.

32. NYSHFA is a state-wide not-for-profit trade association which has operated in New York for approximately 70 years and currently represents the interests of approximately 300 nursing homes with approximately 54,000 beds throughout New York State. The principal office of NYSHFA is located at 33 Elk St., Albany, Albany County, New York 12207.

33. NYSHFA has a history of litigating on behalf of its members regarding issues of significance to its membership, and it has the capacity to assume an adversary position on the issues involved herein. NYSHFA fairly represents nursing homes and their residents in this State, and the Respondents' unlawful conduct at issue directly affects NYSHFA's members and their residents. Accordingly, NYSHFA has standing to maintain this action on its own behalf and on behalf of its members, which would have standing in their own names to pursue this action.

34. SNYA is a corporation organized under the New York State Not-For-Profit Corporation Law and exempt from federal income tax under Internal Revenue Code Section 501(c)(6). SNYA is an association of long term care and skilled nursing facilities, located principally in southern New York State (i.e., New York City and the surrounding suburban counties), that participate in the Medicaid program. SNYA's members include 78 proprietary, not-for-profit and government-run nursing homes. The principal office of SNYA is located at 39 Broadway, Suite 1710, New York, New York County, New York 10006.

35. SNYA has a history of litigating on behalf of its members regarding issues of significance to its membership, and it has the capacity to assume an adversary position on the issues involved herein. SNYA fairly represents nursing homes and their residents in this State, and the Respondents' unlawful conduct at issue directly affects SNYA's members and their residents. Accordingly, SNYA has standing to maintain this action on its own behalf and on behalf of its members, which would have standing in their own names to pursue this action.

36. GNYHCFA is a corporation organized under the New York State Not-for-Profit Corporation Law. It is a trade association whose members consist of 80 for-profit and not-for-profit nursing homes located in the Greater New York City area that participate in New York State's Medical Assistance ("Medicaid") Program. These member facilities have a total of 17,781 nursing home beds. GNYHCFA represents its members' interests before the Legislature and in the courts when necessary to protect those interests. The principal office of GNYHCFA is located at 519 Eighth Avenue, 16th Floor, New York City, New York County, New York 10018.

37. GNYHCFA has a history of litigating on behalf of its members regarding issues of significance to its membership, and it has the capacity to assume an adversary position on the issues involved herein. GNYHCFA fairly represents nursing homes and their residents in this State, and the Respondents' unlawful conduct at issue directly affects GNYHCFA's members and their residents. Accordingly, GNYHCFA has standing to maintain this action on its own behalf and on behalf of its members, which would have standing in their own names to pursue this action.

38. HANYS is New York's statewide hospital and health system association representing over 500 not-for-profit and public hospitals and hospital based skilled nursing

facilities, home health agencies, and hospices. HANYS' members range from rural Critical Access Hospitals to large, urban Academic Medical Centers and other Medicaid and safety net providers. HANYS seeks to advance the health of individuals and communities by providing leadership, representation, and service to health providers and systems across the entire continuum of care.

39. HANYS's membership includes 82 hospital-based nursing homes. HANYS has a history of litigating on behalf of its members regarding issues of significance to its membership, and it has the capacity to assume an adversary position on the issues involved herein. HANYS fairly represents nursing homes and their residents in this State, and the Respondents' unlawful conduct at issue directly affects HANYS's members and their residents. Accordingly, HANYS has standing to maintain this action on its own behalf and on behalf of its members, which would have standing in their own names to pursue this action.

40. CCLC is a state-wide not-for-profit trade association which has operated in New York for 20 years and currently represents the interests of approximately 60 nursing homes with approximately 15,000 beds throughout New York State. The principal office of CCLC is located at 555 West 57th St., New York, New York County, New York 10019.

41. CCLC has a history of advocating on behalf of its members regarding issues of significance to its membership, and it has the capacity to assume an adversary position on the issues involved herein. CCLC fairly represents nursing homes and their residents in this State, and the Respondents' unlawful conduct at issue directly affects CCLC's members and their residents. Accordingly, CCLC has standing to maintain this action on its own behalf and on behalf of its members, which would have standing in their own names to pursue this action.

42. Bethel Croton is a 200-bed not-for-profit nursing home located at 67 Springvale Road, Croton-on-Hudson, Westchester County, New York 10520. Approximately 76% of residents are Medicaid beneficiaries, and Bethel Croton's overall average occupancy rate is approximately 86%. The rate cut challenged in this proceeding will reduce Bethel Croton's Medicaid rate by $23.15 per resident per day, or approximately $1,130,238.56 per year.

43. Bethel Croton has essentially no cash on hand, and the rate cut will force Bethel Croton to take steps that will impact staffing and quality of resident care. These steps may include reductions in staff and cost reductions that could affect both the quality and speed of resident services.

44. In reducing Bethel Croton's rate, the Department did not apply the so-called "circuit breaker," which has always been heretofore applied by the Department and which limits any reduction in the case-mix adjustment to 5% until those reductions can be confirmed pursuant to an audit to be performed by the New York State Office of the Medicaid Inspector General ("OMIG"). This "circuit breaker" is embedded in the Department's own regulations at 10 NYCRR 86-2.40 (m) (10).

45. Upon information and belief, the Department has failed to apply this circuit breaker with respect to Bethel Croton and other Provider Petitioners and members of the Organizational Petitioners whose case-mix adjustment was reduced by more than 5%.

46. Upon information and belief, other Provider Petitioners and members of the Organizational Petitioners may, like Bethel Croton, be required to take steps to reduce costs in response to the rate cut being challenged in this proceeding, and these steps may impact staffing and/or the quality or speed of various resident services.

47. Clove Lakes is a 576-bed nursing home situated at 25 Fanning Street, Staten Island, Richmond County, New York.

48. Clove Lakes employs 707 individuals, 471 of whom are represented by unions.

49. Clove Lakes is rated a 5-star facility by CMS.

50. As a result of the new methodology for calculating the case-mix adjustment which is being challenged in this litigation, Clove Lakes' Medicaid reimbursement rate has been reduced retroactively to July 1, 2019 by the amount of $9.62 per Medicaid patient day.

51. Clove Lakes' rate reduction will have a devastating effect on Clove Lakes' ability to continue to provide the highest quality of care, as it is already in a precarious financial situation. The projected reduction will result in an aggregate revenue reduction of approximately $875,400 between July 1, 2019 and the end of the State's current Fiscal Year (March 31, 2020). This projection is based upon the number of Medicaid patients typically treated by Clove Lakes which routinely has a Medicaid population of approximately 74%.

52. In reducing Clove Lakes' rate, the Department did not apply the so-called "circuit breaker," embedded in 10 NYCRR 86-2.40(m)(10).

53. In addition, Clove Lakes has been exempted by the Department from its "lag system" for reimbursing nursing homes. The lag system was put in place by the Department several years ago as a "budgetary measure" to delay by as much as two weeks payment of claims submitted by nursing homes for reimbursement for care rendered to Medicaid patients.

54. The Department has exempted many facilities in the State from the lag system based upon their precarious financial situation. Due to its financial situation, Clove Lakes has been "off the lag" for a period of more than two years.

55. Bethel Ossining is a 43-bed not-for-profit nursing home located at 17 Narragansett Avenue, Ossining, Westchester County, New York 10562. Approximately 70% residents are Medicaid beneficiaries, and Bethel Ossining's overall occupancy rate is 86%. Bethel Ossining is rated 5 out of 5 stars, the highest quality rating available under the Nursing Home Compare Five Star Rating System established and published by the Centers for Medicare and Medicaid Services ("CMS"), a part of the United States Department of Health and Human Services ("HHS"). The rate cut being challenged in this proceeding will reduce Bethel Ossining's Medicaid rate by $38.37 per resident per day, or approximately $350,035.00 per year. This reduction exceeds Respondents' 5% regulatory "circuit breaker" on rate decreases.

56. Daughters of Sarah is a 210-bed not-for-profit nursing home located at 180 Washington Avenue Extension, Albany, Albany County, New York 12203. Approximately 63% of residents are Medicaid beneficiaries, and Daughters of Sarah's overall occupancy rate is 95%. The rate cut being challenged in this proceeding will reduce Daughters of Sarah's Medicaid rate by $16.56 per resident per day, or approximately $759,690.41 per year. This reduction exceeds Respondents' 5% regulatory "circuit breaker" on rate decreases.

57. Eger is a 378-bed not-for-profit nursing home located at 140 Meisner Avenue, Staten Island, Richmond County, New York 10306. Approximately 65% of residents are Medicaid beneficiaries, and Eger's overall occupancy rate is 94%. Eger is rated 5 out of 5 stars by CMS. The rate cut being challenged in this proceeding will reduce Eger's Medicaid rate by $16.78 per resident per day, or approximately $1,414,548.46 per year. This reduction exceeds Respondents' 5% regulatory "circuit breaker" on rate decreases.

58. Island Nursing is a 120-bed not-for-profit nursing home located at 5537 Expressway Drive North, Holtsville, Suffolk County, New York 11742. Approximately 65% of

residents are Medicaid beneficiaries, and Island Nursing's overall occupancy rate is 86%. Island Nursing is rated 4 out of 5 stars by CMS. The rate cut being challenged in this proceeding will reduce Island Nursing's Medicaid rate by $5.36 per resident per day, or approximately $131,235.31 per year.

59. Victoria Home is a 49-bed not-for-profit nursing home located at 25 N. Malcolm Street, Ossining, Westchester County, New York 10562. Approximately 83% of residents are Medicaid beneficiaries, and Victoria Home's occupancy rate is 87%. Victoria Home is rated 5 out of 5 stars by CMS. The rate cut being challenged in this proceeding will reduce Victoria Home's Medicaid rate by $26.94 per resident per day, or approximately $347,923.59 per year. This reduction exceeds Respondents' 5% regulatory "circuit breaker" on rate decreases.

60. Kirkhaven is a 147-bed not-for-profit nursing home located at 254 Alexander Street, Rochester, Monroe County, New York 14607. Approximately 63% of residents are Medicaid beneficiaries, and Kirkhaven's occupancy rate is 99%. The rate cut being challenged in this proceeding will reduce Kirkhaven's Medicaid rate by $14.00 per resident per day, or approximately $468,504.73 per year. This reduction exceeds Respondents' 5% regulatory "circuit breaker" on rate decreases.

61. Isabella is a 669-bed not-for-profit nursing home located at 515 Audubon Avenue, New York, New York County, New York 10040. Approximately 578 residents are Medicaid beneficiaries, and Isabella's overall average occupancy rate is approximately 99%. The rate cut challenged in this proceeding will reduce Isabella's Medicaid rate by $24.57 per resident per day, or approximately $5,183,532.90 per year. This reduction exceeds Respondents' 5% regulatory "circuit breaker" on rate decreases.

62. Jewish Home is a 328-bed not-for-profit nursing home located at 2021 South Winton Road, Rochester, Monroe County, New York 14618. Approximately 60% of residents are Medicaid beneficiaries, and Jewish Home's overall average occupancy rate is approximately 92%. Jewish Home is rated 4 out of 5 stars by CMS. The rate cut challenged in this proceeding will reduce Jewish Home's Medicaid rate by $9.30 per resident per day, or approximately $614,594.59 per year.

63. New Jewish Home Manhattan is a 514-bed not-for-profit nursing home located at 120 West 106th Street, New York, New York County, New York 10025. Approximately 70% residents are Medicaid beneficiaries, and New Jewish Home's overall average occupancy rate is approximately 98%. New Jewish Home Manhattan is rated 4 out of 5 stars by CMS. The rate cut challenged in this proceeding will reduce New Jewish Home Manhattan's Medicaid rate by $20.73 per resident per day, or approximately $1,861,500.00 per year. This reduction exceeds Respondents' 5% regulatory "circuit breaker" on rate decreases.

64. New Jewish Home Sarah Neuman is a 300-bed not-for-profit nursing home located at 845 Palmer Avenue, Mamaroneck, Westchester County, New York 10543. Approximately 40% of residents are Medicaid beneficiaries, and New Jewish Home Sarah Neuman's overall average occupancy rate is approximately 91%. The rate cut challenged in this proceeding will reduce New Jewish Home Sarah Neuman's Medicaid rate by $29.14 per resident per day, or approximately $1,222,385.00 per year. This reduction exceeds Respondents' 5% regulatory "circuit breaker" on rate decreases.

65. Parker Jewish is a 527-bed not-for-profit nursing home located at 271-11 76th Avenue, New Hyde Park, Nassau County, New York 11040. Approximately 70% residents are Medicaid beneficiaries, and Parker Jewish's overall average occupancy rate is approximately

93%. Parker Jewish Home is rated 5 out of 5 stars by CMS. The rate cut challenged in this proceeding will reduce Parker Jewish's Medicaid rate by $17.21 per resident per day, or approximately $2,179,780 per year. This reduction exceeds Respondents' 5% regulatory "circuit breaker" on rate decreases.

66. Gurwin is a 432-bed not-for-profit nursing home located at 68 Hauppauge Road, Commack, Suffolk County, New York 11725, and is the only kosher long-term care facility on Long Island. Approximately 69% of residents are Medicaid beneficiaries, and Gurwin's overall average occupancy rate is 95%. Gurwin is rated 4 out of 5 stars by CMS. The rate cut being challenged in this proceeding will reduce Gurwin's Medicaid rate by $16.54 per resident per day, or approximately $1,744,721.90 per year. This reduction exceeds Respondents' 5% regulatory "circuit breaker" on rate decreases.

67. Riverledge is a 180-bed not-for-profit nursing home located at 8101 State Highway 68, Ogdensburg, St. Lawrence County, New York 13669 and operated by United Helpers Nursing Home Inc. Approximately 83% of residents are Medicaid beneficiaries, and Riverledge's overall average occupancy rate is approximately 89%. The rate cut challenged in this proceeding will reduce Riverledge's Medicaid rate by $4.13 per resident per day, or approximately $200,439.60 per year.

68. Maplewood is a 96-bed not-for-profit nursing home located at 205 State Street Road, Canton, New York 13617 and operated by United Helpers Canton Nursing Home Inc. Approximately 63% of residents are Medicaid beneficiaries, and Maplewood's overall average occupancy rate is approximately 97%. The rate cut challenged in this proceeding will reduce Maplewood's Medicaid rate by $7.92 per resident per day, or approximately $169,590.52 per year.

69. St. Ann's is a 470-bed not-for-profit nursing home located at 1500 Portland Avenue, Rochester, Monroe County, New York 14621. Approximately 250 residents are Medicaid beneficiaries, and St. Ann's overall average occupancy rate is approximately 77%. The rate cut challenged in this proceeding will reduce St. Ann's Medicaid rate by $8.75 per resident per day, or approximately $798,437.50 per year.

70. Cabrini is a 304-bed not-for-profit nursing home located at 115 Broadway, Dobbs Ferry, Westchester County, New York 10522. Approximately 225 residents are Medicaid beneficiaries, and Cabrini's overall average occupancy rate is approximately 95%. Cabrini is rated 4 out of 5 stars by CMS. The rate cut challenged in this proceeding will reduce Cabrini's Medicaid rate by $12.52 per resident per day, or approximately $1,028,205.00 per year.

71. Saints Joachim & Anne is a 200-bed not-for-profit nursing home located at 2720 Surf Avenue, Brooklyn, Kings County, New York 11224. Approximately 80% of residents are Medicaid beneficiaries, and Saints Joachim & Anne's overall average occupancy rate is approximately 94%. The rate cut challenged in this proceeding will reduce Saints Joachim & Anne's Medicaid rate by $30.14 per resident per day, or approximately $2,000,000 per year. This reduction exceeds Respondents' 5% regulatory "circuit breaker" on rate decreases.

72. St. John's is a 455-bed not-for-profit nursing home located at 150 Highland Avenue, Rochester, Monroe County, New York 14620. Approximately 248 residents are Medicaid beneficiaries, and St. John's overall average occupancy rate is approximately 83%. The rate cut challenged in this proceeding will reduce St. John's Medicaid rate by $11.05 per resident per day, or approximately $1,000,246.00 per year.

73. Friendly Home is a 200-bed not-for-profit nursing home located at 3156 East Avenue, Rochester, Monroe County, New York 14618. Approximately 78 residents are Medicaid beneficiaries, and Friendly Home's overall average occupancy rate is approximately 95%. Friendly Home is rated 5 out of 5 stars by CMS. The rate cut challenged in this proceeding will reduce Friendly Home's Medicaid rate by $12.33 per resident per day, or approximately $351,035.10 per year.

74. Valley View is a 360-bed public nursing home, operated by Orange County, located at 2 Glenmere Cove Road, Goshen, Orange County, New York 10924. Approximately 78% of residents are Medicaid beneficiaries, and Valley View's occupancy rate is approximately 95%. The rate cut challenged in this proceeding will reduce Valley View's Medicaid rate by $16 per resident per day, or approximately $1.3 million per year. This reduction exceeds Respondents' 5% regulatory "circuit breaker" on rate decreases.

75. Glendale Home is a 200-bed public nursing home, operated by the Schenectady County Department of Social Services, located at 59 Hetcheltown Road, Scotia, Schenectady County, New York 12302. Approximately 111 residents are Medicaid beneficiaries, and Glendale Home's occupancy rate is approximately 99%. The rate cut challenged in this proceeding will reduce Glendale Home's Medicaid rate by $16.14 per resident per day, or approximately $653,912.10 per year. This reduction exceeds Respondents' 5% regulatory "circuit breaker" on rate decreases.

76. Wyoming County Skilled Nursing Facility is a 138-bed public nursing home, operated by Wyoming County, located at 400 North Main Street, Warsaw, Wyoming County, New York 14569. Approximately 70% of residents are Medicaid beneficiaries, and Wyoming County Skilled Nursing Facility's occupancy rate is approximately 99%. The rate cut being

challenged in this proceeding will reduce Wyoming County Skilled Nursing Facility's rate by $12.97 per resident per day, or $449,734.75 per year. This reduction exceeds Respondents' 5% regulatory "circuit breaker" on rate decreases.

77. Bethany is a 120-bed not-for-profit nursing home located at 3005 Watkins Road, Horseheads, Chemung County, New York 14845. Approximately 92 residents are Medicaid beneficiaries, and Friendly Home's overall average occupancy rate is approximately 97%. The rate cut being challenged in this proceeding will reduce Bethany's rate by $15.39 per resident per day, or approximately $516,796.20 per year.

78. Hillside Manor Rehabilitation and Extended Care Center is a 203-bed nursing home licensed by the New York State Department of Health and situated at 182-15 Hillside Avenue, Jamaica, New York 11432. As a result of the July 1 case-mix adjustment being challenged in this litigation, Hillside's Medicaid reimbursement rate is being reduced by $9.91 per patient per patient day and the projected impact upon its Medicaid revenue through March 31, 2020 will be $818,764.00.

79. Wingate at Ulster is a 120-bed residential health care facility with a Four Star quality rating and it is licensed by the New York State Department of Health. Its Medicaid population is approximately 59% of its total census. It employs over 150 employees. As a result of the Medicaid rate change effective July 1, the Facility's rate has been reduced by the amount of $8.69, which translates to a projected Medicaid revenue reduction of $139,994.00 between now and March 31, 2020, the end of this State's fiscal year.

80. Crest Manor Living and Rehabilitation Center is a nursing home situated at 6745 Pittsford Palmyra Road in Fairport, New York. It is an 80-bed facility. It employs 162 people, has an average Medicaid census of 57%, and its Medicaid rate was cut by $21.87, retroactive to

July 1, 2019. The Medicaid impact on this facility will be approximately $281,000 through March 31, 2020.

81. Middletown Park Rehabilitation and Health Care Center is a 230-bed nursing home licensed by the New York State Department of Health and located at 121 Dunning Road, Middletown, New York 10940. It enjoys a Five Star rating and has a Medicaid population of approximately 72.23%. It employs 305 people. As a result of the adjustment to the case-mix effective July 1, 2019, that reduction amounts to $15.42 for patient day, which is projected to result in a total revenue impact on Park Manor of $282,161.

82. Putnam Nursing and Rehabilitation Center is a 160-bed skilled nursing facility licensed by the New York State Department of Health and is situated in 404 Luddingtonville Road, Holmes, New York 12531. It is a 160-bed facility and its Medicaid population is approximately 85% of its total census. It employs 150 people and the Medicaid rate reduction applicable to the July 1, 2019 Medicaid rate is approximately $4.31, which is projected to result in a total loss to the Facility of $83,935 between July 1, 2019 and March 31, 2020.

83. Sky View Rehabilitation and Health Care Center is a 192-bed residential health care facility licensed by the New York State Department of Health and is situated at 1280 Albany Post Road, Croton-on-Hudson, New York 10520. It is a Five Star facility with a Medicaid census of approximately 70%. It employs 311 people and as a result of the Medicaid rate cut challenged in this proceeding, its projected losses from July 1, 2019 through March 31, 2020 is $489,027.00.

84. Waterview Hills Rehabilitation and Nursing Center is a 130-bed skilled nursing facility licensed by the New York State Department of Health and located at 537 Route 22, Purdys, New York 10578. It is a Five Star facility with a Medicaid census of approximately 64.97%. It employs 228 people and the Medicaid rate reduction challenged in this proceeding

amounts to $8.19 per day, which will result in a projected loss for the nine month period commencing July 1, 2019 of approximately $156,555.00.

85. Salem Hills Nursing and Rehabilitation Center is a 126-bed skilled nursing facility located at 539 Route 22, Purdys, New York 10578. It is a Four Star facility with a Medicaid census of approximately 87.4%. It employs 154 people and as a result of the Medicaid rate cut challenged in this proceeding, it is projected that it will lose $18.62 per Medicaid patient per day for a total estimated impact over the nine month period commencing July 1, 2019 of $423,870.00.

86. Diamond Hill Nursing and Rehabilitation Center is a 120-bed skilled nursing facility located at 100 New Turnpike Road, Troy, New York 12182, and is licensed by the New York State Department of Health. Its average percentage of Medicaid patients is approximately 75%. It employs 205 people. As a result of the rate cut challenged in this proceeding, its Medicaid per patient day rate will be reduced by $5.67, resulting in a total projected Medicaid impact for the period from July 1, 2019 through March 31, 2020 of approximately $100,000.00.

87. Seagate Nursing and Rehabilitation Center is a 300-bed skilled nursing facility licensed by the New York State Department of Health and located at 3015 West 29th Street, Brooklyn, New York 11224. It is licensed for 360 beds and averages 190 Medicaid patients per day and employs over 400 people. As a result of the change in the Medicaid reimbursement rate effective July 1, 2019, the facility will experience a rate reduction of $5.35 per Medicaid patient per day which will result in a negative revenue impact of approximately $232,000 between July 1, 2019 and March 31, 2020.

88. The New Franklin Rehabilitation and Health Care Facility is a 320-bed facility licensed by the New York State Department of Health and located at 142-27 Franklin Avenue in Flushing, New York 11355. It enjoys a Five Star rating and has a Medicaid census of

approximately 87%. As a result of the change in the Medicaid rate effective July 1, 2019 that is challenged in this proceeding, its Medicaid patient rate per patient day will be reduced by $16.30 resulting in an overall Medicaid impact for the period from July 1, 2019 through March 31, 2020 of approximately $1,223,739.00.

89. Split Rock Rehabilitation and Health Care Center is a 240-bed skilled nursing facility licensed by the New York State Department of Health and located at 3525 Baychester Avenue, Bronx, New York 10466. The average percentage of Medicaid patients in the facility is approximately 94% and as a result of the Medicaid rate change effective July 1, 2019, the Facility's Medicaid rate will be reduced by $17.26 per Medicaid patient day. The projected estimated negative impact on revenue to this Facility for the period from July 1, 2019 through March 31, 2020 will be $1,003,611.00.

90. Fort Tryon Rehabilitation and Health Care Facility is a 205-bed skilled nursing facility licensed by the New York State Department of Health and located at 801 West 190th Street, New York, New York 10040. It is a 205-bed facility with a Medicaid census of approximately 86%. As a result of the change in Medicaid rate effective July 1, 2019, the Facility will now have a reduction in its Medicaid rate of $8.05 per Medicaid patient day with an estimated projected negative impact for the period between July 1, 2019 and March 31, 2020 of $374,819.00.

91. The Maplewood Nursing Home is a 72-bed nursing home licensed by the State of New York and located at 100 Daniel Drive, Webster, New York in Monroe County. It has an average percentage of Medicaid patients of approximately 20% and employs 201 people. As a result of the change in the Medicaid rate effective July 1, 2019 challenged in this proceeding, it

stands to lose approximately $4.88 per Medicaid patient day, with a projected negative impact of approximately $10,000 between the period of July 1, 2019 and March 31, 2020.

92. Wedgewood Care Center, Inc., d/b/a Highfield Gardens Care Center, is a 200-bed skilled nursing facility licensed by the New York State Department of Health and is situated at 199 Community Drive, Great Neck, New York 11021. It enjoys a Five Star rating and employs 364 people. As a result of the Medicaid rate reduction challenged in this proceeding, the Facility is scheduled to have a reduction of $28.76 in its Medicaid rate.

93. The Chateau at Brooklyn Rehabilitation and Nursing Center is a 189-bed skilled nursing facility licensed by the State of New York and located at 3457 Nostrand Avenue, Brooklyn, New York. It enjoys a Four Star quality rating and it has an average census of approximately 60%. As a result of the rate change challenged in this litigation, it stands to lose approximately $89,969.00 between July 1, 2019 and March 31, 2020.

94. Cortlandt Health Care is a 120-bed skilled nursing facility licensed by the New York State Department of Health and is situated at 110 Oregon Road, Cortlandt Manor, New York 10567. It has a census of approximately 63% Medicaid patients. As a result of the rate reduction challenged in its litigation, it stands to lose approximately $5.29 per Medicaid patient day, which should result in an aggregate Medicaid rate reduction of approximately $102,403.00.

95. The Enclave at Port Chester Rehabilitation and Nursing Center is a 160-bed skilled nursing facility licensed by the State of New York and located at 1000 High Street, Port Chester, New York 10573. It has a Medicaid census of approximately 77% and will experience a rate reduction of $12.04 effective July 1, 2019 which will cause the Facility to lose approximately $376,186 between July 1, 2019 and March 31, 2020.

96. The Glengariff Health Care Center is a 262-bed skilled nursing facility licensed by the State of New York and located at 141 Dosoris Lane, Glen Cove, New York 11542. Its Medicaid census is approximately 61% and as a result of the rate change effective retroactively as of July 1, 2019 it stands to lose $16.41 per Medicaid patient day, which will result in a total loss over the nine month period commencing July 1, 2019 of $672,176.

97. The Grand Pavilion for Rehabilitation and Nursing at Rockville Centre is a 150-bed skilled nursing facility licensed by the New York State Department of Health and located at 41 Main Avenue, Rockville Centre, New York 11570 (Nassau County). It is a Five Star facility which will experience a rate reduction of $17.84 per Medicaid patient day that is projected to result in a loss to the Facility of $361,510.

98. The Grove at Valhalla Rehab and Nursing Center is a 160-bed skilled nursing facility licensed by the State of New York located at 61 Grasslands Road, Valhalla, New York. It enjoys a four-star rating and is licensed as a 160-bed facility with 54% Medicaid patients. As a result of the rate reduction challenged in this proceeding, its Medicaid rate per patient day will be reduced by $27.18 as of July 1, 2019 and is projected to cause a loss to the Facility of $575,923.00 over the ensuing nine month period.

99. The Hammond Rehabilitation and Health Care Center at Nesconset is a 240-bed skilled nursing facility located at 100 Southern Boulevard, Nesconset, New York. It has a Medicaid population of approximately 76% and as a result of the rate reduction challenged in this litigation, it stands to lose $14.43 per Medicaid patient day with a resultant total impact for the nine month period commencing July 1, 2019 of $510,398.

100. The Phoenix Nursing and Rehabilitation Center is a 400-bed skilled nursing facility located at 140 St. Edward Street, Brooklyn, New York 11201. It is licensed by the New

York State Department of Health and has a Medicaid census of approximately 82%. As a result of the rate reduction challenged in this litigation, it stands to lose $18.19 per patient day, with a projected loss over the nine month period commencing July 1, 2019 of $1,629,783.00.

101. The Riverside is a 520-bed skilled nursing facility licensed by the New York State Department of Health and located at 150 Riverside Drive, New York, New York 10024. It has a Medicaid population of 68%. It stands to lose $29.18 per Medicaid patient day as a result of the rate change challenged in this litigation, which represents a projected loss through the nine month period commencing July 1, 2019 of $2,659,972.

102. The Rockville Skilled Nursing and Rehabilitation Centre is a 66-bed skilled nursing facility located at 50 Main Avenue, Rockville Centre, New York 11570 (Nassau County). It has a Five Star rating and a Medicaid occupancy rate of approximately 50%. It stands to lose $29.18 per Medicaid patient day as a result of the rate change challenged herein, with a projected loss to the Facility of $17.18 per patient day that will result in a Medicaid loss of approximately $160,744.00.

103. The Sans Souci Rehabilitation and Nursing Center is a 120-bed skilled nursing facility licensed by the New York State Department of Health and situated in 115 Park Avenue, Yonkers, New York 10703. It has a Medicaid census of approximately 66% and stands to lose $14.70 per Medicaid patient day and will result in a total loss over the nine month period commencing July 1, 2019 of $317,171.00.

104. St. James Rehabilitation and Health Care Center is a 230-bed skilled nursing facility located at 275 Moriches Road, St. James, New York 11780. It enjoys a Four Star quality rating and has a Medicaid population of 56%. It stands to lose $26.14 per patient day as a result

of the challenged Medicaid rate reduction effective July 1, 2019 and stands to lose approximately $889,158.00 for the nine month period commencing July 1, 2019.

105. Waters Edge at Port Jefferson is a 120-bed skilled nursing facility licensed by the New York State Department of Health and located at 150 Dark Hollow Road, Port Jefferson, New York. It is licensed for 121 beds and has a Medicaid population of approximately 63%. It stands to lose approximately $7.12 per Medicaid patient day as a result of the rate reduction challenged herein and is projected to lose $142,311.00 for the nine month period commencing July 1, 2019.

106. Silver Lake Specialized Rehabilitation and Care Center is a 270-bed skilled nursing facility licensed by the New York State Department of Health and situated at 275 Castleton Avenue, Staten Island, New York. It employs approximately 300 individuals and 65% of its population are Medicaid patients. On October 9, 2019, the Department of Health announced a $28 per day decrease in Silver Lake's Medicaid rate. This will result in an estimated reduction in revenue of $136,600 over the nine month period commencing July 1, 2019.

107. Forest Hills Care Center is a 100-bed skilled nursing facility licensed by the New York State Department of Health and situated at 7144 Yellowstone Boulevard, Forest Hills, New York 11375. On October 9, 2019, the New York State Department of Health announced a $22.66 cut in the Facility's Medicaid rate, retroactive to July 1, 2019. The overall revenue impact on this Facility for the nine month period commencing July 1, 2019 is estimated to be $302,216.00.

108. New East Side Nursing Home is a 58-bed skilled nursing facility licensed by the New York State Department of Health and located at 25 Bialystoker Place, New York, New York 10002. It has a census of approximately 80-85% Medicaid patients and on October 9, 2019, the New York State Department of Health announced a Medicaid retroactive rate cut of $16.14 per

day retroactive to July 1, 2019. The Facility employs approximately 90 people and the aggregate Medicaid reduction for this Facility for the nine month period commencing July 1, 2019 will be $146,000.00.

109. Berkshire Nursing Home is a 175-bed skilled nursing facility located in West Babylon, New York. It employs approximately 200 people. On October 9, 2019, the New York State Department of Health announced a Medicaid reduction, retroactive to July 1, 2019, which will result in a negative Medicaid impact over the nine month period commencing July 1, 2019 of approximately $137,000.00.

110. Newfane Rehabilitation and Health Care Center is a 165-bed skilled nursing facility licensed by the New York State Department of Health and located at 2709 Transit Road, Newfane, New York 14108. It employs approximately 235 people and has an average Medicaid census of approximately 80%. On October 9, 2019, the New York State Department of Health announced a Medicaid rate reduction of $15 per day retroactive to July 1, 2019. The estimated Medicaid impact on this facility will be -$540,000.00.

111. Wingate at Dutchess is a 160-bed skilled nursing facility located at 3 Summit Court, Fishkill, New York 12563. It is a Four Star facility with 159 employees. It has an average Medicaid census of approximately 70%. On October 9, 2019, the New York State Department of Health announced a Medicaid retroactive rate reduction of $11.27 per patient day retroactive to July 1, 2019. The estimated negative impact of this rate reduction over the nine month period beginning on July 1, 2019 is $269,295.00.

112. Bedford Center for Nursing and Rehabilitation is a 200-bed skilled nursing facility licensed by the New York State Department of Health and located at 40 Heywood Street, Brooklyn, New York 11249. It has an average Medicaid census of 52% and on October 9, 2019,

the New York State Department of Health announced a Medicaid rate reduction of approximately $27.90 per patient day retroactive to July 1, 2019. The estimated negative impact over the next nine months of this Medicaid rate reduction is $782,595.00.

113. Crown Heights Center for Nursing and Rehabilitation is a 200-bed skilled nursing facility located at 810 St. Mark's Street, Brooklyn, New York 11213. It is a Four Star facility. Of its 200 beds, approximately 65% are occupied by Medicaid patients. On October 9, 2019, the New York State Department of Health announced a Medicaid reduction of $40.23 for this Facility retroactive to July 1, 2019. The aggregate negative Medicaid rate reduction attributable to this action by the Department of Health for the next nine months is estimated to be $2,009,489.00.

114. Greater Harlem / Harlem Center is a 200-bed skilled nursing facility that is rated Four Stars and is licensed by the New York State Department of Health and located at 30 West 138th Street, New York, New York 10037. It has an average daily Medicaid census of approximately 53% and the Department of Health announced a retroactive rate reduction of $24.29 per Medicaid patient day, effective as of July 1, 2019. The aggregate negative revenue impact on this Facility for the nine month period commencing July 1, 2019 is estimated to be $709,754.00.

115. Hamilton Park Nursing and Rehabilitation Center is a 200-bed skilled nursing facility licensed by the New York State Department of Health and located 691-92nd Street, Brooklyn, New York 11228. It has an average daily Medicaid census of 44%, and on October 9, 2019, the New York State Department of Health announced a Medicaid retroactive rate reduction of $13.26, effective as of July 1, 2019. The estimated negative Medicaid impact of this rate reduction will be $644,346.00.

116. Linden Center for Nursing and Rehabilitation is a 280-bed skilled nursing facility located at 2335 Linden Boulevard, Brooklyn, New York 11207. Of the 280 beds, approximately 61% are occupied by Medicaid patients. On October 9, 2019, the New York State Department of Health announced a Medicaid rate reduction of $34.83 per patient day, retroactive to July 1, 2019. The estimated negative revenue impact of this rate reduction for the nine month period beginning July 1, 2019 is estimated to be $1,563,867.00.

117. Beach Garden Rehabilitation and Nursing Center is located at 17-11 Brookhaven Avenue, Far Rockaway, New York. It employs approximately 158 people and has a bed capacity of 160, 86% of which are Medicaid beneficiaries. It is a four-star facility. On October 9, 2019, the New York State Department of Health announced a Medicaid rate reduction of $12.93. The estimated impact of this on the Facility's revenue for the nine month period commencing July 1, 2019 is estimated to be $487,492.03.

118. Brooklyn Gardens Nursing and Rehabilitation Center is a not-for-profit nursing home located at 835 Herkimer Avenue, Brooklyn, New York 11226. It employs approximately 273 people and has a licensed bed capacity of 240 residents. The Medicaid census for this facility on a daily basis is approximately 82%. It is a three-star facility. On October 9, 2019, the New York State Department of Health announced a Medicaid rate reduction for this Facility of $7.57 per patient day retroactive to July 1, 2019. It is estimated that the negative aggregate revenue impact on this Facility for the nine-month period commencing July 1, 2019 will be $408,198.62.

119. Caton Park Nursing and Rehabilitation Center is a skilled nursing facility licensed by the New York State Department of Health located at 1312 Caton Avenue, Brooklyn, New York 11226. It employs 152 people and has a licensed bed capacity of 119 residents. The Medicaid census for this facility on a daily basis is approximately 92%. On October 9, 2019, the

New York State Department of Health announced a $17.36 Medicaid rate reduction for this Facility retroactive to July 1, 2019. It is a five-star facility. The estimated impact upon the Facility's revenue for the nine month period commencing July 1, 2019 will be $520,756.95.

120. Hempstead Park Nursing Home is a residential health care facility licensed by the New York State Department of Health and located at 800 Front Street, Hempstead, New York 11550. It employs 246 people and has a bed capacity of 251 residents. Approximately 81% of those beds are occupied by Medicaid beneficiaries. It is a four-star facility. On October 9, 2019, the New York State Department of Health announced a Medicaid rate reduction of $7.38 per patient day, retroactive to July 1, 2019. The estimated negative impact on the Facility's revenue for the nine-month period commencing July 1, 2019 as a result of this rate reduction will be $411,117.22.

121. Park Nursing Home is a residential health care facility licensed by the New York State Department of Health and located at 128 Beach 115th Street, Rockaway Park, New York 11694. It employs 194 people and has a licensed bed capacity of 196 residents. Approximately 89% of those beds are occupied by Medicaid beneficiaries. On October 9, 2019, the New York State Department of Health announced a Medicaid rate reduction for this Facility of $17.62 per patient day. The estimated negative impact on the Facility's revenue for the nine month period commencing July 1, 2019 will be $378,505.79.

122. Regency Extended Care Center is a skilled nursing facility located at 65 Ashburton Avenue in Yonkers, New York. It employs an average of 615 people and has a bed capacity of 315 residents. It has an average Medicaid daily census of 90%. On October 9, 2019, the New York State Department of Health announced a Medicaid rate reduction of $13.69 per

patient day. The estimated negative impact of this rate reduction on the Facility for the nine month period commencing July 1, 2019 will be 1,063,425.51.

123. Rockaway Care Center is a licensed skilled nursing facility located at 353 Beach 48th Street, Far Rockaway, New York 11691. It employs an average of 210 people and has a bed capacity of 228. Its average daily Medicaid census is 94%. It is a four-star facility. On October 9, 2019, the New York State Department of Health announced a Medicaid rate reduction to this facility of $17.34 per Medicaid patient day. The estimated negative revenue impact on this facility for the nine month period commencing July 1, 2019 is $1,018,268.61.

124. Yonkers Gardens Center for Nursing & Rehabilitation is located at 127 South Broadway, Yonkers, New York 10701. It employs an average of 190 people and has a bed capacity of 200. Its average daily Medicaid census is 84%. On October 9, 2019, the New York State Department of Health announced a Medicaid rate reduction to this facility of $27.77 per Medicaid patient day. The estimated negative revenue impact on this facility for the nine month period commencing July 1, 2019 is $1,278,308.64.

125. Schofield Residence is a Five Star not-for-profit skilled nursing facility with a licensed capacity of 120 beds located at 3333 Elmwood Avenue in Kenmore, New York. It has a licensed bed capacity of 120 beds and it has an average daily Medicaid census of 85%. It employs 259 individuals. On October 9, 2019, the New York State Department of Health announced a Medicaid rate reduction of $7.07 per Medicaid patient day retroactive to July 1, 2019. The estimated negative impact on this Facility for the nine month period beginning July 1 will $153,525.00.

126. Pontiac Nursing Home is an 80-bed skilled nursing facility located at 303 East River Road, Oswego, New York 13126 and is licensed by the New York State Department of

Health with a bed capacity of 80 beds. Its average daily Medicaid census is approximately 90% and it employs 86 individuals. On October 9, 2019, the New York State Department of Health announced that Pontiac Nursing Home will receive a Medicaid retroactive rate reduction of $10.63 effective as of July 1, 2019. The estimated negative impact on the Facility's revenue for the nine month period commencing July 1, 2019 is $66,000.

127. Blossom Center for Nursing and Rehabilitation is a skilled nursing facility licensed by the New York State Department of Health and located at 1335 Portland Avenue, Rochester, New York 14610. On October 9, 2019, the New York State Department of Health announced that this Facility would have its Medicaid rate reduced by $26.05 per Medicaid patient day retroactive to July 1, 2019. The negative impact upon this Facility's revenue for the six month period commencing July 1, 2019 is estimated to be $423,399.00.

128. Fishkill Center for Nursing and Rehabilitation is a 160-bed skilled nursing facility licensed by the New York State Department of Health and located at 22 Robert Kasin Way in Beacon, New York. On October 9, 2019, the New York State Department of Health announced that the Facility would receive $11.47 reduction in its daily Medicaid rate retroactive to July 1, 2019. The estimated negative impact on the Facility's revenue is estimated to be $240,216.00 for the rate period commencing July 1, 2019.

129. Sapphire Nursing and Rehabilitation Center at Goshen is a 120-bed skilled nursing facility licensed by the New York State Department of Health and located at 46 Harriman Drive in Goshen, New York. On October 9, 2019, the New York State Department of Health announced that this Facility would receive a negative Medicaid retroactive rate reduction of $8.43 retroactive to July 1, 2019. The estimated negative impact on the Facility's revenue for the period commencing July 1, 2019 is estimated to be $115,879.00.

130. Sapphire Nursing at Meadowhill is a 190-bed skilled nursing facility located at 172 Meadowhill Road, Newburgh, New York. On October 9, 2019 the New York State Department of Health announced a Medicaid rate reduction of $12.81 per Medicaid patient day for this Facility. The overall estimated impact of this rate reduction for the nine month period commencing July 1, 2019 is $332,765.00.

131. Sapphire Rehabilitation of Northtowns is a 100-bed skilled nursing facility located at 2799 Sheridan Drive in Tonawanda, New York. On October 9, 2019, the New York State Department of Health announced that this Facility's Medicaid rate would be reduced by $24.05 with an overall Medicaid revenue rate reduction of $278,788 for the nine month period commencing July 1, 2019.

132. Park Gardens Rehabilitation and Nursing Center is a 200-bed skilled nursing facility located at 6585 Broadway, Bronx, New York 10471. On October 9, 2019, the New York State Department of Health announced a retroactive Medicaid rate reduction of $30.87 effective as of July 1, 2019. The estimated negative impact on this Facility for the nine month period commencing July 1, 2019 is $831,730.00.

133. Sapphire Center for Nursing and Rehabilitation of Central Queens is a 227-bed skilled nursing facility located at 3515 Parsons Boulevard, Flushing, New York 11354. On October 9, 2019, the New York State Department of Health announced that this Facility's Medicaid rate would be reduced by $13.53 retroactive to July 1, 2019. The estimated impact upon this facility is $336,735.00 for the nine month period commencing July 1, 2019.

134. Sapphire Rehabilitation of Smithtowns is a 120-bed skilled nursing facility located at 300 Dorrance Avenue in Buffalo, New York. On October 9, 2019, the New York State Department of Health announced that this Facility would receive a retroactive Medicaid rate

reduction of $11.16 per patient day. It is estimated that the overall negative impact of this rate reduction for the nine month period commencing July 1, 2019 is $149,321.00.

135. Sapphire Nursing of Wappinger Falls is a 62-bed skilled nursing facility licensed by the State of New York and located at 37 South Mesier Avenue in Wappingers Falls, New York 12590. On October 9, 2019, the New York State Department of Health announced a retroactive Medicaid rate reduction of $11.89 per Medicaid patient day for this Facility, retroactive to July 1, 2019. The estimated overall negative impact of this rate reduction for the nine month period commencing July 1, 2019 is $108,330.00.

136. Williamsville Suburban Sapphire Nursing and Rehabilitation Center is a 220-bed skilled nursing facility located at 193 South Main Street in Buffalo, New York. On October 9, 2019, the New York State Department of Health announced that this Facility's Medicaid rate would be reduced by $11.66 per Medicaid patient day retroactive to July 1, 2019. The overall estimated impact on this Facility is $253,175.00.

137. Cedar Manor Nursing and Rehabilitation Center is a 153-bed skilled nursing facility located at Cedar Lane, Ossining, New York 10562. It has a licensed bed capacity of 153 beds and approximately 83 of those beds are occupied by Medicaid patients on a daily basis. On October 9, 2019, the New York State Department of Health announced that this Facility's Medicaid rate would be reduced by $46.01 per Medicaid patient day retroactive to July 1, 2019. The estimated negative impact upon this Facility's revenue for the nine month period commencing July 1, 2019 is $1,008,539.00.

138. Betsy Ross Nursing and Rehabilitation Center is a 120-bed skilled nursing facility licensed by the New York State Department of Health and located at 1 Elsie Street, Rome, New York 13440. It has an average daily Medicaid census of approximately 78%. On October 9,

2019, the New York State Department of Health announced that this Facility's Medicaid rate will be reduced by $12.20 per Medicaid patient day retroactive to July 1, 2019. The estimated Medicaid impact on this Facility will be $315,613.00.

139. Dumont Center for Nursing and Rehabilitation is a 181-bed skilled nursing facility licensed by the New York State Department of Health and located at 675 Pelham Road, New Rochelle, New York 10805. On October 9, 2019, the New York State Department of Health announced that this Facility would receive a negative retroactive Medicaid rate reduction of $34.45, effective July 1, 2019.

140. Friedwald Center for Rehabilitation and Nursing is a 168-bed skilled nursing facility licensed by the New York State Department of Health and located at 475 New Hempstead Road, New City, New York. On October 9, 2019, the New York State Department of Health announced that this Facility would receive a Medicaid rate reduction of $17.45 retroactive to July 1, 2019, causing a revenue reduction of $573,756 for the nine months beginning July 1, 2019.

141. Kings Harbor Multicare Center is a 720-bed skilled nursing facility located at 2000 East Gun Hill Road, Bronx, New York 10469. It employs 988 individuals and has an average Medicaid daily census of approximately 86%. On October 9, 2019, the New York State Department of Health announced that this Facility would receive a Medicaid rate reduction of $12.91 per Medicaid patient day retroactive to July 1, 2019. The overall negative revenue impact upon this Facility for the nine month period commencing July 1, 2019 is estimated to be $2,400,000.00.

142. Horizon Care Center is a 280-bed skilled nursing facility located at 64-11 Beach Channel Drive in Arverne, New York 11692. It has an average daily Medicaid census of approximately 96% and employs 210 individuals. On October 9, 2019, the New York State

Department of Health announced that this Facility would receive a Medicaid rate reduction of $9.07 retroactive to July 1, 2019. The estimated negative impact on this Facility for the nine month period commencing July 1, 2019 is $650,000.00.

143. New Surfside Nursing Home d/b/a Corning Family Nursing and Rehabilitation Center is a Five Star facility licensed for 183 beds located at 22-41 New Haven Avenue, Far Rockaway, New York 11691. It has an average daily Medicaid census of approximately 99% and employs 165 individuals. On October 9, 2019, the New York State Department of Health announced that this Facility's Medicaid rate would be reduced by $20.48 per Medicaid patient day retroactive to July 1, 2019. The estimated negative impact upon this Facility will be approximately $1,100,000.00 as a result of this rate reduction.

144. Northwoods Rehabilitation and Nursing Care Center at Moravia is a 40-bed skilled nursing facility located at 7 Keeler Avenue, Moravia, New York 11118. It is a 40-bed facility with an average daily Medicaid census of approximately 90%. It is a Five Star rated facility and employs approximately 45 individuals. On October 9, 2019, the New York State Department of Health announced that its Medicaid rate was being reduced by $24.73 per Medicaid patient day retroactive to July 1, 2019. The estimated negative impact upon the Facility's revenue for the nine-month period commencing July 1, 2091 as a result of this rate reduction will be $240,000.00.

145. Tarrytown Health Care Center is a 120-bed skilled nursing facility located at 20 Wood Court in Tarrytown, New York 10591. It has an average daily Medicaid census of approximately 80% and employs 125 individuals. On October 9, 2019, the New York State Department of Health announced that this Facility would receive a $10.52 reduction in its Medicaid rate per patient day retroactive to July 1, 2019. The estimated impact of this rate

reduction on the Facility for the nine month period commencing July 1, 2019 will be approximately $244,813.00.

146. Alpine Rehabilitation and Nursing Center is an 80-bed skilled nursing facility located at 755 East Monroe Street, Little Falls, New York 13365. It is licensed by the New York State Department of Health and has an average Medicaid occupancy of 81%. It employs 126 individuals. On October 9, 2019, the New York State Department of Health advised Alpine that its Medicaid rate was being reduced by $16.59 retroactive to July 1, 2019. The anticipated negative impact upon Alpine's revenues for the period commencing July 1, 2019 will be $254,474.00.

147. Norwich Rehabilitation and Nursing Center is an 82-bed skilled nursing facility licensed by the New York State Department of Health and located at 88 Calvary Drive, Norwich, New York 13815. It employs 115 individuals and has an average Medicaid daily census of 64%. On October 9, 2019, the New York State Department of Health announced that Norwich's Medicaid rate was being reduced by $11.25 per Medicaid patient day retroactive to July 1, 2019. The anticipated impact upon this Facility of that reduction for the nine month period commencing July 1, 2019 is $154,710.00.

148. Highland Rehabilitation and Nursing Center is a 98-bed skilled nursing facility located at 120 Highland Avenue, Middletown, New York 10940. It is licensed by the New York State Department of Health and has an average Medicaid census of 68%. Highland employs 110 employees. On October 9, 2019, the New York State Department of Health announced that Highland's Medicaid rate was being reduced by $7.02 per Medicaid patient day retroactive to July 1, 2019. The anticipated impact upon the Facility will be $150,830.00.

149. Utica Rehabilitation and Nursing Center is a 120-bed skilled nursing facility located at 2535 Genesee Street, Utica, New York 13501. It has an average daily Medicaid census of 90% and employs 100 individuals. On October 9, the New York State Department of Health announced that the Facility's Medicaid rate was being reduced by $16.85 per Medicaid patient day retroactive to July 1, 2019. The estimated Medicaid impact of this rate reduction for the nine month period commencing July 1, 2019 is $327,733.00.

150. Sodus Rehabilitation and Nursing Center is a 125-bed skilled nursing facility licensed by the New York State Department of Health and located at 6884 Maple Avenue in Sodus, New York 14451. It has an average daily Medicaid census of 86% and it employs approximately 115 individuals. On October 9, 2019, the New York State Department of Health announced that this Facility's Medicaid reimbursement rate was being reduced by $23.18 retroactive to July 1, 2019. The estimated impact on this Facility for the nine month period commencing July 1, 2019 is $558,545.00.

151. Auburn Rehabilitation and Nursing Center is a 92-bed skilled nursing facility located at 85 Thornton Avenue, Auburn, New York 13021. Its average daily Medicaid census is 77% and it employs 106 individuals. On October 9, 2019, the New York State Department of Health announced that this Facility's Medicaid rate was being reduced by $10.17, which will have an estimated Medicaid impact on the Facility of approximately $150,597.00 for the nine month rate period commencing July 1, 2019.

152. Orchard Rehabilitation and Nursing Center is a 160-bed skilled nursing facility licensed by the New York State Department of Health and located at 600 Bates Road, Medina, New York 14013. It has an average daily Medicaid census of approximately 81% and employs 180 individuals. On October 9, 2019, the New York State Department of Health announced that

Orchard's Medicaid reimbursement rate was being reduced by $22.89 retroactive to July 1, 2019. The estimated Medicaid impact upon this Facility for the nine month period beginning July 1, 2019 is $753,516.00.

153. Gowanda Rehabilitation and Nursing Center is a 160-bed skilled nursing facility located at 100 Miller Street, Gowanda, New York 14070. It is licensed by the New York State Department of Health and has an average Medicaid census of 78% and employs 165 individuals. On October 9, 2019, the New York State Department of Health announced that this Facility's Medicaid rate was being reduced by $22.20 per Medicaid patient day retroactive to July 1, 2019. The estimated impact on this Facility will be $604,195.00 for the nine month period commencing July 1, 2019.

154. Eden Rehabilitation and Nursing Center is located at 2806 George Street, Eden, New York 14057. It is licensed by the New York State Department of Health as a skilled nursing facility with an average daily Medicaid census of 76% and it employs 60 individuals. On October 9, 2019, the New York State Department of Health announced that this Facility's Medicaid reimbursement rate was being reduced by $19.02 retroactive to July 1, 2019. The estimated impact upon this Facility is $159,645.00 for the nine month period commencing July 1, 2019.

155. Dunkirk Rehabilitation and Nursing Center is a 40-bed skilled nursing facility located at 447 Lake Shore Drive, Dunkirk, New York 14048. Its daily Medicaid census averages 68% and it employs 65 individuals. On October 9, 2019, the New York State Department of Health announced that this Facility's Medicaid rate was being reduced by $14.04 per Medicaid patient day. The estimated impact of this rate reduction on the Facility for the nine month period commencing July 1, 2019 is $84,998.00.

156. Houghton Rehabilitation and Nursing Center is a 120-bed skilled nursing facility located at 451 Broad Street, Salamanca, New York. It has an average daily Medicaid census of 81% and is licensed by the New York State Department of Health as a residential health care facility. It employs 130 individuals and on October 9, 2019 the New York State Department of Health announced that this Facility's Medicaid reimbursement rate was being reduced by $9.81 retroactive to July 1, 2019. The estimated impact upon this Facility is $211,276.00 for the nine month period commencing July 1, 2019.

157. Yorktown Rehabilitation and Nursing Center is a 127-bed skilled nursing facility licensed by the New York State Department of Health and located at 2300 Catherine Street, Cortlandt Manor, New York. It has an average Medicaid census of approximately 40% and employs 149 individuals. Its Medicaid reimbursement rate for the period commencing July 1, 2019 was reduced by $33.62 by the New York State Department of Health retroactive to July 1, 2019. The overall impact upon the Facility will be $580,651.00 for the nine month period commencing July 1, 2019 as a result of this rate reduction.

158. Cosden LLC d/b/a Palatine Nursing Home is a 70-bed skilled nursing facility located at 154 Lafayette Street, Palatine Bridge, New York. It has an average daily Medicaid census of 74% and employs 58 individuals. On October 9, 2019, the New York State Department of Health announced that this Facility's Medicaid rate was being reduced by $6.97 per Medicaid patient day retroactive to July 1, 2019. The anticipated negative effect on this Facility's Medicaid revenues for the nine month period commencing July 1, 2019 is $85,034.

159. Brookhaven Rehabilitation and Health Care Center is a 290-bed skilled nursing facility licensed by the New York State Department of Health and located at 250 Beach 17th Street, Far Rockaway, New York 11691. It is licensed by the State of New York and has an

average Medicaid census of 90%. It employs 275 individuals and as a result of the action taken by the Department of Health, its Medicaid reimbursement rate has been reduced by $6.41 per Medicaid patient day retroactive to July 1, 2019. It is expected that the projected impact based on estimated Medicaid patient days between July 1, 2019 and March 31, 2020 is $425,000.00.

160. Northern Manhattan Rehabilitation and Nursing Center is a 320-bed skilled nursing facility located at 116 East 125th Street, New York, New York 10035. Northern Manhattan has an average of 90% Medicaid patients and employs 273 individuals. As a result of the action taken by the Department of Health, its Medicaid reimbursement rate has been reduced by $23.53 per Medicaid patient day and it is anticipated that this will have an adverse impact of approximately $1,825,000.00 on the Facility for the nine-month period commencing July 1, 2019.

161. Medford Multi-Care Center is a 320-bed skilled nursing facility licensed by the New York State Department of Health and located at 3115 Horseblock Road, Medford, New York. It employs 420 employees and has an average Medicaid census of 82%. The New York State Department of Health has advised this Facility that as of July 1, 2019 its Medicaid reimbursement rate is being reduced by $25.89 per Medicaid patient day. This will have an impact of $1,750,000.00 on this Facility for the nine month period commencing July 1, 2019.

162. Manhattanville Health Care Center is a 200-bed skilled nursing facility licensed by the New York State Department of Health and located at 311 West 231st Street, Bronx, New York 10463. It has an average Medicaid census of 98% and employs 163 people. The New York State Department of Health has advised this Facility that effective July 1, 2019, its Medicaid reimbursement rate is being reduced by $20.69, which will have an impact of approximately $950,000.00 in revenue reduction for the nine-month period beginning July 1, 2019.

163. Resort Nursing Home is a 280-bed skilled nursing facility whose average daily Medicaid census is approximately 91%. It employs 240 individuals. It has been advised by the New York State Department of Health that its Medicaid reimbursement rate is being reduced by $21 per day retroactive to July 1, which will have an anticipated Medicaid impact upon the Facility of $772,800.00 for the nine-month period beginning July 1, 2019.

164. Dry Harbor Nursing Home is a 300-bed skilled nursing facility licensed by the New York State Department of Health and located at 61-35 Dry Harbor Road, Middle Village, New York 11379. It employs about 518 individuals and has an average Medicaid percentage of 61%. It has been advised by the New York State Department of Health that its Medicaid reimbursement rate will be reduced by $20.19 retroactive to July 1, 2019. The anticipated negative impact on this Facility's Medicaid revenue for the nine-month period beginning July 1, 2019 is $1,178,968.00.

165. Forest View Center for Rehabilitation and Nursing is a New York City-based residential health care facility licensed by the New York State Department of Health with a bed capacity of 160 beds. It is located at 71-20 110th Street, Forest Hills, New York 10375. It has an average Medicaid census of 65% and employs 200 people. It has been advised by the New York State Department of Health that its Medicaid rate has been reduced by $12.70 per Medicaid patient day retroactive to July 1, 2019. The projected impact to this Facility based on Medicaid patient days between July 1, 2019 and March 31, 2020 is $310,000.00.

166. Woodcrest Rehabilitation and Residential Health Care Facility is a 200-bed skilled nursing facility licensed by the New York State Department of Health and located at 119-09 26th Avenue, Flushing, New York 11354. It has a Medicaid census of approximately 87% and employs 200 people. It has been advised by the New York State Department of Health that

its Medicaid rate has been retroactively reduced by $16.20 per Medicaid patient day effective July 1, 2019. This will have an estimated negative Medicaid revenue impact upon the Facility of $718,000.00 for the nine month period commencing July 1, 2019.

167. West Lawrence Care Center, LLC is a 215-bed residential health care facility licensed by the New York State Department of Health located at 1410 Seagirt Boulevard, Far Rockaway, New York 11691. It has a Medicaid census that averages 94% and employs approximately 130 people. Its Medicaid rate was reduced effective July 1, 2019 by $23.75, which will have an estimated negative impact on the Facility's revenue of $1,123,000.00 for the nine-month period commencing July 1, 2019.

168. Avon Nursing Home is a 40-bed skilled nursing facility located at 215 Clinton Street, Avon, New York 14014 that is licensed by the New York State Department of Health. It has an average Medicaid census of 76% and employs 70 people. The New York State Department of Health has advised that its Medicaid rate had been reduced by $26.69 retroactive to July 1, 2019 and the expected Medicaid impact upon this Facility's revenue for the nine month period commencing July 1, 2019 is $199,202.00.

169. The Brightonian Nursing Home is a 54-bed skilled nursing facility licensed by the New York State Department of Health and located at 1919 Elmwood Avenue, Rochester, New York 14620. It has a 53% average Medicaid census and employs 108 people. It has been advised by the New York State Department of Health that its Medicaid reimbursement rate is being reduced by $19.23 retroactive to July 1, 2019. The expected impact on this Facility's Medicaid revenue for the nine-month period commencing July 1, 2019 is $141,381.00.

170. Hamilton Manor Nursing Home is a 40-bed skilled nursing facility that employs 82 people with an average Medicaid census of 79%. It is licensed by the New York State

Department of Health and located at 1172 Long Pond Road, Rochester, New York. It has been advised that its Medicaid rate will be reduced by $9.92 retroactive to July 1, 2019. The expected impact upon this Facility will be $78,104.00 for the nine-month period commencing July 1, 2019.

171. Hornell Gardens, LLC is a residential health care facility licensed by the New York State Department of Health and situated at 434 Monroe Avenue, Rochester, New York. It has 114 licensed beds and employs 129 people and has an average Medicaid census of 88%. It was advised by the New York State Department of Health that its Medicaid rate is being retroactively reduced by $8.01 per Medicaid patient day for the period commencing July 1, 2019. The expected Medicaid impact on this Facility for the period July 1, 2019 through March 31, 2020 is $139,213.00.

172. The Hurlbut Nursing Home is a 160-bed residential health care facility licensed by the New York State Department of Health and located at 1177 East Henrietta Road, Rochester, New York. It has an average Medicaid census of 91% and employs 226 individuals. It has been advised by the New York State Department of Health that its Medicaid reimbursement rate is being reduced by $11.62 per Medicaid patient day retroactive to July 1, 2019 and the expected negative impact upon the Facility's Medicaid revenue for the nine month period commencing July 1 ,2019 is $396,984.00.

173. The Latta Road Nursing Home East is a residential health care facility licensed by the New York State Department of Health for 40 beds and is located at 2102 Latta Road, Rochester, New York. It has been advised by the Facility that its Medicaid reimbursement rate is being reduced by $7.64 retroactive to July 1, 2019 and that it is expected that this Medicaid reduction in rates will result in a loss to the Facility of $58,107.00 for the nine month period commencing July 1, 2019.

174. Latta Road Nursing Home West is a 40-bed residential health care facility licensed by the New York State Department of Health and is located at 2100 Latta Road, Rochester, New York. It has an average Medicaid census of 84% and employs 86 individuals. Its Medicaid reimbursement rate has been reduced by $6.43 retroactive to July 1, 2019, which will have a negative impact upon the Facility of $55,661.00 for the nine-month Medicaid rate period commencing July 1, 2019.

175. Newark Manor Nursing Home is a 60-bed skilled nursing facility with an average Medicaid census of 82% that employs 99 people. It is licensed by the New York State Department of Health and is located at 22 West Pearl Street, Newark, New York 13513. This Facility has been advised by the New York State Department of Health that its Medicaid rate will be reduced by $6.18 retroactive to July 1, 2019. The expected overall Medicaid impact on this Facility for the nine-month period beginning July 1, 2019 is expected to be $82,510.Penfield Place Nursing Home is a 50-bed residential health care facility that employs 81 individuals and is located at 1700 Penfield Road, Penfield, New York 14526. It has been advised by the New York State Department of Health that its Medicaid reimbursement rate has been reduced by $6.62 retroactive to July 1, 2019. It is anticipated that the Medicaid revenue impact upon this Facility will be a negative $54,389.00 for the nine-month period commencing July 1, 2019.

177. Seneca Nursing and Rehabilitation Center is a 120-bed residential health care facility that has an average Medicaid census of 83%. It employs 125 people and is situated at 200 Douglas Drive, Waterloo, New York 13165. This Facility was advised that its Medicaid reimbursement rate was being reduced by $12.62 retroactive to July 1, 2019 and the Medicaid impact upon this Facility will be $210,605.00.

178. The Shore Winds Nursing Home is a 229-bed residential health care facility licensed by the New York State Department of Health and located at 425 Beach Avenue, Syracuse, New York. It has an average Medicaid census of 92% and employs 283 people. It was advised by the New York State Department of Health that its Medicaid rate is being reduced by $11.52 retroactive to July 1, 2019 and it is anticipated that its Medicaid revenue reduction as a result thereof will be $506,108.00 for the nine month period beginning July 1, 2019.

179. Bainbridge Nursing & Rehabilitation Center is a 200-bed residential health care facility licensed by the New York State Department of Health and is situated at 3518 Bainbridge Avenue, Bronx, New York 10467. It is a Five Star facility with a Medicaid census of approximately 92%. It employs 258 people and as a result of the Medicaid rate cut challenged in this proceeding, its projected losses from July 1, 2019 through March 31, 2020 is $1,266,741.

180. East Haven Nursing & Rehabilitation Center is a 200-bed residential health care facility licensed by the New York State Department of Health and is situated at 2323 Eastchester Road, Bronx, New York 10469. It is a Five Star facility with a Medicaid census of approximately 89%. It employs 203 people and as a result of the Medicaid rate cut challenged in this proceeding, its projected losses from July 1, 2019 through March 31, 2020 is $169,886.

181. Mosholu Parkway Nursing & Rehabilitation Center is a 122-bed residential health care facility licensed by the New York State Department of Health and is situated at 3356 Perry Avenue, Bronx, New York 10467. It is a Five Star facility with a Medicaid census of approximately 92%. It employs 140 people and as a result of the Medicaid rate cut challenged in this proceeding, its projected losses from July 1, 2019 through March 31, 2020 is $447,280.

182. Wayne Center for Nursing & Rehab is a 243-bed residential health care facility licensed by the New York State Department of Health and is situated at 3530 Wayne Avenue,

Bronx, New York 10467. It is a Five Star facility with a Medicaid census of approximately 96%. It employs 263 people and as a result of the Medicaid rate cut challenged in this proceeding, its projected losses from July 1, 2019 through March 31, 2020 is $1,193,945.

183. The Grand at Barnwell is a 236-bed nursing home located at 3230 Church Street, Valatie, Columbia County, New York 12184. Approximately 73% of residents are Medicaid beneficiaries, and The Grand at Barnwell's overall average occupancy rate is approximately 96%. The rate cut challenged in this proceeding will reduce The Grand at Barnwell's Medicaid rate by $4.81 per resident per day, or approximately $303,030 per year.

184. The Grand at Guilderland is a 127-bed nursing home located at 428 State Route 146, Altamont, Albany County, New York 12009. Approximately 68% of residents are Medicaid beneficiaries, and The Grand at Guilderland's overall average occupancy rate is approximately 98%. The rate cut challenged in this proceeding will reduce The Grand at Guilderland's Medicaid rate by $7.48 per resident per day, or approximately $231,880 per year.

185. The Grand at Utica is a 220-bed nursing home located at 1657 Sunset Avenue, Utica, Oneida County, New York 13502. Approximately 84% of residents are Medicaid beneficiaries, and The Grand at Utica's overall average occupancy rate is approximately 94%. The rate cut challenged in this proceeding will reduce The Grand at Utica's Medicaid rate by $9.62 per resident per day, or approximately $625,000 per year.

186. The Grand at Pawling is a 122-bed nursing home located at 9 Reservoir Road, Pawling, Dutchess County, New York 12564. Approximately 78% residents are Medicaid beneficiaries, and The Grand at Pawling's overall average occupancy rate is approximately 89%. The rate cut challenged in this proceeding will reduce The Grand at Pawling's Medicaid rate by

$13.95 per resident per day, or approximately $460,350 per year. This reduction exceeds Respondents' 5% regulatory "circuit breaker" on rate decreases.

187. The Grand at Queens is a 179-bed nursing home located at 157-15 19th Avenue, Whitestone, Queens County, New York 11357. Approximately 70% residents are Medicaid beneficiaries, and The Grand at Queens' overall average occupancy rate is approximately 98%. The Grand at Queens is rated 5 out of 5 stars by CMS. The rate cut challenged in this proceeding will reduce The Grand at Queens' Medicaid rate by $8.24 per resident per day, or approximately $362,560 per year.

188. Chestnut Park is an 80-bed nursing home located at 330 Chestnut Street, Oneonta, Otsego County, New York 13820. Approximately 63% of residents are Medicaid beneficiaries, and Chestnut Park's overall average occupancy rate is approximately 98%. The rate cut challenged in this proceeding will reduce Chestnut Park's Medicaid rate by $5.43 per resident per day, or approximately $92,310 per year.

189. Emerald North is a 95-bed nursing home located at 1205 Delaware Avenue, Buffalo, Erie County, New York 14209. Approximately 85% of residents are Medicaid beneficiaries, and Emerald North's overall average occupancy rate is approximately 97%. The rate cut challenged in this proceeding will reduce Emerald North's Medicaid rate by $30.43 per resident per day, or approximately $821,610 per year. This reduction exceeds Respondents' 5% regulatory "circuit breaker" on rate decreases.

190. The Grand at South Point is a 185-bed nursing home located at One Long Beach Road, Island Park, Nassau County, New York 11558. Approximately 88% of residents are Medicaid beneficiaries, and The Grand at South Point's overall average occupancy rate is approximately 59%. The Grand at South Point is rated 4 out of 5 stars by CMS. The rate cut

challenged in this proceeding will reduce The Grand at South Point's Medicaid rate by $32.21 per resident per day, or approximately $1,739,340 per year. This reduction exceeds Respondents' 5% regulatory "circuit breaker" on rate decreases.

191. Park Terrace Care Center is a 160-bed skilled nursing facility located at 59-20 Van Doren Street, Corona, New York 11368. Effective July 1, 2019, the New York State Department of Health cut this Facility's rate by $21.66, which will have an expected negative impact of $543,382.00 over the ensuing nine months.

192. Queens Nassau Nursing Home is a 180-bed skilled nursing facility located at 520 Beach 15th Street, Far Rockaway, New York 11691. Effective July 1, 2019, the New York State Department of Health cut this Facility's Medicaid reimbursement rate by $10.36 which will have an expected negative impact on the Facility over the ensuing nine months of $363,957.00.

193. Adira at Riverside Rehab & Nursing is a 120-bed residential health care facility licensed by the New York State Department of Health and is situated at 120 O'Dell Avenue, Yonkers, New York 10701. It has a Medicaid census of approximately 60%. It employs 116 people and as a result of the Medicaid rate cut challenged in this proceeding, its projected losses from July 1, 2019 through March 31, 2020 are $250,693.

194. Bensonhurst Center for Rehabilitation & Healthcare is a 200-bed residential health care facility licensed by the New York State Department of Health and is situated at 1740 84th Street, Brooklyn, New York 11214. It is a Five Star facility with a Medicaid census of approximately 44%. It employs 234 people and as a result of the Medicaid rate cut challenged in this proceeding, its projected losses from July 1, 2019 through March 31, 2020 are $468,535.

195. Hilaire Rehab & Nursing is a 76-bed residential health care facility licensed by the New York State Department of Health and is situated at 9 Hilaire Drive, Huntington, New

York 11743. Its average percentage of Medicaid patients is approximately 71%. It employs 113 people and as a result of the Medicaid rate cut challenged in this proceeding of $51.70 per Medicaid patient day, its projected losses from July 1, 2019 through March 31, 2020 are $660,777.

196. Smithtown Center for Rehab & Nursing Care is a 162-bed residential health care facility licensed by the New York State Department of Health and is situated at 391 North Country Road, Smithtown, New York 11787. It is a Five Star facility with a Medicaid census of approximately 64%. It employs 261 people and as a result of the Medicaid rate cut challenged in this proceeding, its projected losses from July 1, 2019 through March 31, 2020 are $320,565.

197. Sprain Brook Manor Rehab is a 121-bed residential health care facility licensed by the New York State Department of Health and is situated at 77 Jackson Avenue, Scarsdale, New York 10583. Its average percentage of Medicaid patients is approximately 65%. It employs 107 people and as a result of the Medicaid rate cut challenged in this proceeding, its projected losses from July 1, 2019 through March 31, 2020 are $372,886.

198. Greene Meadows Nursing & Rehabilitation Center is a 120-bed residential health care facility licensed by the New York State Department of Health and is situated at 161 Jefferson Heights, Catskill, New York 12414. Its average percentage of Medicaid patients is approximately 71%. As a result of the Medicaid rate cut challenged in this proceeding, its projected losses from July 1, 2019 through March 31, 2020 are $327,289.

199. Premier Genesee is a 160-bed residential health care facility licensed by the New York State Department of Health and is situated at 278 Bank Street, Batavia, New York 14020. Its average percentage of Medicaid patients is approximately 82%. It employs 235 people and

as a result of the Medicaid rate cut challenged in this proceeding, its projected losses from July 1, 2019 through March 31, 2020 are $790,248.

200. LeRoy Village Green Residential Health CF Inc. is a 140-bed residential health care facility licensed by the New York State Department of Health and is situated at 10 Munson Street, LeRoy, New York 14482. It has a Medicaid census of approximately 65%. It employs 299 people and as a result of the Medicaid rate cut challenged in this proceeding, its projected losses from July 1, 2019 through March 31, 2020 are $351,857.

201. Pine Haven Home is a 120-bed residential health care facility licensed by the New York State Department of Health and is situated at 201 Main Street, Philmont, New York 12565. Its average percentage of Medicaid patients is approximately 74%. It employs 80 people and as a result of the Medicaid rate cut challenged in this proceeding, its projected losses from July 1, 2019 through March 31, 2020 are $499,108.

202. Bellhaven Center for Rehab. & Nursing is a 240-bed residential health care facility licensed by the New York State Department of Health and is situated at 110 Beaver Dam Road, Brookhaven, New York 11719. It is a Four Star facility with a Medicaid census of approximately 82%. It employs 269 people and as a result of the Medicaid rate cut challenged in this proceeding, its projected losses from July 1, 2019 through March 31, 2020 are $650,000.

203. Whittier Rehab. & Skilled Nursing Center is a 120-bed residential health care facility licensed by the New York State Department of Health and is situated at 1 Whittier Way, Ghent, New York, 12075. Its average percentage of Medicaid patients is approximately 73%. It employs 184 people and as a result of the Medicaid rate cut challenged in this proceeding, its projected losses from July 1, 2019 through March 31, 2020 are $768,778.

204. Beach Gardens Rehabilitation and Nursing Center is a 163-bed skilled nursing facility located at 1711 Brookhaven Avenue, Far Rockaway, New York 11691. As a result of the rate cut of $14.16 per Medicaid patient day by the Department of Health, it stands to lose $433,337.00 for the nine-month period commencing July 1, 2019.

205. Bronx Garden Rehabilitation and Nursing Center is located at 2175 Quarry Road, Bronx, New York 10457. It has a licensed capacity of 199 beds and its Medicaid rate was reduced effective July 1, 2019 by $20.18. Its projected losses for the nine-month period commencing July 1, 2019 are $529,059.00.

206. The Plaza Rehabilitation and Nursing Center is a 159-bed skilled nursing facility located at 100 West Kingsbridge Road, Bronx, New York 10465. The Department of Health reduced this Facility's Medicaid reimbursement rate by $12.43 effective July 1, 2019. The projected impact of this loss over the next nine months commencing July 1, 2019 is $1,185,524.00.

207. Grandell Rehabilitation and Nursing Center is a 278-bed skilled nursing facility located at 645 West Broadway, New York, New York. The Department of Health cut this Facility's Medicaid rate by $13.52 effective July 1, which will have an anticipated negative impact on the Facility's revenue for the nine month period commencing July 1, 2019 of $526,009.00.

208. Oceanside Care Center is a 100-bed skilled nursing facility located at 2914 Lincoln Avenue, Oceanside, New York 11572. This Facility's Medicaid rate was cut by $7.44 effective July 1, 2019. The overall impact over the next nine months is expected to be $73,580.00.

209. Beach Terrace Care Center is a 182-bed skilled nursing facility located in the Long Island region. Its Medicaid rate was cut by $12.53 effective July 1, 2019. The estimated impact of this rate cut for the nine months commencing July 1, 2019 is $423,852.00.

210. Absolut Care at Orchard Park is a 202-bed skilled nursing facility located at 6060 Armor Road, Orchard Park, New York 14127. The Department of Health cut this Facility's Medicaid rate by $4.08 effective July 1, 2019. The estimated overall negative impact on this Facility for the nine month period commencing July 1, 2019 is $40,607.00.

211. Absolut Care of Westfield is a 120-bed skilled nursing facility located at 26 Cass Street in Westfield, New York. Effective July 1, 2019, the New York State Department of Health cut the Facility's Medicaid reimbursement rate by $13.18. This will have a negative impact on the Facility for the ensuing nine-month period of $138,865.00.

212. Absolut Care of Allegany is a 37-bed skilled nursing facility located at 2178 North Street, Allegany, New York 14706. Effective July 1, 2019, the New York State Department of Health cut this Facility's Medicaid reimbursement rate by $44.45. The expected negative impact over the ensuing nine months is $118,932.00.

213. Absolut Care of Aurora Park is a 320-bed skilled nursing facility located at 292 Main Street, East Aurora, New York. Effective July 1, 2019, the New York State Department of Health cut this Facility's Medicaid reimbursement rate by $5.58 which will have an anticipated overall negative impact for the ensuing nine months of $145,209.00.

214. Absolut Care of Gasport is an 83-bed skilled nursing facility located at 4540 Lincoln Drive, Gasport, New York 14067. Effective July 1, 2019, the New York State Department of Health cut this Facility's Medicaid reimbursement rate by $10.26, which will have an expected negative impact over the ensuing nine months of $76,805.00.

215. Meadowbrook Care Center is a 282-bed skilled nursing facility located at 320 West Merrick Road, Freeport, New York 11520. It is a 282-bed skilled nursing facility and its Medicaid rate was cut by the New York State Department of Health effective July 1, 2019 by $17.99 per patient day, with an expected overall Medicaid impact for the next nine months of $985,505.00.

216. Meadowbrook Healthcare is a 287-bed skilled nursing facility located at 154 Prospect Avenue, Plattsburgh, New York. Effective July 1, 2019, the New York State Department of Health cut this Facility's Medicaid reimbursement rate by $11.56, which will have an anticipated negative revenue impact over the next nine months of $459,279.00.

217. New York Center for Rehabilitation and Nursing is a 280-bed skilled nursing facility situated in the downstate area of New York. Effective July 1, 2019, the New York State Department of Health cut this Facility's Medicaid rate by $18.02, which will have an anticipated negative impact upon the Facility's revenue over the ensuing nine months of $936,590.00.

218. East Rockaway Care Center d/b/a Lynbrook Restorative Therapy and Nursing is a 100-bed skilled nursing facility located at 243 Atlantic Avenue, Lynbrook, New York 11563. Effective July 1, 2019, the New York State Department of Health cut this Facility's Medicaid reimbursement rate by $13.45, which will have an expected negative impact over the ensuing nine months of $81,000.00.

219. Excel at Woodbury for Rehabilitation and Nursing is a 123-bed skilled nursing facility located at 8553 Jericho Turnpike, Woodbury, New York 11797. It is a 123-bed facility whose Medicaid rate was cut by $15.25 by the New York State Department of Health effective July 1, 2019. This is expected to have a $126,000.00 negative impact upon the Facility for the nine month period commencing July 1, 2019.

220. Forest Manor Care Center d/b/a Glen Cove Center for Nursing and Rehabilitation is a 154-bed nursing home located at 6 Medical Plaza, Glen Cove, New York 11542. Effective July 1, 2019, the New York State Department of Health cut this Facility's Medicaid reimbursement rate by $13.52, which will have a negative impact over the ensuing nine months of $135,000.00.

221. Long Island Care Center is a 200-bed skilled nursing facility located at 144-61 38th Avenue, Flushing, New York 11354. Effective July 1, 2019, the New York State Department of Health cut this Facility's Medicaid reimbursement rate by $21.16, which will have an estimated negative impact on the Facility's revenue over the ensuing nine months of $550,000.00.

222. Montclair Care Center d/b/a Emerge Nursing and Rehabilitation Center is a 102-bed skilled nursing facility located at 2 Medical Plaza, Glen Cove, New York 11542. Effective July 1, 2019, this Facility's Medicaid reimbursement rate was cut by $4.73, which will have an anticipated negative impact of $46,000.00 over the ensuing nine months.

223. Oasis Rehabilitation and Care Center is a 100-bed skilled nursing home located at 6 Frowein Road, Center Moriches, New York. Effective July 1, 2019, its Medicaid reimbursement rate was cut by $6.88 and the anticipated negative impact on this Facility's revenue over the ensuing nine months will be $51,000.00.

224. Quantum Rehabilitation and Nursing Center is a 120-bed skilled nursing facility located at 63 Oakcrest Avenue, Middle Island New York 11953. Effective July 1, 2019, the New York State Department of Health cut this Facility's Medicaid reimbursement rate by $25.93, which will have an expected negative impact over the ensuing nine months of approximately $340,000.00.

225. Suffolk Restorative Care and Nursing Center d/b/a Momentum at South Bay is a 160-bed skilled nursing facility located at 30 East Montauk Avenue, East Islip, New York 11370. Effective July 1, 2019, the New York State Department of Health cut this Facility's Medicaid reimbursement rate by $28.21, which will have an estimated negative impact on the Facility's revenue over the ensuing nine months of $300,000.00.

226. Haym Solomon Home for the Aged is a 240-bed skilled nursing facility located at 2340 Cropsey Avenue, Brooklyn, New York 11214. Effective July 1, 2019, the New York State Department of Health reduced its Medicaid reimbursement rate by $29.51 retroactive to July 1, 2019. The anticipated overall impact upon this Facility is $1,246,148.00 over the ensuing nine month period.

227. Highland Care Center is a 320-bed skilled nursing facility located at 91-31 175th Street, Jamaica, New York 11432. Effective July 1, 2019, the New York State Department of Health reduced this Facility's Medicaid reimbursement rate by $33.09, which will have an anticipated negative impact over the ensuing nine months of approximately $2,150,000.00.

228. Oxford Nursing Home Inc. is a 235-bed residential health care facility licensed by the New York State Department of Health and is situated at 144 South Oxford Street, Brooklyn, New York 11217. It has a Medicaid census of approximately 85%. It employs 191 people and as a result of the Medicaid rate cut challenged in this proceeding, its projected losses from July 1, 2019 through March 31, 2020 is $2,484,711.

229. New Carlton Rehab Nursing Center is a 148-bed residential health care facility licensed by the New York State Department of Health and is situated at 405 Carlton Avenue, Brooklyn, New York 11238. Its average percentage of Medicaid patients is approximately 78%.

It employs 175 people and as a result of the Medicaid rate cut challenged in this proceeding, its projected losses from July 1, 2019 through March 31, 2020 is $720,253.

230. Laconia Nursing Home is a 240-bed residential health care facility licensed by the New York State Department of Health and is situated at 1050 E. 230th Street, Bronx, New York 10466. It is a Four Star facility with a Medicaid census of approximately 92%. It employs 191 people and as a result of the Medicaid rate cut challenged in this proceeding, its projected losses from July 1, 2019 through March 31, 2020 is $1,646,720.

231. Schervier Nursing Care Center is a 364-bed residential health care facility licensed by the New York State Department of Health and is situated at 2975 Independence Avenue, Bronx, New York 10463. It is a Four Star facility with a Medicaid census of approximately 65%. It employs 418 people and as a result of the Medicaid rate cut challenged in this proceeding, its projected losses from July 1, 2019 through March 31, 2020 is $692,393.

232. Brookside Multicare Center is a 353-bed skilled nursing facility licensed by the New York State Department of Health and is situated at 7 Route 25A, Smithtown, New York 11787. It has approximately 380 employees and its typical Medicaid census is 88%. The Department of Health reduced its Medicaid rate effective July 1, 2019 by $14.00 per day, which will have a projected negative impact for the nine-month period between July 1, 2019 of $1,026,564.00.

233. Little Neck Care Center is a 120-bed skilled nursing facility located at 260-19 Nassau Boulevard, Little Neck, New York. It has an average Medicaid census of 64% and the New York State Department of Health reduced its Medicaid reimbursement rate effective July 1, 2019 by $17.00 per day. This will result in a projected negative impact for the nine months commencing July 1, 2019 of $649,536.00.

234. White Plains Center for Nursing is an 88-bed skilled nursing facility located at 220 West Post Road, White Plains, New York 10606. It employs 78 people and the Department of Health reduced its Medicaid rate effective July 1, 2019 by $38.00 per patient day and will have a projected negative impact for the nine-month period beginning July 1, 2019 of $545,148.00.

235. Elcor Nursing and Rehabilitation Center is a licensed skilled nursing facility located at 48 Colonial Drive, Horseheads, New York 14845. It has an average Medicaid census of 86% and employs 516 individuals. It suffered a Medicaid rate reduction of $20.00 effective July 1, 2019 and the projected Medicaid impact on this Facility for the nine-month period beginning July 1, 2019 is $1.375 million.

236. Hudson Valley Rehabilitation and Extended Care Facility ("Hudson Valley") is a skilled nursing facility located at 260 Vineyard Avenue, Highland, New York 12528. It is in a precarious financial situation as it has a negative equity as of June 30, 2019 of $791,072.00. As a result of the case-mix adjustment being challenged in this litigation, Hudson Valley's rate is being reduced by $9.57. Given the average Medicaid census of this Facility of 130 patients, the projected negative impact on this Facility for the period from July 1, 2019 through March 31, 2020 is $335,907.00. This Facility has already been exempted from the lag system.

237. Regeis Care Center is a skilled nursing facility located at 3200 Baychester Avenue, Bronx, New York 10475. Its Medicaid rate was reduced by $26.37 effective July 1, 2019 by the New York State Department of Health. This will result in an anticipated reduction in Medicaid revenue of approximately $120,000 for the nine month period commencing July 1, 2019.

238. Westchester Center for Rehabilitation and Nursing is a 240-bed skilled nursing facility located at 10 Claremont Avenue, Mount Vernon, New York 10550. On July 1, 2019, its

Medicaid reimbursement rate was reduced by $29.40 such that the anticipated impact on its Medicaid revenue for the nine-month period commencing July 1, 2019 is $1 million.

239. Spring Creek Rehabilitation & Nursing Care Center is a 188-bed nursing home located at 660 Louisiana Avenue, Brooklyn, New York 11239. Approximately 75% of residents are Medicaid beneficiaries. The facility employs approximately 223 people. On July 1, 2019, its Medicaid reimbursement rate was reduced by $29.27 per resident per day, and the anticipated impact on its Medicaid revenue for the nine-month period commencing July 1, 2019 is $1,134,944.25.

240. Buena Vida Continuing Care and Rehabilitation Center is a 240-bed not-for-profit nursing home located at 48 Cedar Street, Brooklyn, New York 11221. Approximately 179 of the residents are Medicaid beneficiaries. This five-star rated facility employs approximately 320 people. On July 1, 2019, its Medicaid reimbursement rate was reduced by $23.32 per resident per day, and the anticipated impact on its Medicaid revenue for the nine-month period commencing July 1, 2019 is $1,001,827.20.

241. Bezalel Rehabilitation & Nursing Center ("Bezalel") is a 120-bed not-for-profit nursing home located at 29-38 Far Rockaway Road, Far Rockaway, New York 11691. Approximately 68% of the residents at this three-star facility are Medicaid beneficiaries. On July 1, 2019, its Medicaid reimbursement rate was reduced by $41.36 per resident per day, and the anticipated impact on its annual Medicaid revenue is $1,179,566.85. Bezalel anticipates that this cut may impact staffing, an ongoing facility renovation, and/or spending on goods, foods, and supplies purchased for the benefit of residents.

242. Beacon Rehabilitation is a 120-bed residential health care facility licensed by the New York State Department of Health and is situated at 140 Beach 113 Street, Rockaway Park,

New York 11694. It has a Medicaid census of approximately 62%. It employs 188 people and as a result of the Medicaid rate cut challenged in this proceeding, its projected losses from July 1, 2019 through March 31, 2020 is approximately $485,000.

243. Pelham Parkway is a 200-bed residential health care facility licensed by the New York State Department of Health and is situated at 2401 Laconia Avenue, Bronx, New York 10469. It has a Medicaid census of approximately 70%. It employs 179 people and as a result of the Medicaid rate cut challenged in this proceeding, its projected losses from July 1, 2019 through March 31, 2020 is $375,000.

244. Lawrence is a 200-bed residential health care facility licensed by the New York State Department of Health and is situated at 350 Beach 54th Street, Averne, New York 11692. It has a Medicaid census of approximately 67%. It employs 185 people and as a result of the Medicaid rate cut challenged in this proceeding, its projected losses from July 1, 2019 through March 31, 2020 is approximately $436,582.

245. Westhampton Care Center is a 180-bed residential health care facility licensed by the New York State Department of Health and is situated at 78 Old Country Road, Westhampton, New York 11977. It has a Medicaid census of approximately 66%. It employs 283 people and as a result of the Medicaid rate cut challenged in this proceeding, its projected losses from July 1, 2019 through March 31, 2020 is $573,904.

246. In addition to all of the aforementioned facilities, there are, upon information and belief, many other facilities that are members of the respective Association plaintiffs named in this action and that have been adversely affected by the actions taken by the Department of Health that are challenged herein. However, in light of the fact that these rate reductions were announced on October 9, 2019 and became generally known the following day, and because of the large

number of religious holidays that occur during this time of year, many facilities have been unable to amass the relevant data in time for the Plaintiffs to include them in their effort to obtain an Order to Show Cause before November 6, 2019, but the Associations in their representative are also bringing this action on behalf of these facilities.

247. The Department is the state agency charged under Public Health Law with administering New York State's participation in the Medicaid Program, pursuant to 10 NYCRR subpart 86-1.

248. Respondent Howard A. Zucker, M.D., J.D. (the "Commissioner"; collectively with the Department, the "Respondents") is the Commissioner of Health of the State of New York, and as such, he is responsible for carrying out the duties assigned by law to him, and to the New York State Department of Health (see Public Health Law § 200).

249. Respondents' principal office is located in Corning Tower, Empire State Plaza, Albany, New York.

250. Letitia A. James, Attorney General of the State of New York, is being provided with notice of this proceeding pursuant to CPLR 7804.

The Medicaid Program

251. Medicaid is a joint federal and state program established pursuant to Title XIX of the Social Security Act, 42 USC § 1396 et seq. (the "Medicaid Statute"), which aims to provide medical care to those who would otherwise be unable to afford such care.

252. According to Department data, approximately 72% of nursing home residents in New York are Medicaid beneficiaries. This amounts to approximately 69,000 individuals (see also Henry J. Kaiser Family Foundation, Medicaid's Role in Nursing Home Care [June 20, 2017], available at http://kff.org/infographic/medicaids-role-in-nursing-home-care/ [accessed Oct. 23,

2019]). Petitioners' members do not discriminate amongst residents based upon their ability to pay, or what "sponsor," such as Medicaid, pays for their services (see 10 NYCRR 415.26 [i] [1] [x]). Petitioners' members have a resident population that reflects the state average number of Medicaid beneficiaries and, consequently, Medicaid pays for most long term care services for most residents of Petitioners' member nursing homes.[1]

253. In order to participate in Medicaid, New York must comply with various requirements imposed by the Medicaid Statute and federal regulations promulgated thereunder, including the requirement that it submit to the CMS a State Plan for medical assistance which sets forth its methodology for compensating providers, and justifications for the proposed rates for the medical assistance they render to Medicaid recipients (see 42 USC §§ 1396a, 1396b). Any changes to New York's Medicaid plan must be submitted to and approved by CMS as a SPA. A copy of the October 1, 2010 letter from CMS detailing its approval process is annexed hereto as Exhibit "B".

254. The State of New York has participated in the Medicaid program at all relevant times.

255. Pursuant to Article 28 of the New York State Public Health Law, "[t]he Commissioner [of Health] administers the State's Medical Assistance Plan (Medicaid) and sets Medicaid reimbursement rates for nursing homes, more formally called 'residential health care facilities ["nursing homes"],' for medical services provided to the indigent" (Matter of Blossom

[1] Although a number of nursing home residents are Medicare beneficiaries, Medicare covers only a limited period of post-acute care, leaving most low-income residents and seniors reliant upon Medicaid, not Medicare, for long term care services (see 42 USC 1395d).

View Nursing Home v Novello, 4 NY3d 581, 584 [2005], citing Public Health Law §§ 2807 [3], 2808 [3]).

256. The Commissioner is required to "determine" and "certify [to the Director of the Budget] that the proposed rate schedules" for nursing home Medicaid rates are "reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities" (Public Health Law § 2807 [3]).

257. Respondents' methodology for the computation of nursing home Medicaid reimbursement rates is set forth in 10 NYCRR subpart 86-2.

258. The prospective rates are comprised of two components: (1) an operating component (the sum of direct,[2] indirect,[3] and non-comparable[4] components), *i.e.*, a non-capital component; and (2) a capital component[5] (see generally 10 NYCRR 86-2.40). The facility is paid a per-patient, per-day rate that is based upon these components.

Case-Mix Adjustments to Medicaid Rates

259. The "operating component" of each nursing home's Medicaid rate is subject to periodic adjustment by Respondents to reflect the facility's "case-mix" (Public Health Law § 2808 [2-b]). "Case-mix" is defined as "the patient population of a facility as classified and aggregated into patient classification groups," defined by the patients' acuity of care (10 NYCRR

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[2] The direct component of a facility's rate is normally the largest single category of a nursing home's total operating costs. It includes costs for 'direct' hands-on care, such as salaries for nurses (Registered and LPNs), nurse's aides, physical therapy, occupational therapy, social service and related disciplines.

[3] Indirect costs include items such as those incurred in connection with administrative services, fiscal services, maintenance (other than utilities and real estate taxes), patient food services, cafeteria, housekeeping, and medical records.

[4] Non-comparable costs include items such as laboratory services, radiology, podiatry, dental, psychiatric, and utilities.

[5] Capital costs include items such as interest expense on current and capital indebtedness, and depreciation on plant, non-movable equipment and movable equipment.

86-2.1 [c]). There are 53 different patient classification groups within the current Resource Utilization Group-III or "RUG-III" category system.[6] The RUG-III categories were intended to "identif[y] the relative resource consumption required by different groups of long-term care patients" (10 NYCRR 86-2.1 [b]).

260. In 2006, the Legislature amended Section 2808 of the Public Health Law to direct DOH to make semi-annual case-mix adjustments 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 title XVIII of the federal social security act (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 commissioner"

(L 2006, ch 109, pt C, § 47; see Public Health Law § 2808 [2-b] [b] [ii]).

261. Certain of these 53 RUG-III groups require a greater amount or intensity of services than others. Essentially, the case-mix adjustment modifies the facility's reimbursement rate based upon the proportion of residents in higher-intensity or lower-intensity service groups. "In other words, a facility that has more patients requiring intensive services will receive a greater reimbursement rate" (Matter of Elcor Health Servs. v Novello, 100 NY2d 273, 277 [2003]).

262. On or about February 3, 2014, Respondents adopted 10 NYCRR 86-2.40, titled "Statewide prices for non-capital reimbursement," which generally governs the operating

[6] Notably, although RUG-III was originally developed by CMS, CMS has since issued a more current, and specific, set of classification groups known as RUG-IV, which the Department has not implemented.

component of nursing home reimbursement (i.e., direct staff care, laboratory services, etc.) effective January 1, 2012.

263. 10 NYCRR 86-2.40 (m) provides, as relevant here:

> "The 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.
>
> (2) New York State wages shall be used to determine the weight of each RUG. The cost for each RUG shall be calculated using the relative resources for registered nurses, licensed practical nurses, aides, therapists, and therapy aides and the 1995-97 Federal time study. The minutes from the Federal time study shall be multiplied by the New York average dollar per hour to determine the fiscal resources need to care for that patient type. This amount shall be multiplied by the number of patients in that RUG. RUG weights shall be assigned based on the distance from the statewide average. . . .
>
> (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 Medicaid rate adjustment attributable to such a change in the reported case mix may be limited to 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."

(emphasis added). To date, this language remains unchanged.

264. Upon information and belief, 10 NYCRR 86-2.40 (m) (6) has been approved by CMS and is incorporated into the State's Medicaid Plan as its methodology for conducting case-mix adjustments (see Approved New York State Medicaid Plan, Attachment 4.19-D, § 110 [d] [13] ["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 (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)."]).

265. Upon information and belief, Section 86-2.40 (m) (10)'s five percent cap on rate changes (upward or downward) limits the immediate impact of a change in a nursing home's case-mix adjustment, which benefits the State, nursing homes, and their residents by ensuring that payment amounts retain a degree of predictability while accounting for resident need. In other words, the facility's rate will increase or decrease with each case-mix adjustment to reflect the evolving needs of the resident population, but within limits to protect the State and nursing homes from dramatic payment swings.

266. Predictable funding is of particular import to not-for-profit and mission-driven providers, which include many of Petitioners' members. These facilities operate on extremely low or negative margins, and have limited capacity to raise additional funds when anticipated revenue is disrupted. Because these mission-driven, "not-for-profit providers got into the stand-alone skilled nursing business years ago to enhance their mission," when their "nursing facilities . . . operate at a significant financial loss," the facilities "become a detriment to their mission" that must be addressed before it presents a "threat to the organization's viability" (Ziegler

Investment Banking, Senior Living Finance Z-News, Jan. 22, 2018, at 2, available at http://eziegler.com/files/SL_ZNEWS_012218.pdf).

Data for Case-Mix Adjustments

267. Upon information and belief, the Department assigns a RUG-III classification to each resident based upon resident assessment data submitted to it, or to CMS, by facilities.

268. The Department requires that nursing homes "conduct a comprehensive assessment of each resident's needs, which describes the resident's capability to perform daily life functions and identifies significant impairments in functional capacity" (10 NYCRR 415.11 [a] [1]). The comprehensive assessment must be conducted within 14 days after a resident is admitted, "promptly after a significant improvement or decline" in a resident's status, and must be revised "no less than once every three months" thereafter "to assure the continued accuracy of the assessment" (10 NYCRR 415.11 [a] [3]).

269. Nursing homes must also "develop a comprehensive care plan for each resident" based upon the "needs that are identified in the comprehensive assessment" (10 NYCRR 415.11 [c] [1]).

270. At present, CMS has substantially similar resident assessment requirements (see 42 CFR 483.20 [b]).

271. Under its present rules, CMS requires that nursing homes submit data contained in the resident assessments, known as the Minimum Data Set or "MDS" (see 42 CFR 483.20 [f]).[7] Respondents require nursing homes to submit the same MDS information to them (see 10 NYCRR 86-2.37).

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[7] CMS is changing its assessment and data reporting requirements, effective October 1, 2019, in order to implement a new Medicare payment model known as the Patient Driven Payment Model ("PDPM"). As part of

272. Respondents also require nursing homes to submit a "bed census" detailing the number of residents on Wednesday of each week (10 NYCRR 415.32; DRS/DAL 09-02: Weekly Bed Census Data Survey, available at https://health.ny.gov/professionals/nursing_home_administrator/docs/dal_09-02_weekly_bed_census_data_survey.pdf).

273. Upon information and belief, Respondents use the MDS and weekly census data to calculate the case-mix index for each nursing home.

274. Upon information and belief, from approximately July 1, 2012, through June 30, 2019, Respondents utilized the following methodology to calculate each facility's case-mix:

- For each semi-annual adjustment, Respondents examined each nursing home's resident population on the last Wednesday of the first month of the previous six-month adjustment period (i.e., for the January 1, 2013 adjustment, Respondents utilized the weekly census submitted by each facility for July 25, 2012, the last Wednesday of that month);
- Respondents identified the RUG-III category for each resident on the census based upon the MDS data the facility had submitted to CMS for that individual that was closest in time to the relevant census; and

the transition to PDPM, CMS has "retired" the "myriad" resident assessments it currently requires in favor of a "streamlined assessment schedule," and will require all states to change their assessment requirements effective October 1, 2020; notably, CMS will also cease reporting data used for New York's RUG-III system on that date (Centers for Medicare and Medicaid Services, Patient Driven Payment Model: Frequently Asked Questions [rev. Aug. 27, 2019], at 39-41, available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/Downloads/PDPM_FAQ_Final_v5.zip [accessed Oct. 23, 2019]). The relatively short interval of time left before Respondents will need to transition their data collection to align with federal requirements is further evidence of the irrationality of their methodological change.

- Respondents would not adjust a facility's case-mix index by more than 5%, upwards or downwards, to contain the impact of the adjustment, pending an audit by the Office of Medicaid Inspector General ("OMIG").

275. In sum, and consistent with the Legislative directive in Public Health Law § 2808 (2-b) (b) (ii), and Respondents' own regulation codified at 10 NYCRR 86-2.40 (m), Respondents utilized a methodology that determined each facility's semi-annual case-mix index adjustment based upon assessment data from the immediately preceding six-month adjustment period.

276. In addition, when issuing rates, Respondents would share with each nursing home the assessment data used, which would enable the facility to validate that the correct assessments were used (e.g., assessments were from time periods covered by Medicaid, as opposed to Medicare), and that rate additions provided under Respondents' regulations (such as for residents suffering from a traumatic brain injury) were applied to the correct individuals.

Respondents' Changes to their Case-Mix Adjustment Methodology

277. On or about March 27, 2019, ostensibly pursuant to federal regulations, the Department published a public notice in the State Register that it intended to, at some time in the future, seek CMS approval to modify the State 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 and shall be updated for 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)"

(NY Reg, Mar 27, 2019 at 89).[8]

278. Notably, the applicable federal regulation—42 CFR 447.205 (c)—requires Respondents to both "[d]escribe the proposed change in methods and standards" and "[e]xplain why the agency is changing its methods and standards" in its public notice. In this instance, Respondents did neither. Respondents' statement in the State Register did not articulate, nor notify the public of, a change in methodology. As discussed above, 10 NYCRR 86-2.40 (m) provides for adjustment of the case-mix in January and July of each year based upon case-mix data from the previous six-month period. The Register statement says, essentially, that Respondents will keep doing what they had been doing, but may pay nursing homes less.

279. On or about April 12, 2019, in the enacted State budget, the Legislature directed Respondents as follows:

> "§ 9 Residential health care facilities case mix adjustment workgroup.
>
> The commissioner of health or his or her designee shall convene and chair a 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. The workgroup shall be comprised of residential health care facilities or representatives from such facilities, representatives from the statewide associations and other such experts on case mix as required by the commissioner or his or her designee. The workgroup shall review recent case mix data and recent analyses conducted by the department with respect to the department's implementation of the July 1, 2019 change in methodology, the department's minimum data set collection process, and case mix adjustments authorized under subparagraph (ii) of paragraph (b) of subdivision 2-b of section 2808 of the public health law. Such review shall seek to promote a higher degree of accuracy in the minimum data set data, and target abuses. The workgroup may 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. In developing such recommendations, the workgroup shall ensure that the collection process and case mix adjustment recognizes the appropriate acuity for residential health care residents. The workgroup may provide

[8] Notably the amount of the cut in the State Register ($191 million) has no apparent relationship to the number in the State Budget ($246 million, inclusive of both reduced state and federal payments).

> recommendations regarding the proposed patient driven payment model and the administrative complexity in revising the minimum data set collection and rate promulgation process. The commissioner shall not modify the method used to determine the case mix adjustment for periods prior to June 30, 2019. Notwithstanding any changes in federal law or regulation relating to nursing home acuity reimbursement, the workgroup shall report its recommendations no later than June 30, 2019"

(L 2019, ch 57, pt G, § 9).

280. Respondents thereafter convened, and a designee of the Commissioner chaired, the residential health care facilities case-mix adjustment workgroup, which operated under the working title "Nursing Home Acuity Workgroup" (the "Workgroup").

281. Contrary to the Legislature's directive, Respondents did not provide all of the "recent case mix data and recent analyses conducted by the department with respect to the department's implementation of the July 1, 2019 change in methodology" to the Workgroup.

282. On or about June 28, 2019, the Workgroup delivered its recommendations to Respondents. A copy is annexed hereto as Exhibit "C". Upon information and belief the Workgroup's recommendations were not considered in Respondents' SPA discussed below.

283. On or about June 28, 2019, Respondents submitted a SPA (SPA #19-0033) to CMS. A copy is annexed hereto as Exhibit "D". SPA 19-0033 details the methodology Respondents intend to use for the July 1, 2019 semi-annual case-mix adjustment, and for subsequent adjustments:

> "4) <u>(a)</u> Subsequent case mix adjustments to the direct component of the price for rate periods effective after January 1, 2012 [shall] <u>will</u> be made in July and January of each calendar year and [shall] <u>will</u> use Medicaid-only case mix data applicable to the previous case mix period (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).

4) (b) The 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.

4) (c) The case mix adjustment to the direct component of the price for 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)"

(SPA 19-0033, at Appendix I).

284. Upon information and belief, Respondents had developed the methodology in SPA 19-0033 prior to receiving the Workgroup's recommendations and, consequently, failed to consider any of these recommendations when developing the challenged methodology.

285. As of the date of this Verified Petition/Complaint, CMS has not approved SPA 19-0033.

286. Although not approved by CMS, the revised methodology has been adopted by Respondents through the October 9, 2019 DAL and is being implemented, effective July 1, 2019.

287. Respondents' stated rationale for changing their methodology was provided in Appendix VI to SPA 19-0033:

"CMS Standard Access Questions

The following questions have been asked by CMS and are answered by the State in relation to all payments made to all providers under Attachment 4.19-D of the state plan.

1. Specifically, how did the State determine that the Medicaid provider payments that will result from the change in this amendment are sufficient to comply with the requirements of 1902(a) (30)?

Response: This amendment seeks to rationalize the case mix reimbursement system. This will be accomplished through a change from a census-based case mix calculation to a system which will use all valid MDS assessments filed during a six-month period.

> 2. How does the State intend to monitor the impact of the new rates and implement a remedy should rates be insufficient to guarantee required access levels?
>
> Response: The State has various ways to ensure that access levels in the Medicaid program are retained and is currently not aware of any access issues, particularly since there is excess bed capacity for both hospitals and nursing homes. Additionally, hospital and nursing home providers must notify and receive approval from the Department's Office of Health Systems Management (OHSM) in order to discontinue services. This Office monitors and considers such requests in the context of access as they approve/deny changes in services. Finally, providers cannot discriminate based on source of payment.
>
> For providers that are not subject to an approval process, the State will continue to monitor provider complaint hotlines to identify geographic areas of concern and/or service type needs. If Medicaid beneficiaries begin to encounter access issues, the Department would expect to see a marked increase in complaints. These complaints will be identified and analyzed in light of the changes proposed in this State Plan Amendment.
>
> Finally, the State ensures that there is adequate provider capacity for Medicaid Managed Care plans as part of its process to approve managed care rates and plans. Should the necessary access to services be compromised, the State would be alerted and would take appropriate action to ensure retention of access to such services.
>
> 3. How were providers, advocates and beneficiaries engaged in the discussion around rate modifications? What were their concerns and how did the State address these concerns?
>
> Response: This change was enacted by the State Legislature as part of the negotiation of the 2019-2020 Budget. The impact of this change was weighed in the context of the overall State Budget. The legislative process provides opportunities for all stakeholders to lobby their concerns, objections, or support for various legislative initiatives."

288. 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 Director of the Budget and expressed "concern[] to hear from representatives of stakeholders that efforts of the workgroup have been ignored" and noted that the Workgroup had made "useful" proposals. A copy of the September 9, 2019 letter is annexed hereto as Exhibit "E".

289. On or about September 11, 2019, the Chairs of the New York State Health and Finance Committees, and 23 other New York State Senators, sent a letter to the Director of the Budget, with a copy to the Commissioner, to "express [their] concern about the impact of administrative rate changes to residential health care facilities" and requested "delay" of "the implementation of these cuts pending further review in conformity with the Legislature's intent in reviewing and implementing these changes". A copy of the September 11, 2019 letter is annexed hereto as Exhibit "F".

290. Upon information and belief, Respondents have determined to implement the change to the case-mix adjustment methodology irrespective of the letters from members of the State Legislature. A copy of the October 9, 2019 DAL informing nursing homes of the new methodology is annexed hereto as Exhibit "G". Notably, contrary to Respondents' standard practice, they did not disclose the underlying MDS data used when providing the new rates to facilities.

The Changed Methodology Is A Disguised Rate Cut

291. Upon information and belief, the revised methodology, which is contrary to law and arbitrary and capricious for reasons discussed below, is being implemented in order to dramatically cut Medicaid rates, not to, in the Department's words, "rationalize" case-mix reimbursement (nor has DOH articulated how this change "rationalizes" case-mix reimbursement).

292. Upon information and belief, Respondents adopted the new methodology solely to reduce Medicaid reimbursement rates by over $246 million, inclusive of federal payments, over the balance of the State's fiscal year, which ends March 31, 2020.

293. Upon information and belief, Respondents selected the roughly eight-month assessment window period of August 8, 2018 through March 31, 2019 because they had already calculated that, based upon this data, they could achieve a rate reduction target of over $246 million, inclusive of federal payments, over the balance of the State's fiscal year ending March 31, 2020. This assessment window is contrary to the six-month assessment window propounded in the applicable statute and regulations, which have not been amended.

294. Upon information and belief, Respondents elected to use a case-mix assessment window that is also more remote from the case-mix adjustment date (i.e., looking back farther in time, and for a longer period, than data arising from the preceding six-month adjustment period) because they believe that such a window will allow them to achieve lower Medicaid payment rates.

295. Respondents will no longer limit case-mix adjustments to 5% per period. This change conflicts with the plain text of the applicable regulations.

296. The effect of ignoring this regulatory circuit-breaker limiting swings in reimbursement is to accelerate the rate reduction Respondents wish to achieve—over $246 million, inclusive of federal payments—over the balance of the State's fiscal year ending March 31, 2020.

Respondents' Rate Cut Will Adversely Impact Medicaid Beneficiaries and Healthcare Workers, Not Just Nursing Home Operators

297. Upon information and belief, based upon the number of nursing home residents who are Medicaid beneficiaries, a $246 million annual rate cut equates to approximately $11.47 per resident per day, with major variations at the facility level.

298. Provider Petitioners, which include not-for-profit, publicly-owned, and proprietary facilities from across the state, are instructive. They will experience cuts of between $4.00 per resident per day to $51.70 per resident per day.

299. Even before this rate cut, a national accounting firm had calculated that New York's Medicaid rate was 20% less than the average facility's actual cost to provide care (i.e., $64 less than costs per patient per day) (see Exh. A).[9]

300. Further, even before this cut, according to the 2017 Medicaid cost report data for New York nursing homes, the average 2017 operating margin for New York's nursing homes was -1.3 percent. The cost report data indicated that approximately 41% of nursing homes operated at a loss that year. Petitioners' members are similarly situated. Notably, Petitioners' many not-for-profit or public facilities are particularly vulnerable to operating losses.

301. Decreasing Medicaid rates by $246 million will more than double the size of this operating loss, from -1.3% to -3.2%. Based upon the 2017 cost report data, an estimated 56% of nursing homes will operate at a loss in 2019 if this rate cut is fully implemented.

302. Upon information and belief, negative operating margins, particularly when such margins impact a majority of service providers, are unsustainable and are associated with business failures. Not-for-profit, mission-driven, and public nursing homes are at a particular risk of reduction in services, curtailment of programs, or, ultimately, closure, if they cannot adequately fund their operations. These types of facilities, in particular, already operate on tight

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[9] New York had the largest difference between costs and reimbursement rates among states surveyed. The stark disparity is, however, easy to understand. New York pays an average Medicaid rate that is less than other states, such as Maryland and Wyoming, even though New York is a more expensive state in which to operate.

margins and often rely upon accounts receivable financing and donations to support resident services.

303. Respondents' rate reduction cuts across facilities, regardless of the rating assigned to them by CMS for quality of care. Upon information and belief, approximately 43% of the nursing homes projected to have negative operating margins under the revised methodology, including a number of Provider Petitioners, received four or five stars (out of five) from CMS. Indeed, upon information and belief, half of CMS's highest-rated, five-star nursing homes, including certain Provider Petitioners, will have a negative operating margin under the new methodology. These rate cuts threaten the viability of Provider Petitioners, and other similarly situated nursing homes that are members of the Organizational Petitioners, as going concerns. Thus, the rate cut is not intended to, and will not, improve quality of care.

304. Already, 12 nursing homes have closed in New York over the past five years, and 4 more were merged into other facilities. Respondents' aggressive rate-cutting will only accelerate this trend.

305. Moreover, Respondents should not be heard to claim that the threat of facility closures is of no moment, because other nursing homes may have space. According to the most recent available data from the Department, the median nursing home occupancy rate in New York is 95%. And, according to the federal Centers for Disease Control, New York has the second-highest nursing home occupancy rate in the country (see Centers for Disease Control and Prevention, Nursing homes, beds, residents, and occupancy rates, by state: United States, selected years 1995-2016, available at https://cdc.gov/nchs/data/hus/2017/092.pdf).

306. Further, any claim of sufficient statewide capacity to absorb a significant Medicaid rate cut would not account for the fact that, according to the Department's own records,

a number of rural, Upstate counties, such as Chenango, Delaware, and Franklin, already need more beds, not less, due to having a limited number of facilities that are already more than 92% full (see Department of Health, Estimates of RHCF Bed Need by County, https://health.ny.gov/facilities/nursing/rhcf_bed_need_by_county.htm [accessed Oct. 23, 2019]). In all of these counties, the Department has already determined that the population is in need of additional nursing home capacity. Instead of facilitating this increase, the Department's rate cut will exacerbate this existing, demonstrated need.

307. Urban residents could also suffer adverse consequences from Respondents' dramatic rate cut. New York County has just 17 nursing homes to serve a population of over 1.6 million people. These facilities have an average occupancy of over 96%, leaving practically no capacity to absorb residents displaced by a facility reduction or closure (see Department of Health, Nursing Home Weekly Bed Census, available at https://health.data.ny.gov/Health/Nursing-Home-Weekly-Bed-Census-Beginning-2009/uhyy-xp9s [accessed Oct. 23, 2019]). Residents disrupted by facility service reductions or closure could be forced to move to another borough, a significant disruption.

308. Inasmuch as New York already has relatively high nursing home occupancy rates, facility downsizings and closures place Medicaid beneficiaries at risk of adverse impacts on their ability to access nursing home care. Put simply, drastic rate cuts will expose residents to the same access crisis presently experienced in states such as South Dakota (see Jack Healy, Nursing Homes Are Closing Across Rural America, Scattering Residents, NY Times [Mar. 4, 2019], available at https://nytimes.com/2019/03/04/us/rural-nursing-homes-closure.html [accessed Oct. 23, 2019]).

309. Further, these substantial, and unanticipated, rate reductions threaten the ability of nursing homes to meet recently negotiated wage increases in collective bargaining agreements (see e.g. Crain's Health Pulse, Nursing Homes Reach Labor Deal with 1199SEIU [Dec. 21, 2018], available at https://www.1199seiu.org/media-center/daily-clips/nursing-homes-reach-labor-deal-1199seiu [noting that contracts between GNYHCFA and another employer organization and 1199SEIU, which apply to approximately 30,000 Downstate healthcare workers, were negotiated following state assurance that "it would increase the operating component of their Medicaid reimbursement rates" and permit nursing homes to "revisit the wage increases with the union if their reimbursement changes"] [accessed Oct. 23, 2019]).

310. Upon information and belief, Respondents have disregarded these indicia of economical and efficient operations by Petitioners' members in implementing their unfair, across-the-board reduction in Medicaid reimbursements.

311. Petitioners and their members are not required to exhaust any administrative remedies that may be available to them under 10 NYCRR subpart 86-2, inasmuch as this proceeding involves a challenge to Respondents' rate-setting methodology itself (see Matter of United Helpers Canton Nursing Home, Inc. v Zucker, 145 AD3d 1413, 1414 [3d Dept 2016]).

AS AND FOR A FIRST CAUSE OF ACTION
CPLR 7803 (3) — New Methodology Is Contrary to L 2019, Ch. 57, Pt. G, § 9

312. Petitioners repeat and re-allege the allegations set forth above as if more fully set forth herein.

313. In Section 9 of Part G of Chapter 57 of the Laws of 2019, the Legislature provided Respondents with specific instructions related to implementation of the methodology change proposed to take effect on July 1, 2019.

314. Specifically, the Legislature stated that the methodology change should be implemented "to promote a higher degree of accuracy in the minimum data set data, and target abuses" while also ensuring "that the collection process and case mix adjustment recognizes the appropriate acuity for residential health care residents."

315. Respondents' new methodology is not targeted towards any particular abuses, inasmuch as it uses a preselected data set to achieve a planned rate cut. It does not promote data accuracy, because it simply aggregates data, regardless of accuracy, from a stale review window. Nor does the new methodology recognize the appropriate acuity for nursing home residents, because it relies upon stale data.

316. Moreover, Respondents' new methodology does not comply with the Public Health Law, which was not amended by L 2019, ch 57, pt G, § 9. Nor does the new methodology comply with Respondents' own regulations, which require Respondents to use a particular review period and to limit the impact of case-mix adjustments.

317. Instead, Respondents' new methodology was intended to cut Medicaid reimbursement rates by a significant, pre-determined amount, by basing case-mix adjustments upon an arbitrarily selected snapshot in time that produces a lower Statewide case-mix.

318. For these reasons, Respondents acted in violation of, and failed to comply with, the instructions provided by the Legislature in L 2019, ch 57, pt G, § 9.

319. Accordingly, this Court should annul Respondents' methodology for the July 1, 2019 semi-annual case-mix adjustment, and for future semi-annual case-mix adjustments, as arbitrary, capricious, and contrary to law; compel Respondents to recalculate the July 1, 2019 semi-annual case-mix adjustment within sixty (60) calendar days; and reimburse Petitioners' members for any underpayments.

AS AND FOR A SECOND CAUSE OF ACTION

CPLR 7803 (3) — New Methodology Is Contrary to Public Health Law § 2807 (3)

320. Petitioners repeat and re-allege each of the foregoing paragraphs as if fully set forth herein.

321. Public Health Law § 2807 (3) requires that Respondents promulgate Medicaid rates that "are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities."

322. Respondents' new methodology for calculation of case-mix adjustments is intended to reduce Medicaid rates by a substantial amount—$246 million per year (including federal share)—without regard to whether that amount is reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities.

323. Upon information and belief, more than half of nursing homes in New York will operate at a loss for 2019 due to the arbitrary and capricious methodological change implemented by Respondents effective July 1, 2019. The cut is so pervasive that it impacts many nursing homes that are efficiently and economically operated. Nothing in the SPA indicates that the Department considered whether the costs incurred by efficiently and economically operated facilities would be met. Upon information and belief, such costs will not be met by the reduced rates. Accordingly, under these circumstances, Respondents should not be heard to argue that, essentially, all nursing homes are inefficiently and uneconomically operated.

324. Upon information and belief, making case-mix adjustments in excess of 5%, before any audit by OMIG, in order to achieve substantial Medicaid payment reductions, is not reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities.

325. Upon information and belief, the revenue shock of case-mix adjustments in excess of 5% will overwhelm the capacity of efficiently and economically operated facilities, such as Petitioners' members, many of which are not-for-profit facilities with limited financial resources, to absorb semi-annual payment adjustments.

326. Accordingly, this Court should annul Respondents' methodology for the July 1, 2019 semi-annual case-mix adjustment, and for future semi-annual case-mix adjustments, as arbitrary, capricious, and contrary to law; compel Respondents to recalculate the July 1, 2019 semi-annual case-mix adjustment within sixty (60) calendar days; and reimburse Petitioners' members for any underpayments.

AS AND FOR A THIRD CAUSE OF ACTION

CPLR 7803 (3) — New Methodology Is Contrary to Public Health Law § 2808 (2-b) (b) (ii) and its associated regulation, 10 NYCRR 86-2.40 (m)

327. Petitioners repeat and re-allege each of the foregoing paragraphs as if fully set forth herein.

328. Public Health Law § 2808 (2-b) (b) (ii) directs respondents to make a "case mix adjustment" to the "operating component of rates . . . in January and July of each calendar year" and to promulgate "regulations" to implement this provision.

329. Respondents' implementing regulation, 10 NYCRR 86-2.40 (m) (6), provides that "[s]ubsequent 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."

330. The plain language of this regulation, and Respondents' own interpretation thereof as articulated in the State's approved Medicaid Plan, requires Respondents to base the

January 1 and July 1 case-mix adjustments upon assessment data from the previous six-month period.

331. Moreover, 10 NYCRR 86-2.40 (m) (10) provides that "the impact" of case-mix adjustments is limited to "reflect no more than a five percent change in such reported data, pending a prepayment audit of such reported MDS data" by OMIG.

332. Respondents' methodology for calculation of the case-mix adjustment effective July 1, 2019 is contrary to the Public Health Law § 2808 (2-b) (b) (ii), and 10 NYCRR 86-2.40 (m), inasmuch as it is based upon the arbitrary and capricious selection of data for the period of August 8, 2018-March 31, 2019, rather than the period of January 1, 2019-June 30, 2019 that is required by law. Respondents' approximately eight-month window for the July 1, 2019 case-mix adjustment exceeds the six month period required by law and falls outside of the six months preceding July 1, 2019 required by law.

333. Respondents' methodology for calculation of the case-mix adjustment effective January 1, 2020, and thereafter, is contrary to the Public Health Law § 2808 (2-b) (b) (ii), and 10 NYCRR 86-2.40 (m), inasmuch as it is based upon the arbitrary and capricious selection of data for the periods of April-September and October-March, rather than data from the periods of January-June and July-December that are required by law.

334. Respondents' methodology for calculation of the July 1, 2019 case-mix adjustment, and all subsequent adjustments, is contrary to 10 NYCRR 86-2.40 (m) (10) inasmuch as it disregards the 5% limit in that regulation.

335. For the same reasons, this Court should annul Respondents' new case-mix adjustment methodology as arbitrary, capricious, and contrary to law; compel Respondents to

recalculate the July 1, 2019 case-mix adjustment within sixty (60) calendar days in a manner consistent with applicable law; and reimburse Petitioners' members for any underpayments.

AS AND FOR A FOURTH CAUSE OF ACTION
CPLR 7803 (3) — New Methodology Is Arbitrary and Capricious

336. Petitioners repeat and re-allege each of the foregoing paragraphs as if fully set forth herein.

337. Respondents' revised case-mix adjustment methodology, effective July 1, 2019, is unreasonable and unsupported by any evidence.

338. Upon information and belief, Respondents arbitrarily and capriciously revised their methodology to utilize a specific, 8-month look-back period for the July 1, 2019 case-mix adjustment in order to achieve a predetermined rate reduction, was made without regard for any actual cause of the facility's change in case-mix index. Accordingly, it lacks a rational basis (see e.g. New York State Assn. of Counties v Axelrod, 78 NY2d 158, 167 [1991]).

339. Upon information and belief, Respondents arbitrarily and capriciously revised their methodology to utilize a look-back period for the January 1, 2020 and subsequent case-mix adjustments that utilize data from outside of the previous six-month period, which is required by law, and which are more remote in time from the actual adjustment date, in order to achieve a pre-determined rate reduction, was made without regard for any actual cause of the facility's change in case-mix index. Indeed, by selecting a period that is farther from the adjustment date, Respondents are guaranteeing that their adjustment will be less reflective of the facility's actual resident mix on the adjustment date. Accordingly, it lacks a rational basis (see e.g. New York State Assn. of Counties v Axelrod, 78 NY2d 158, 167 [1991]).

340. Upon information and belief, Respondents have arbitrarily and capriciously disregarded an important circuit-breaker that was designed to ensure that facility reimbursement rate changes are aligned with resident need, yet smoothed to ensure predictable funding for the State, nursing homes, and their residents. Upon information and belief, Respondents adopted this circuit-breaker, a 5% limit on case-mix adjustments, in 10 NYCRR 86-2.40 (m) (10) to limit the disruption to nursing homes and their residents if rates are subject to an immediate, substantial decrease, inasmuch as such a decrease is too dramatic of a penalty to impose upon a nursing home prior to an audit by OMIG. The limit also protects the State from dramatic increases in Medicaid reimbursement rates. By disregarding this circuit-breaker, Respondents have acted without a rational basis (see e.g. New York State Assn. of Counties v Axelrod, 78 NY2d 158, 167 [1991]).

341. Accordingly, this Court should annul Respondents' methodology for the July 1, 2019 semi-annual case-mix adjustment, and for future semi-annual case-mix adjustments, as arbitrary, capricious, and contrary to law; compel Respondents to recalculate the July 1, 2019 semi-annual case-mix adjustment within sixty (60) calendar days; and reimburse Petitioners' members for any underpayments.

AS AND FOR A FIFTH CAUSE OF ACTION
CPLR 3001 — Declaratory Relief

342. Petitioners repeat and re-allege the allegations set forth above as if more fully set forth herein.

343. Contrary to clear legal precedent and unambiguous statutes and regulations, Respondents have changed the methodology for performing case-mix adjustments to the Medicaid rates for Petitioners' members.

344. As recently as June 28, 2019, Respondents continued to assert that their new methodology is permitted.

345. However, there is a justiciable controversy as to whether Respondents may alter their methodology in the manner that they propose.

346. By reason of the foregoing, this Court should declare that Respondents may not utilize assessment data from outside of the six-month period preceding the case-mix adjustment in calculating the semi-annual case-mix adjustment.

347. By reason of the foregoing, this Court should declare that Respondents must utilize the 5% pre-audit limit on adjustments contained within their regulations in calculating the semi-annual case-mix adjustment.

AS AND FOR A SIXTH CAUSE OF ACTION
CPLR article 63 and CPLR 7805 — Injunctive Relief

348. Petitioners repeat and re-allege the allegations set forth above as if more fully set forth herein.

349. Respondents promulgate case-mix adjustments for nursing homes at least twice per year.

350. For the July 1, 2019 case-mix adjustment, and future rate case-mix adjustments, Respondents should be permanently enjoined from using the methodology they adopted effective July 1, 2019, unless and until such methodology is explicitly permitted by a duly enacted statute and/or regulation.

351. For the July 1, 2019 case-mix adjustment, and future rate case-mix adjustments, Respondents should be permanently enjoined from using the methodology they adopted effective July 1, 2019, unless and until such methodology is explicitly permitted by a duly approved SPA.

352. Petitioners and their members have no other adequate remedy at law.

353. No prior application for the relief herein has been made by Petitioners, or any of their members, to this Court or any other court.

WHEREFORE, Petitioners respectfully request:

a. A judgment under CPLR article 78 annulling Respondents' methodology for the July 1, 2019 semi-annual case-mix adjustment, and for future semi-annual case-mix adjustments, upon the ground that Respondents acted arbitrarily, capriciously, and contrary to law;

b. A judgment under CPLR article 78 directing Respondents to recalculate the July 1, 2019 case-mix adjustment for Petitioners' members, and any subsequent case-mix adjustments during the pendency of this proceeding, within 60 days in compliance with the methodology required by the Public Health Law and 10 NYCRR 86-2.40 (m);

c. A judgment under CPLR article 78 directing Respondents to reimburse Petitioners' members for any underpayments made pursuant to their erroneous methodology;

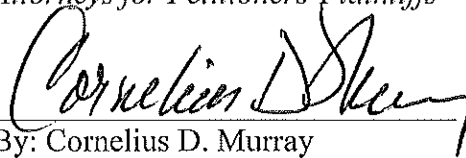
d. A declaratory judgment pursuant to CPLR 3001 declaring that the Respondents must rely upon assessment data for the six month period before the semi-annual case-mix adjustment for calculation of that adjustment;

e. A permanent injunction pursuant to Article 63 and Section 7805 of the Civil Practice Law and Rules prohibiting Respondents from utilizing the methodology they adopted effective July 1, 2019 for the semi-annual case-mix adjustment; and

f. A judgment awarding Petitioners such other and further relief that the Court deems just, proper, and equitable, including, but not limited to, reasonable attorneys' fees and other relief pursuant to Article 86 of the Civil Practice Law and Rules, and the costs, disbursement, and other allowances of this proceeding.

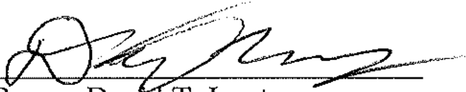
Dated: Albany, New York
October 24, 2019

O'CONNELL & ARONOWITZ
Attorneys for Petitioners-Plaintiffs



By: Cornelius D. Murray
54 State Street
Albany, New York 12207
Tel.: 518-462-5601
Fax: (518) 427-6988 (not for service)
nmurray@oalaw.com

HINMAN STRAUB P.C.
Attorneys for Petitioners-Plaintiffs



By: David T. Luntz
David B. Morgen
121 State Street
Albany, New York 12207
Tel.: (518) 436-0751
Fax: (518) 436-4751 (not for service)
dmorgen@hinmanstraub.com

VERIFICATION

STATE OF NEW YORK }
} ss.:
COUNTY OF ALBANY }

JAMES CLYNE, being duly sworn, deposes and says as follows:

I am the President and Chief Executive Officer of LeadingAge New York, Inc., a petitioner-plaintiff in this hybrid proceeding and action and I have read the foregoing Verified Petition and Complaint and know the contents thereof. The same is true to my knowledge, except as to those matters alleged upon information and belief, and as to those matters as I believe them to be true.

JAMES CLYNE

Sworn to before me this 24th
day of October, 2019.

Notary Public

LAURIE DINGMON
Notary Public, State of New York
No. 01DI 4795637
Qualified in Saratoga County
Commission Expires November 30, 2021

EXHIBIT "A"

HANSEN HUNTER & CO. P.C.
Certified Public Accountants

A Report on Shortfalls in Medicaid Funding for Nursing Center Care

HANSEN HUNTER & COMPANY, PC

**FOR THE
AMERICAN HEALTH CARE ASSOCIATION**

NOVEMBER 2018

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Medicaid Shortfalls in 2015 and Projected Shortfalls for 2017 – Nursing Center Shortfall Study Overview

Hansen, Hunter, & Company, PC (HHC) was engaged by the American Health Care Association (AHCA) to work with its state affiliates and other sources to compile information on the difference between Medicaid reimbursement and allowable Medicaid costs in as many states as feasible.[1] The report identifies the shortfall for the latest year in which audited or desk-reviewed cost reports were available, which in most states was 2015. In some states, cost reports for providers with year ends in 2016 were available and used. Similar to last year's study, a shortfall for the current year (2017) is projected by trending the 2015 costs (or 2016, if available) to the current year and comparing them to current Medicaid rates.

I. Methodology

Twenty-eight of AHCA state affiliates participated in the study and provided the most recently available cost reports (2015 for most states) to HHC. Data from almost half of the states reporting were based upon audited or desk-reviewed cost reports, or some blend of both. As-filed Medicaid cost reports or Medicare cost reports were used for the remaining states.[2]

HHC projected the shortfall in Medicaid reimbursement for the current year (2017) by comparing current year rates to 2015 allowable costs (or 2016, if available) trended to the current year. The trending factor used in projecting 2015 or 2016 costs to the current rate year was the Medicare Skilled Nursing Facility Market Basket Index (Market Basket), the same inflation index used by most states to inflate costs for rate setting purposes and by the Centers for Medicare & Medicaid Services (CMS) in setting Medicare rate increases. In addition, the trended costs were increased by the estimated cost of any new or expanded provider tax programs if that cost was not already included in the base year's cost reports.

Historically, allowable Medicaid costs have often increased annually by a greater percentage than the Market Basket, meaning that once actual 2017 cost data become available, the actual shortfall for 2017 will likely be higher than what is projected in this report. To illustrate, authors of this study conducted a state-by-state comparison of the actual 2015 shortfalls and the shortfalls projected for that year in the April 2016 report. The comparison revealed that 20 of the participating states had greater actual shortfalls than projected.

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[1] Hansen Hunter & Company P.C. (HHC) is a firm of certified public accountants and clinical consultants founded in 1979. Each partner, staff accountant, and clinical consultant has substantial experience in the health care field; the partners leading the HHC team each have more than 25 years of experience in the field.

[2] In some states, as-filed reports for 2015 were available and used. In others, as-filed Medicaid cost reports or Medicare cost reports were the only available reports, typically in states where rates were not based upon the most current cost report. In this situation, the state may not have audited the cost reports since they were not yet being used in the rate setting process. These cost reports, however, already exclude non-allowable costs per cost report instructions although additional adjustments would typically be made if audited by the state agency or its contractor.

2. 2015 Estimated and 2017 Projected Medicaid Shortfall

With states setting the Medicaid rates paid to nursing centers, there is a wide variation in the percentage of costs covered by the rates. In 2015, the coverage ranged from a low of 73.5 percent to a high of 100 percent. A similar range exists with the 2017 projected shortfall across the states.

3. Medicaid Allowable Costs Compared to Total Costs

If all costs of operations were considered—not just Medicaid allowable costs—the shortfall would be significantly greater. Allowable costs include only those costs recognized by the state Medicaid agency as directly or indirectly related to patient care and typically exclude necessary operating costs. Non-allowable costs include, but are not limited to, marketing and public relations, bad debts, income taxes, stockholder servicing costs, contributions, certain legal and professional fees, property costs related to purchases of centers, and out-of-state travel.

Based upon historical analysis of non-allowable costs in states where such detail was available and HHC's experience preparing and analyzing cost reports, these legitimate business costs typically constitute two to three percent of total costs.

4. State-by-State Data Tables

Tables 1 and 2, on the following pages, provide an overview of state-by-state comparisons of 2015 rates to 2015 costs and 2017 rates compared to projected 2017 costs, as well as the difference in these amounts for these two years.

Table 1. State-by-State Comparison of 2015 Rates to 2015 Costs			
State	**2015 Rate**	**2015 Cost**	**2015 Difference**
Arizona	$210.92	$223.63	($12.71)
California	$197.15	$211.99	($14.84)
Colorado	$232.86	$242.85	($9.99)
Connecticut	$235.92	$258.43	($22.51)
Florida	$224.47	$237.47	($13.00)
Georgia[3]	$167.41	$176.85	($9.44)
Hawaii	$280.27	$285.57	($5.30)
Illinois	$155.03	$179.25	($24.22)
Iowa	$168.27	$184.21	($15.94)
Kansas	$164.59	$183.30	($18.71)
Maine	$213.16	$230.49	($17.33)
Maryland	$248.84	$260.64	($11.80)
Massachusetts	$202.82	$236.73	($33.91)
Minnesota	$180.18	$215.60	($35.42)
Missouri	$153.20	$170.64	($17.44)
Montana	$186.17	$209.15	($22.98)
Nebraska	$165.94	$200.28	($34.34)
Nevada	$206.11	$232.04	($25.93)
New Jersey	$207.94	$244.80	($36.86)
New Mexico	$172.57	$201.06	($28.49)
New York[4]	$231.10	$292.42	($61.32)
North Dakota	$256.06	$263.42	($7.36)
Ohio	$182.61	$201.12	($18.51)
South Dakota	$131.26	$163.39	($32.13)
Virginia[5]	$176.26	$176.30	($0.04)
Washington	$195.85	$233.44	($37.59)
Wisconsin	$167.89	$228.53	($60.64)
Wyoming	$229.25	$252.25	($23.00)

[3] The Medicaid rate does not include the supplemental payments made to 45 non-state government owned facilities. These facilities represent only 14 percent of the facilities in cost report database. Including that revenue in the Medicaid weighted average rate calculation materially distorts the shortfall being incurred by the other facilities in the state.

[4] The Medicaid rate does not include the supplemental payments made to 35 non-state government owned facilities. These facilities represent only 9 percent of the facilities in the cost report database. Including that revenue in the Medicaid weighted average rate calculation materially distorts the shortfall being incurred by the other facilities in the state.

[5] The Medicaid rate does not include the supplemental payments made to 5 non-state government owned facilities. These facilities represent only 2 percent of the facilities in the cost report database. Including that revenue in the Medicaid weighted average rate calculation materially distorts the shortfall being incurred by the other facilities in the state.

Table 2. State-by-State Comparison of 2017 Rates to Projected 2017 Costs			
State	**2017 Rate**	**Projected 2017 Cost**	**Projected Difference**
Arizona	$226.77	$236.09	($9.32)
California	$209.97	$219.46	($9.49)
Colorado	$231.39	$247.98	($16.59)
Connecticut	$237.38	$263.20	($25.82)
Florida	$226.50	$242.70	($16.20)
Georgia[6]	$172.30	$183.23	($10.93)
Hawaii	$286.96	$292.26	($5.30)
Illinois	$156.00	$181.82	($25.82)
Iowa	$173.53	$192.98	($19.45)
Kansas	$169.10	$187.49	($18.39)
Maine	$216.37	$234.42	($18.05)
Maryland	$250.93	$265.55	($14.62)
Massachusetts	$207.04	$246.89	($39.85)
Minnesota	$225.17	$226.09	($0.92)
Missouri	$158.91	$177.81	($18.90)
Montana	$191.14	$219.40	($28.26)
Nebraska	$169.33	$205.40	($36.07)
Nevada	$206.63	$237.12	($30.49)
New Jersey	$208.64	$255.76	($47.12)
New Mexico	$172.59	$203.91	($31.32)
New York[7]	$243.33	$307.51	($64.18)
North Dakota	$257.87	$271.33	($13.46)
Ohio	$189.37	$203.98	($14.61)
South Dakota	$139.02	$170.30	($31.28)
Virginia[8]	$178.34	$183.29	($4.95)
Washington	$200.37	$236.37	($36.00)
Wisconsin	$170.57	$234.28	($63.71)
Wyoming	$249.30	$263.81	($14.51)

[6] The Medicaid rate does not include the supplemental payments made to 45 non-state government owned facilities. These facilities represent only 14 percent of the facilities in cost report database. Including that revenue in the Medicaid weighted average rate calculation materially distorts the shortfall being incurred by the other facilities in the state.

[7] The Medicaid rate does not include the supplemental payments made to 35 non-state government owned facilities. These facilities represent only 9 percent of the facilities in the cost report database. Including that revenue in the Medicaid weighted average rate calculation materially distorts the shortfall being incurred by the other facilities in the state.

[8] The Medicaid rate does not include the supplemental payments made to 5 non-state government owned facilities. These facilities represent only 2 percent of the facilities in the cost report database. Including that revenue in the Medicaid weighted average rate calculation materially distorts the shortfall being incurred by the other facilities in the state.

Outlook for Medicaid Financing

Over the course of 2017, the House and Senate considered various bills that made sweeping changes to the structure and financing of the Medicaid program. In the future, due to continued Medicaid growth and concerns about federal and state program oversight, it is likely that Congress will consider changes that could result in shifting Medicaid program costs to states, beneficiaries, and providers. This could have a devastating impact on a profession already struggling to deliver care and supports at Medicaid payment rates that do not adequately cover the costs of such care. Even in the absence of federal reforms, there are significant changes that states could elect to make under existing authorities, such as 1115 demonstrations that could impact nursing center care.

In an effort to control growth of the federal deficit, Congress enacted the Budget Control Act of 2012 (BCA), which set caps on security and non-security budget authority.[9] Since Congress did not act upon legislation aimed at reining in spending, the BCA spending caps were reset to apply to the 2013 through 2021 budgets. Additionally, automatic procedures went into effect to reduce both discretionary and mandatory spending during that period (e.g., sequestration), with $1.2 trillion in cuts going into effect in March 2013, including cuts to Medicare but not Medicaid, which was excluded.

Another factor that could potentially influence financing in the future is the number of seniors living in poverty. Research based on the Census Bureau's supplemental poverty measure indicates that the poverty rate among people ages 65 and older may be higher than is reflected in the official poverty measure, and is particularly high in some states. Although there are notable differences between the two measures, there is ongoing interest in assessing these methods for measuring poverty.[10] If these data prove correct and more seniors are living in poverty than expected, this could have significant implications on any policy changes Congress considers to entitlement programs such as Social Security and Medicare, which could in turn affect the Medicaid program.

Nursing Center Outlook

Historically, nursing centers have struggled with Medicaid rates insufficient to cover the costs of delivering care to an increasingly frail and medically complex population. The future appears to hold additional instability. Among the states, key trends impacting nursing center capacity include increasingly tight Medicaid long term services and supports (LTSS) budgets as states expand home and community-based services to meet growing demand and expanding use of Medicaid managed LTSS, as well as decreasing occupancy.

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[9] Congressional Budget Office. Sequestration Update Report: August 2012.

[10] Levinson, Z. et al. A State-by-State Snapshot of Poverty Among Seniors: Findings From Analysis of the Supplemental Poverty Measure. May, 2013. http://kaiserfamilyfoundation.files.wordpress.com/2013/05/8442-state-by-state-snapshot-of-poverty-among-seniors-may.pdf

State economic health varies significantly. Although most states saw improved revenue conditions in fiscal year 2018 following slowdowns during the previous two years, in some cases these improvements have been bolstered by increases in taxes. Although total state general fund revenues grew at an estimated 4.9 percent in 2018, the median revenue growth is 2.7 percent, which demonstrates the variation in growth states are experiencing.[11]

At the federal level, the sequestration includes some reductions in Medicare reimbursement, impacting an already fragile industry delivering care and supports to some of the nation's most vulnerable citizens. Additionally, CMS is in the process of overhauling its Medicare payment system for skilled nursing centers, which will change payment incentives for providers, as well as require operational changes to operate in this new system, with the current Resource Utilization Group-IV payment model being replaced by the Patient-Driven Payment Model on October 1, 2019. While it is too early to tell what the impact will be on the provider landscape, previous payment system changes have forced dramatic changes to the industry, and current Medicare changes could well impact state Medicaid reimbursement methodologies.

In the near term, as Congress considers additional changes to Medicare or Medicaid, it is possible further changes will be considered to bad debt, provider tax, and supplemental payments, as well as broader financing changes to the program writ large. If Congress were to make such changes, state Medicaid agencies and the profession would suffer significant budgetary challenges. However, the federal government does not necessarily need to act in order for significant changes to be made at the state level. Through the use of 1115 demonstrations, there is tremendous flexibility for states and the federal government to overhaul their Medicaid programs. While these changes may initially focus on certain populations that do not impact nursing centers, it remains to be seen how broad some governors may go using this authority to change Medicaid in their state.

The federal government and states also are experimenting with payment and service delivery system innovations including Medicare and Medicaid Accountable Care Organizations (ACOs), Medicare-Medicaid integration efforts, and Medicare and Medicaid bundled payment methodologies. While it is unclear how these approaches will impact the nursing center sector in the long term, providers are raising preliminary concerns about excessive pressures to reduce overall spending, while maintaining and/or improving quality of care, associated with these payment reform movements.

In conclusion, current financial challenges and future uncertainty paints a difficult picture for the nursing center sector. As the number of older adults increase and the profession continues to see rising levels of multiple chronic conditions, the ability to meet the needs and expectations of the growing elderly and disabled populations without major overhauls in how the services are funded is major cause for concern.

[11] The Fiscal Survey of States: A Report by the National Governors Association and the National Association of State Budget Officers. Spring 2018.

Appendices

Appendix 1

Project Approach and Methodology

PROJECT APPROACH AND METHODOLOGY

The American Health Care Association initially surveyed its state affiliates as to the availability of a database of state-specific Medicaid rate and allowable cost information. Those that responded and agreed to participate were asked to complete "data collection spreadsheets" reflecting the Medicaid rates and allowable costs for each provider based upon the provider's fiscal or calendar year ending in 2015 (or 2016, if available). In addition, the state affiliates were requested to provide current Medicaid rates by provider to allow comparisons, not only between allowable costs and Medicaid rates in 2015, but between current (FY 2017) rates and 2015 (or 2016, if available) costs trended to the same time period.[12]

HHC was engaged to assist in this process by:

1. Developing the data collection spreadsheets;
2. Instructing and guiding state affiliates through the process;
3. Reviewing the results for reasonableness and compliance with document instructions;
4. Contacting other sources such as state agencies, their consultants and independent accounting firms to obtain the data in those states where the data was readily available, but the state affiliate did not have it;
5. Developing the comparisons between current Medicaid rates and the most recent cost reports trended to the same time frame; and
6. Compiling the results into a report.

In almost all cases, the state affiliates indicated that the data were derived from a database of Medicaid rates and allowable costs obtained from their state agencies. Allowable costs include only those costs recognized by the state agency as directly or indirectly related to patient care and typically exclude necessary operating costs including, but not limited to, marketing and public relations, bad debts, income taxes, stockholder servicing costs, contributions, certain legal and professional fees, property costs related to purchases of centers, and out-of-state travel. The cost database reflected costs that have been audited or desk-reviewed by the Medicaid state agency in almost two-thirds of the participating states. HHC did not replicate the calculations nor trace individual center cost or rate data to Medicaid cost reports, rate worksheets, or state agency databases.

Comparisons of Medicaid rates and allowable costs for 2015 (or 2016 if available) were derived for 28 states. Current Medicaid rates by provider were also obtained, allowing us to determine an estimated 2017 shortfall for these states. States included in this report reflect all regions of the country and are a fair representation of Medicaid shortfalls nationwide.

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[12] Some state affiliates did not participate either through their own choice or because the data were not available.

Appendix 2

Calculation of 2015 and Projected 2017
Weighted Average Medicaid Shortfall
State-by-State Comparison

Table A2-1. Calculation of 2015 Weighted Average Medicaid Shortfall							
State	2015 Rate	2015 Cost	2015 Difference	Annual Medicaid Days	Gross Revenue	Gross Cost	Total Difference
Arizona	$210.92	$223.63	($12.71)	2,522,150	$531,971,878	$564,028,405	($32,056,527)
California	$197.15	$211.99	($14.84)	23,345,035	$4,602,473,650	$4,948,913,970	($346,440,319)
Colorado	$232.86	$242.85	($9.99)	3,590,140	$836,000,000	$871,865,499	($35,865,499)
Connecticut	$235.92	$258.43	($22.51)	6,000,600	$1,415,661,552	$1,550,735,058	($135,073,506)
Florida	$224.47	$237.47	($13.00)	15,288,390	$3,431,851,209	$3,630,573,570	($198,722,361)
Georgia[13]	$167.41	$176.85	($9.44)	8,719,850	$1,459,790,089	$1,542,105,473	($82,315,384)
Hawaii	$280.27	$285.57	($5.30)	827,090	$231,808,514	$236,192,091	($4,383,577)
Illinois	$155.03	$179.25	($24.22)	15,404,095	$2,388,096,848	$2,761,184,029	($373,087,181)
Iowa	$168.27	$184.21	($15.94)	4,284,005	$720,869,521	$789,156,561	($68,287,040)
Kansas	$164.59	$183.30	($18.71)	3,508,015	$577,384,189	$643,019,150	($65,634,961)
Maine	$213.16	$230.49	($17.33)	1,439,925	$306,934,413	$331,888,313	($24,953,900)
Maryland	$248.84	$260.64	($11.80)	5,470,620	$1,361,309,081	$1,425,862,397	($64,553,316)
Massachusetts	$202.82	$236.73	($33.91)	9,037,035	$1,832,891,439	$2,139,337,296	($306,445,857)
Minnesota	$180.18	$215.60	($35.42)	4,939,545	$890,007,218	$1,064,965,902	($174,958,684)
Missouri	$153.20	$170.64	($17.44)	8,788,470	$1,346,393,604	$1,499,664,521	($153,270,917)
Montana	$186.17	$209.15	($22.98)	938,780	$174,772,673	$196,345,837	($21,573,164)
Nebraska	$165.94	$200.28	($34.34)	2,255,335	$374,250,290	$451,698,494	($77,448,204)
Nevada	$206.11	$232.04	($25.93)	1,024,190	$211,095,801	$237,653,048	($26,557,247)
New Jersey	$207.94	$244.80	($36.86)	9,726,520	$2,022,532,569	$2,381,052,096	($358,519,527)
New Mexico	$172.57	$201.06	($28.49)	1,303,050	$224,867,339	$261,991,233	($37,123,895)
New York[14]	$231.10	$292.42	($61.32)	25,705,855	$5,940,623,091	$7,516,906,119	($1,576,283,029)
North Dakota	$256.06	$263.42	($7.36)	1,043,535	$267,207,572	$274,887,990	($7,680,418)

[13] The Medicaid rate does not include the supplemental payments made to 45 non-state government owned facilities. These facilities represent only 14 percent of the facilities in cost report database. Including that revenue in the Medicaid weighted average rate calculation materially distorts the shortfall being incurred by the other facilities in the state.

[14] The Medicaid rate does not include the supplemental payments made to 35 non-state government owned facilities. These facilities represent only 9 percent of the facilities in the cost report database. Including that revenue in the Medicaid weighted average rate calculation materially distorts the shortfall being incurred by the other facilities in the state.

Table A2-1.							
State	2015 Rate	2015 Cost	2015 Difference	Annual Medicaid	Gross Revenue	Gross Cost	Total Difference
Ohio	$182.61	$201.12	($18.51)	16,479,385	$3,009,300,495	$3,314,333,911	($305,033,416)
South Dakota	$131.26	$163.39	($32.13)	1,205,960	$158,294,310	$197,041,804	($38,747,495)
Virginia[15]	$176.26	$176.30	($0.04)	5,962,640	$1,050,974,926	$1,051,213,432	($238,506)
Washington	$195.85	$233.44	($37.59)	3,663,505	$717,497,454	$855,208,607	($137,711,153)
Wisconsin	$167.89	$228.53	($60.64)	5,451,640	$915,275,840	$1,245,863,289	($330,587,450)
Wyoming	$229.25	$252.25	($23.00)	514,285	$117,899,836	$129,728,391	($11,828,555)

[15] The Medicaid rate does not include the supplemental payments made to 5 non-state government owned facilities. These facilities represent only 2 percent of the facilities in the cost report database. Including that revenue in the Medicaid weighted average rate calculation materially distorts the shortfall being incurred by the other facilities in the state.

Table A2-2. Calculation of Projected 2017 Weighted Average Medicaid Shortfall							
State	2017 Rate	2017 Cost	2017 Difference	Annual Medicaid Days	Gross Revenue	Gross Cost	Total Difference
Arizona	$226.77	$236.09	($9.32)	2,548,795	$577,990,242	$601,745,012	($23,754,769)
California	$209.97	$219.46	($9.49)	22,770,890	$4,781,203,773	$4,997,299,519	($216,095,746)
Colorado	$231.39	$247.98	($16.59)	3,666,425	$848,374,081	$909,200,072	($60,825,991)
Connecticut	$237.38	$263.20	($25.82)	5,896,575	$1,399,728,974	$1,551,978,540	($152,249,567)
Florida	$226.50	$242.70	($16.20)	15,424,535	$3,493,657,178	$3,743,534,645	($249,877,467)
Georgia[16]	$172.30	$183.23	($10.93)	8,770,585	$1,511,171,796	$1,607,034,290	($95,862,494)
Hawaii	$286.96	$292.26	($5.30)	828,550	$237,760,708	$242,152,023	($4,391,315)
Illinois	$156.00	$181.82	($25.82)	14,458,015	$2,255,450,340	$2,628,756,287	($373,305,947)
Iowa	$173.53	$192.98	($19.45)	4,000,035	$694,126,074	$771,926,754	($77,800,681)
Kansas	$169.10	$187.49	($18.39)	3,402,895	$575,429,545	$638,008,784	($62,579,239)
Maine	$216.37	$234.42	($18.05)	1,453,430	$314,478,649	$340,713,061	($26,234,412)
Maryland	$250.93	$265.55	($14.62)	5,587,420	$1,402,051,301	$1,483,739,381	($81,688,080)
Massachusetts	$207.04	$246.89	($39.85)	9,057,475	$1,875,259,624	$2,236,200,003	($360,940,379)
Minnesota	$225.17	$226.09	($0.92)	4,832,965	$1,088,238,729	$1,092,685,057	($4,446,328)
Missouri	$158.91	$177.81	($18.90)	9,073,170	$1,441,817,445	$1,613,300,358	($171,482,913)
Montana	$191.14	$219.40	($28.26)	923,085	$176,438,467	$202,524,849	($26,086,382)
Nebraska	$169.33	$205.40	($36.07)	2,236,720	$378,743,798	$459,422,288	($80,678,490)
Nevada	$206.63	$237.12	($30.49)	1,067,625	$220,603,354	$253,155,240	($32,551,886)
New Jersey	$208.64	$255.76	($47.12)	9,319,545	$1,944,429,869	$2,383,566,829	($439,136,960)
New Mexico	$172.59	$203.91	($31.32)	1,367,290	$235,980,581	$278,804,104	($42,823,523)

[16] The Medicaid rate does not include the supplemental payments made to 45 non-state government owned facilities. These facilities represent only 14 percent of the facilities in cost report database. Including that revenue in the Medicaid weighted average rate calculation materially distorts the shortfall being incurred by the other facilities in the state.

Table A2-2. Calculation of Projected 2017 Weighted Average Medicaid Shortfall							
State	2017 Rate	2017 Cost	2017 Difference	Annual Medicaid Days	Gross Revenue	Gross Cost	Total Difference
New York[17]	$243.33	$307.51	($64.18)	23,880,125	$5,810,750,816	$7,343,377,239	($1,532,626,423)
North Dakota	$257.87	$271.33	($13.46)	1,068,720	$275,590,826	$289,975,798	($14,384,971)
Ohio	$189.37	$203.98	($14.61)	16,494,350	$3,123,535,060	$3,364,517,513	($240,982,454)
South Dakota	$139.02	$170.30	($31.28)	1,170,920	$162,781,298	$199,407,676	($36,626,378)
Virginia[18]	$178.34	$183.29	($4.95)	6,104,260	$1,088,633,728	$1,118,849,815	($30,216,087)
Washington	$200.37	$236.37	($36.00)	3,599,995	$721,330,998	$850,930,818	($129,599,820)
Wisconsin	$170.57	$234.28	($63.71)	5,018,020	$855,923,671	$1,175,621,726	($319,698,054)
Wyoming	$249.30	$263.81	($14.51)	538,010	$134,125,893	$141,932,418	($7,806,525)

[17] The Medicaid rate does not include the supplemental payments made to 35 non-state government owned facilities. These facilities represent only 9 percent of the facilities in the cost report database. Including that revenue in the Medicaid weighted average rate calculation materially distorts the shortfall being incurred by the other facilities in the state.

[18] The Medicaid rate does not include the supplemental payments made to 5 non-state government owned facilities. These facilities represent only 2 percent of the facilities in the cost report database. Including that revenue in the Medicaid weighted average rate calculation materially distorts the shortfall being incurred by the other facilities in the state.

EXHIBIT "B"

Department of Health & Human Services
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

Center for Medicaid, CHIP and Survey & Certification

SMD #10-020

October 1, 2010

Re: Revised State Plan Amendment Review Process

Dear State Medicaid Director:
Dear State Health Official:

The Centers for Medicare & Medicaid Services (CMS) is issuing this letter to inform you of changes CMS is making in the State plan amendment (SPA) review process. These changes are being made to implement a more efficient process for the review of proposed modifications to the State Medicaid plan.

Background

Federal statute and regulations require CMS to review and approve SPAs for consistency with the requirements of Section 1902(a) of the Social Security Act (the Act) before a State may implement Medicaid program modifications. SPAs are generally transmitted to CMS as pages excerpted from the existing approved State plan containing the provisions that the State wishes to modify. CMS reviews the proposed specific amendment and all other provisions contained on the submitted State plan page(s). In addition, CMS reviews any related or corresponding State plan provisions contained elsewhere in the State plan that are integral to understanding the pages submitted. This review process may lead to the identification of existing State plan provisions that the State is not proposing to modify and that are not integral to the proposed SPA modifications but that appear to be contrary to Federal statute, regulations, or established guidance. In the past, the review process has required that any issue identified during the review of a SPA must be resolved in order to take action on the submitted SPA. In some instances, this practice has resulted in a delay in the State's authority to promptly implement the program change for which the amendment was originally submitted.

Recognizing States' need to advance modifications to their Medicaid programs, CMS has consulted with States and identified a process that will expedite the review of SPAs while ensuring that CMS and States resolve other questions that may arise. As described in detail below, States will now have the option to resolve issues related to State plan provisions that are not integral to the SPA through a separate process.

New Procedures for SPA Processing

CMS has a continuing obligation to review all provisions of a State plan amendment for compliance with Federal statute and regulations State plans, including those on submitted pages and corresponding provisions contained within the existing approved State plan. However, CMS will no longer require States to resolve those issues that may arise in the course of the review of the submitted SPA – but are not integral to the provision modified by the SPA – prior to taking action on the submitted SPA. Instead, CMS will follow the procedure described below.

- In the event that CMS identifies potentially non-compliant State plan provisions, we will discuss those provisions with the State during the initial stages of the SPA review. The State will have the option to resolve all issues during the review of the submitted SPA or to focus solely on the provision modified by the SPA, and resolve issues unrelated to the actual SPA change through a separate process.

- If the State chooses a separate process to resolve issues unrelated to the modifications proposed in the submitted SPA, and if CMS needs additional information relating to the SPA, a request for additional information (RAI) will be issued. The RAI will include only those questions or requests for information that are applicable to the SPA submitted. The SPA will not be delayed, but the decision letter communicating the disposition of the SPA will note that additional issues are being reviewed through a separate process.

- CMS will describe the specific issues and/or questions related to those provisions that are not addressed in the context of the SPA review, but are problematic, in a letter to the State Medicaid Director on or before the date of ultimate SPA disposition. In doing so, CMS will identify the statutory or regulatory provision or guidance pertaining to the issue identified. We will not pursue matters that are not based on statute, regulations, or generally available guidance. Within 90 days from the date of the letter, States should provide information that explains why the provision is consistent with Federal statute, regulation, and existing guidance, or should submit to CMS a SPA which will bring the State plan into compliance. During this time, CMS will provide technical assistance and respond to questions from the State.

- CMS may initiate formal compliance action as described in 42 CFR 430.35 at any time. However, CMS will ordinarily delay taking action pending the discussions with the State through the process described above, and may delay taking action if the State demonstrates good faith actions to come into compliance (for example, when there are implementation or State authority issues that must be resolved). As always, the formal compliance process offers States formal appeal rights through an established hearing process.

To further explain how this new process will work and to promote consistent application of the new policy, we have enclosed several examples in which the review of issues related to the State plan can be divorced from changes proposed in the submitted SPA. The examples are based on actual State plan issues we have faced and are intended to clarify how we envision this new process.

We hope you will find this information helpful. We believe this new approach will resolve many SPA processing issues and allow SPAs to be approved more quickly. We will also be taking this new approach in our review of SPAs related to the Children's Health Insurance Program (CHIP). We are committed to working with States to ensure that CMS carries out its responsibilities in ways that advance States' ability to carry out their responsibilities.

If you have any additional questions, please contact Ms. Dianne Heffron, Director, Financial Management Group, who may be reached at 410-786-3247.

Sincerely,

/s/

Cindy Mann
Director

Enclosure

cc:

CMS Regional Administrators

CMS Associate Regional Administrators
Division of Medicaid and Children's Health

Richard Fenton
Acting Director
Health Services Division
American Public Human Services Association

Joy Wilson
Director, Health Committee
National Conference of State Legislatures

Matt Salo
Director of Health Legislation
National Governors Association

EXHIBIT “C”

June 28, 2019

Ms. Ann Foster
Deputy Director
New York State Department of Health
Empire State Plaza, Corning Tower
Albany, NY 12237

Mr. Michael Ogborn
Medicaid Chief Financial Officer
New York State Department of Health
Empire State Plaza, Corning Tower
Albany, NY 12237

Dear Ms. Foster and Mr. Ogborn:

On behalf of the Residential Health Care Facilities Case Mix Adjustment Workgroup (known as the Nursing Home Acuity Workgroup)[1], we write to express grave concerns with the impending change in acuity adjustments to the July 1, 2019 Medicaid rates for skilled nursing providers to be implemented by the Department of Health ("DOH" or "Department"). This change 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.

Based on the clear language of Chapter 57 of the Laws of 2019, stakeholders understood that the Workgroup would provide recommendations and advice to the Department on the methodology utilized to calculate case-mix adjustments to nursing home reimbursement rates. The Department recently indicated that it plans to implement the cut on July 1st, using unrepresentative resident assessment data from the period August 8, 2018 through March 31, 2019. **A retroactive cut of this magnitude will without question damage the financial viability of numerous financially fragile nursing homes, endanger quality resident care and put crucial health care jobs at risk.** The Legislature has given no indication that it intended for the statute to result in a $246 million cut based on a retroactive change in methodology.

Detrimental Fiscal Impact

The large and unpredictable fiscal impact that DOH's proposed July 1, 2019 methodology will create on the provision of patient care throughout New York cannot be understated. Inasmuch as nursing home reimbursement is based on 2007 costs and Medicaid providers have received no inflation adjustment in over 10 years, a cut of $246 million (or potentially more) is simply unsustainable. According to a November 2018 report from a national accounting firm, New York's

[1] To clarify, the Residential Health Care Facilities Case Mix Adjustment Workgroup is the statutory name for the Workgroup, but the 'Nursing Home Acuity Workgroup' is used as the working title for the Workgroup.

Medicaid program paid the average facility 20 percent less than their actual costs of providing care, a $64 per patient per day shortfall.

As New York's nursing homes face annual staffing cost increases, such a reduction would not only negate the benefits of the State's promised 1.5 percent adjustment to reflect increased workforce costs, it would call into serious question facilities' ability to meet the requirements of recently negotiated collective bargaining agreements. Nursing home finances would be further destabilized by cutting rates by an average of at least $9.50 per Medicaid day, with major variations at the facility level. To further emphasize the magnitude of this cut, 1199 SEIU, the State's largest nursing home union with over 50,000 members, has written a letter to the Executive expressing its significant concern with the implementation of changes to acuity adjustments in the July 1, 2019 Medicaid rates for skilled nursing providers as this cut would threaten the above-mentioned collective bargaining agreements.

Lack of Access to Case Mix Data for Review and Removal of Safeguards

Workgroup members reasonably expected, based on the language of the statute, that the Workgroup would be permitted to review in detail the case-mix data and related analyses conducted by DOH, as well as how the $246 million in estimated savings was arrived at by the State. As of June 25, 2019, the Department has provided no such data or related analyses. DOH has also indicated that it plans to not invoke the current 5 percent constraint on case-mix changes during each six-month period pending completion of an OMIG audit. This 5 percent limit provides a safeguard to avoid jeopardizing the viability of many nursing homes, however, DOH has indicated this constraint needs to be removed as it anticipates case-mix decreases of greater than 5 percent.

Many providers will be unable to absorb the rate reduction, but few businesses of any kind can mitigate the impact of a dramatic, retroactive reduction in revenue with no advance warning. We strongly urge the Department of Health to collaborate with the Workgroup in order to develop the prospective acuity methodology the law requires so as to not disrupt resident care or threaten the financial viability of skilled nursing providers.

Failure to Achieve Savings on Enacted Managed Long-Term Care Policies

The 2018-19 Enacted Budget included a provision to exclude from managed long-term care ("MLTC") enrollment nursing home residents following three months of nursing home permanent placement. Individuals that meet these requirements would be disenrolled from MLTC and revert to FFS Medicaid for their nursing home stay.

This policy was expected to result in a total savings of $245 million for SFY 2019-20, in addition to the $147 million in savings for 2018-19. This initiative was effective in state law on April 1, 2018; however, as the Workgroup understands it, the State is still awaiting authorization from CMS and the policy cannot be implemented. **We believe that the State's efforts to achieve fiscal savings should focus on securing the requisite CMS approval for this initiative (which**

has clear legislative authority), rather than unilaterally pursuing savings by retroactively changing the methodology for calculating case-mix adjustments.

Nursing Home Acuity Workgroup Recommendations

Chapter 57 of the Laws of 2019 authorized a Nursing Home Acuity Workgroup to discuss and make recommendations on the methodology used to determine case-mix adjustments to nursing home Medicaid rates. The law requires the Workgroup to review case-mix data and related analyses conducted by the Department of Health with respect to July 1, 2019 rates and prohibits the Department from modifying the method used to determine the case-mix adjustment for periods prior to June 30, 2019. As noted above, Workgroup members have not received data or related analyses conducted by the Department as required by the law.

The legislative intent of convening the Nursing Home Acuity Workgroup was to "seek to promote a higher degree of accuracy in the minimum data set data." The current proposed methodology does not accomplish this and essentially ignores the requirement for "the commissioner not to modify the method used to determine the case mix adjustment for periods prior to June 30, 2019." Prior to June 30, 2019, nursing homes were notified of the measurement period and given the opportunity to validate the accuracy of the data submitted. The new methodology proposed by DOH changes this long-standing practice in order to achieve rate reductions in violation of the spirit of the enacted law.

In furtherance of the statutory requirement of the Nursing Home Acuity Workgroup set forth in Chapter 57 of the Laws of 2019, we submit the following proposals to promote accuracy, stability and transparency within the system that provides essential care for thousands of frail and elderly New Yorkers. **Please note, all proposals are subject to change contingent upon receipt and review of the outstanding data and analyses owed to the Workgroup from the Department.**

Consistent with the Workgroup statute and with the objective of ensuring the integrity of case-mix data, our recommendations are as follows:

For the July 1, 2019 Rate Period and January 1, 2020 Rate Period

- Freeze and apply the July 2018 CMI (utilized in the recently released January 1, 2019 rates) for the six-month rate periods commencing July 1, 2019 and January 1, 2020;
- Proposals that would utilize different assessment datasets for periods prior to June 30, 2019 and apply these to case-mix determination for July 1, 2019 rates, such as patient assessment data from August 8, 2018 through March 31, 2019, would base rates on unrepresentative data, be detrimental to providers and violate current law and practices.
- The above proposal for the July 1, 2019 Rate Period and the January 1, 2020 Rate Period is subject to change contingent upon receipt and review of the outstanding data and analyses owed to the Workgroup from the Department.

For the July 2020 Rate Period

- Utilize a quarterly calculation (the average) of all Medicaid MDSs as a temporary methodology. DOH would use the quarterly average of all MDSs for the six-month period from July 1, 2019 through December 31, 2019;
- Continue the practice of releasing to each facility the data sets that are being used for reimbursement prior to the promulgation of any rate so that each facility can validate the data and make corrections to pay sources along with updating for dementia and bariatric add-ons; and
- Apply the 5 percent constraint for each six-month period.
- The above proposal for the July 2020 Rate Period is subject to change contingent upon receipt and review of the outstanding data and analyses owed to the Workgroup from the Department.

For the January 2021 Rate Period (starting date subject to change)

- Transition to the RUG-IV 48-Group model, which collapses the 23 Rehabilitation groups in the RUG-IV 66-Group model in 5 Rehabilitation groups (which are based on ADL scoring levels not minutes of therapy).
  - The overall 48-Group model and simplified 5-category Rehabilitation hierarchy are more relevant to the Medicaid long-term care population in that they classify residents based on the need for nursing care.
  - In studies, RUG-IV has been shown to have a greater ability to predict differences in resource usage among various types of patients than RUG-III.
  - As with the current RUG-III system in use, this new methodology would utilize index maximizing classification.
  - As it did for the current pricing system, the State would calculate revised case-mix weights for RUG-IV using minutes of care from the STRIVE staff time and New York State wage data.
- Continuation of the 5 percent constraint.
- The above proposal for the January 2021 Rate Period is subject to change contingent upon receipt and review of the outstanding data and analyses owed to the Workgroup from the Department.

Nursing Home Acuity Workgroup Continuation

- The Nursing Home Acuity Workgroup would 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.

- Oversee development and implementation of the transitional methodology beginning July 2020;
- Oversee development and implementation of the RUG-IV model and associated changes;
- Review the basis for, qualifiers for and calculation of existing add-ons (e.g., TBI extended care, bariatric, dementia) for possible continuation/revision, as well as other possible adjustments to case-mix/add-ons;
- Develop recommendations to enhance the timeliness of case-mix determination and finalization for each rate period;
- Develop recommendations on a possible update of the base year costs and the wage equalization factors used to calculate statewide prices; and
- Establish transitional corridors over a specific phase-in period (for example, 3-5 years) relative to implementation of RUG-IV and associated rate changes.
- Study the implementation and outcomes of the new federal Patient Driven Payment Model which is being implemented beginning October 1, 2019, and determine whether certain elements of it can be adapted for use in New York's acuity determination and rate setting processes.

We urge the Department of Health to reconsider its proposed methodology for case-mix adjustments and respectfully request the State provide feedback to the Workgroup regarding its recommendations as soon as possible as the July 1, 2019 date is rapidly approaching. The Department's proposed methodology would destabilize nursing home finances, threaten access to high quality nursing home care and negatively impact health care workers that provide essential long-term care services.

Sincerely,

The Nursing Home Acuity Workgroup[2]

cc: Robert Mujica, Director, Division of Budget
Donna Frescatore, Interim Deputy Commissioner
Howard A. Zucker, M.D., J.D., Commissioner of Health
Paul Francis, Secretary for Health and Human Services
Megan Baldwin, Assistant Secretary for Health
Senate Majority Leader Stewart-Cousins
Assembly Speaker Heastie

[2] Scott Amrhein, Michael Balboni, David Berkowitz, Andrea Brindisi, Sean Doolan, Mary Gracey-White, Stephen Hanse, Dan Heim, Neil Heyman, Darius Kirstein, Gedalia Klein, Christopher Koenig, Dov Lebovic, Nancy Leveille, Mitch Marsh, James McGregor, Robert McLeod, John Murray, Robert Nasso, Christine Pesiri, Paul Rosenfeld, Jeffrey Rubin, Mojdeh Rutigliano, Larry Slatky, Michele Synakowski, Robert Werner, Douglas Wissmann

Senator Gustavo Rivera
Assemblyman Richard Gottfried
Senator Rachel May
Assemblyman Harry B. Bronson
Senator James Skoufis
Senator Jen Metzger

(Sent via Mail and E-mail)

EXHIBIT "D"

Department of Health

ANDREW M. CUOMO
Governor

HOWARD A. ZUCKER, M.D., J.D.
Commissioner

SALLY DRESLIN, M.S., R.N.
Executive Deputy Commissioner

June 28, 2019

Mr. Ricardo Holligan
Acting Associate Regional Administrator
Department of Health & Human Services
Centers for Medicare & Medicaid Services
New York Regional Office
Division of Medicaid and Children's Health Operations
26 Federal Plaza - Room 37-100 North
New York, New York 10278

RE: SPA #19-0033
Long Term Care Facility Services

Dear Mr. Holligan:

The State requests approval of the enclosed amendment #19-0033 to the Title XIX (Medicaid) State Plan for long term care facility services to be effective April 1, 2019 (Appendix I). This amendment is being submitted based on enacted legislation. A summary of the proposed amendment is provided in Appendix II.

This amendment is submitted pursuant to §1902(a) of the Social Security Act (42 USC 1396a(a)) and Title 42 of the Code of Federal Regulations, Part 447, Subpart C, (42 CFR §447).

A copy of the pertinent section of enacted legislation is enclosed for your information (Appendix III). Copies of the public notice of this proposed amendment, which was given in the New York State Register on March 27, 2019, is also enclosed for your information (Appendix IV). In addition, responses to the five standard funding questions and the standard access questions are also enclosed (Appendix V and VI, respectively).

If you have any questions regarding this State Plan Amendment submission, please do not hesitate to contact Regina Deyette, Medicaid State Plan Coordinator, Division of Finance and Rate Setting, Office of Health Insurance Programs at (518) 473-3658.

Sincerely,

Donna Frescatore
Medicaid Director
Office of Health Insurance Programs

Enclosures
cc: Mr. Tom Brady

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 1 9 — 0 0 3 3

2. STATE: New York

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)
TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
CENTERS FOR MEDICARE & MEDICAID SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE: April 1, 2019

5. TYPE OF PLAN MATERIAL *(Check One)*

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION
§ 1902(a) of the Social Security Act and 42 CFR 447

7. FEDERAL BUDGET IMPACT
a. FFY 04/01/19-09/30/19 $ (47,750.00)
b. FFY 10/01/19-09/30/20 $ (95,500.00)

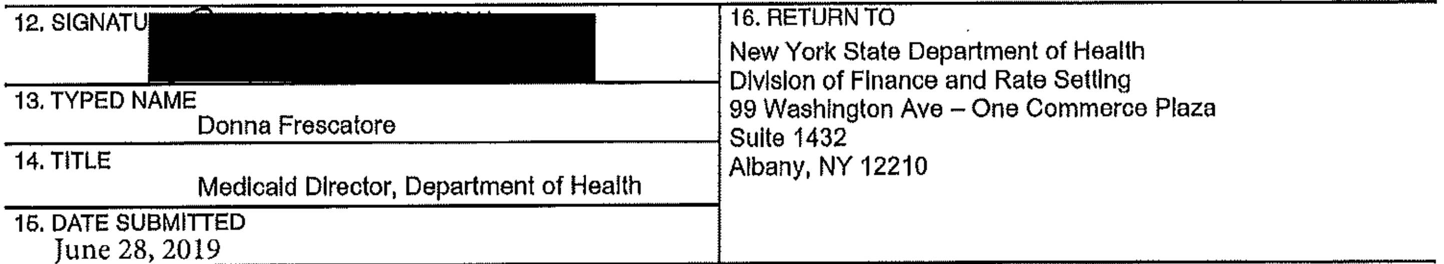
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Attachment 4.19-D: Page 110(d)(13)
Attachment 4.19-D: Page 110(d)(14)

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Attachment 4.19-D: Page 110 (d)(13)
Attachment 4.19-D: Page 110(d)(14)

10. SUBJECT OF AMENDMENT
Nursing Home Case Mix Adjustments
(FMAP=50%)

11. GOVERNOR'S REVIEW *(Check One)*

☒ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED



12. SIGNATU

13. TYPED NAME: Donna Frescatore

14. TITLE: Medicaid Director, Department of Health

15. DATE SUBMITTED: June 28, 2019

16. RETURN TO
New York State Department of Health
Division of Finance and Rate Setting
99 Washington Ave – One Commerce Plaza
Suite 1432
Albany, NY 12210

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED

18. DATE APPROVED

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL

20. SIGNATURE OF REGIONAL OFFICIAL

21. TYPED NAME

22. TITLE

23. REMARKS

Appendix I
2019 Title XIX State Plan
Second Quarter Amendment
Amended SPA Pages

New York
110(d)(13)

Calculation of 2007 All Payer Base Year Case Mix			
Peer Group	**Case Mix Total (Count x Weight)***	**Total Patient Days**	**Weighted Average Case Mix (Case Mix Total/ Patient Days)**
NSHB/NS300+	12,385,293	13,623,548	0.9091
NS300-	22,137,438	24,403,182	0.9072
Statewide/All Non-Specialty Facilities	34,522,731	38,026,730	0.9079
2007 Base Year Case Mix = NSHB/NS300+ (50% NSHB/NS300+/ 50% Statewide)			0.9085
2007 Base Year Case Mix = NS300- (50% NS300- / 50% Statewide)			0.9075

*Count is defined as the number of patients in each Resource Utilization Group and Weight is calculated and defined as described above in paragraph g(1) and g(2).

4) (a) Subsequent case mix adjustments to the direct component of the price for rate periods effective after January 1, 2012, [shall] will be made in July and January of each calendar year and [shall] will use Medicaid-only case mix data applicable to the previous case mix period (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).

4) (b) The 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.

4) (c) The case mix adjustment to the direct component of the price for 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).

New York
110(d)(14)

5) Case mix adjustments to the direct component of the price for facilities for which facility-specific case mix data is unavailable or insufficient [shall] will be equal to the [base year] previous case mix of the peer group applicable to such facility.

6) The adjustments and related patient classifications for each facility [shall] will be subject to audit review by the Office of Medicaid Inspector General, and/or other agents as authorized by the Department.

h) The indirect component of the price [shall] will consist of a blended rate to be determined as follows:

1) For NSHB/NS300+ the indirect component of the price [shall] will consist of a blended rate equal to:

i) 50% of the Statewide indirect NSF price which [shall] will be the allowable operating costs and statistical data for the indirect component of the price as reported by all non-specialty facilities in its cost reports for the 2007 calendar year, reduced by the allowable costs percent reduction, and divided by total 2007 patient days; and

ii) 50% of the indirect NSHB/NS300+ price which [shall] will be the allowable operating costs and statistical data for the indirect component of the price as reported by all non-specialty hospital-based facilities and all non-specialty freestanding facilities with certified bed capacity of 300 beds or more in its cost reports for the 2007 calendar year, reduced by the allowable costs percent reduction, and divided by total 2007 patient days; or

2) For NS300- the indirect component of the price [shall] will consist of a blended rate equal to:

i) 50% of the Statewide indirect NSF price which [shall] will be the allowable operating costs and statistical data for the indirect component of the price as reported by all non-specialty facilities in its cost reports for the 2007 calendar year, reduced by the allowable costs percent reduction, and divided by total 2007 patient days; and

ii) 50 % of the indirect NS300- prices which [shall] will be the allowable operating costs and statistical data for the indirect component of the price as reported by all non-specialty facilities with certified bed capacity of less than 300 beds in its cost reports for the 2007 calendar year, reduced by the allowable costs percent reduction, and divided by total 2007 patient days.

Appendix II
2019 Title XIX State Plan
Second Quarter Amendment
Summary

Summary
SPA #19-0033

This State Plan Amendment proposes to establish a new methodology for the Minimum Data Set (MDS) data in the calculation of the case mix index.

The direct price is subject to a case mix adjustment and a wage index adjustment. Effective April 1, 2019, the case mix index used to adjust the direct component price will be base on all MDS data submitted by NYS nursing facilities for a six-month period preceding the effective date of the Medicaid rates.

Appendix III
2019 Title XIX State Plan
Second Quarter Amendment
Authorizing Provisions

15 § 9. Residential health care facilities case mix adjustment workgroup.
16 The commissioner of health or his or her designee shall convene and
17 chair a workgroup on the implementation of the change in case mix
18 adjustments to Medicaid rates of payment of residential health care
19 facilities that will take effect on July 1, 2019. The workgroup shall be
20 comprised of residential health care facilities or representatives from
21 such facilities, representatives from the statewide associations and
22 other such experts on case mix as required by the commissioner or his or
23 her designee. The workgroup shall review recent case mix data and
24 related analyses conducted by the department with respect to the depart-
25 ment's implementation of the July 1, 2019 change in methodology, the
26 department's minimum data set collection process, and case mix adjust-
27 ments authorized under subparagraph (ii) of paragraph (b) of subdivision
28 2-b of section 2808 of the public health law. Such review shall seek to
29 promote a higher degree of accuracy in the minimum data set data, and
30 target abuses. The workgroup may offer recommendations on how to improve
31 future practice regarding accuracy in the minimum data set collection
32 process and how to reduce or eliminate abusive practices. In developing
33 such recommendations, the workgroup shall ensure that the collection
34 process and case mix adjustment recognizes the appropriate acuity for
35 residential health care residents. The workgroup may provide recommenda-
36 tions regarding the proposed patient driven payment model and the admin-
37 istrative complexity in revising the minimum data set collection and
38 rate promulgation processes. The commissioner shall not modify the meth-
39 od used to determine the case mix adjustment for periods prior to June
40 30, 2019. Notwithstanding any changes in federal law or regulation
41 relating to nursing home acuity reimbursement, the workgroup shall
42 report its recommendations no later than June 30, 2019.

Appendix IV
2019 Title XIX State Plan
Second Quarter Amendment
Public Notice

the 2006 final trend factor equal to the final Consumer Price Index (CPI) for all urban consumers less 0.25%.

Institutional Services

Effective on or after April 1, 2019, annual indigent care pool distributions for certain providers will be reduced.

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 ($275.6 million).

Effective on or after April 1, 2019, continues the supplemental upper payment limit payments made to general hospitals, other than major public general hospitals under institutional services of $339 million annually.

For state fiscal year beginning April 1, 2019 through March 31, 2020, continues specialty hospital adjustments for hospital inpatient services provided on and after April 1, 2012, to public general hospitals, other than those operated by the State of New York or the State University of New York, located in a city with a population of over one million and receiving reimbursement of up to $1.08 billion annually based on criteria and methodology set by the Commissioner of Health, which the Commissioner may periodically set through a memorandum of understanding with the New York City Health and Hospitals Corporation. Such adjustments shall be paid by means of one or more estimated payments. Payments to eligible public general hospitals may be added to rates of payment or made as aggregate payments.

Additional medical assistance, known as, Intergovernmental Transfer (IGT) payments, for inpatient hospital services may be made to public general hospitals operated by the State of New York or the State University of New York, or by a county which shall not include a city with a population over one million, and those public general hospitals located in the counties of Westchester, Erie, or Nassau, up to one hundred percent (100%) of each such public hospital's medical assistance, and uninsured patient losses after all other medical assistance, including disproportionate share hospital (DSH) payments to such public general hospitals. Payments will be made by means of one or more estimated distributions initially based on the latest DSH audit results, which shall later be reconciled to such payment year's actual DSH audit uncompensated care costs. Payments may be added to rates of payment or made as aggregate payments. Such payments will continue April 1, 2019 through March 31, 2021.

There is no change in gross Medicaid expenditures for this update.

Extends current provisions for services on April 1, 2019 through March 31, 2024 and thereafter, the reimbursable operating cost component for general hospital inpatient rates will be established with the 2006 final trend factor equal to the final Consumer Price Index (CPI) for all urban consumers less 0.25%.

The estimated annual net aggregate decrease in gross Medicaid expenditures for state fiscal year 2019/2020 is ($114.5 million).

Capital related costs of a general hospital excluding 44% of the major movable costs and excluding staff housing costs will continue effective April 1, 2019 through March 31, 2024 and thereafter.

The estimated annual net aggregate decrease in gross Medicaid expenditures for state fiscal year 2019/2020 is ($48.4 million).

Budgeted capital inpatient costs of a general hospital applicable to the rate year will be decreased to reflect the percentage amount by which the budget for the base year two years prior to the rate year for capital related inpatient expenses of the hospital exceeded actual expenses will continue effective April 1, 2019 through March 31, 2024 and thereafter.

The estimated annual net aggregate decrease in gross Medicaid expenditures for state fiscal year 2019/2020 is ($15.9 million).

Effective for dates of service on or after April 1, 2019, update the historical year Medicaid claims used in the general hospital acute rate statewide price development from 2014 to 2017.

There is no change in gross Medicaid expenditures for this update.

Long Term Care Services

Effective on or after April 1, 2019, continues additional payments to non-state government operated public residential health care facilities, including public residential health care facilities located in Nassau, Westchester, and Erie counties, but excluding public residential health care facilities operated by a town or city within a county, in aggregate amounts of up to $500 million. The amount allocated to each eligible public RHCF will be in accordance with the previously approved methodology, provided, however that patient days shall be utilized for such computation reflecting actual reported data for 2016 and each representative succeeding year as applicable. Payments to eligible RHCF's may be added to rates of payment or made as aggregate payments.

Effective on or after April 1, 2019 and thereafter, the appeals cap in PHL 2808(1)(a)(17)(b) is extended. The current appeals cap provision establishes an eighty-million-dollar annual budget for the processing of rate appeals or reimbursement for construction that has been approved by the commissioner.

There is no additional estimated annual change to gross Medicaid expenditures as a result of the extension.

Effective on or after April 1, 2019 and thereafter the provision that rates of payment for RHCFs shall not reflect trend factor projection or adjustments for the period April 1, 1996 through March 31, 1997 is extended.

The estimated annual net aggregate decrease in gross Medicaid expenditures attributable to this initiative is ($12.7 million).

Effective on or after April 1, 2019 and thereafter this provision continues a.0.25 reduction in the statutory trend factors of 2006.

The estimated annual net aggregate decrease in gross Medicaid expenditures attributable to this initiative is ($13.4 million).

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 and shall be updated for 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).

Effective for dates of service on or after April 1, 2019 and thereafter, Certified Home Health Agencies (CHHAs) payments will continue to be based on episodic payments, except for such services provided to children under 18 years of age.

There is no additional estimated annual change to gross Medicaid expenditures as a result of this extension.

Effective on or after April 1, 2019, The Consumer Directed Personal Assistance Program (CDPAP), a personal care service model, permits chronically ill and/or physically disabled individuals receiving home care under the medical assistance program greater flexibility and freedom of choice in obtaining such services. Reimbursement for CDPAP services has been based on a per hour billing methodology. This change will move the administrative reimbursement methodology for CDPAP to a per member per month basis and maintains an hourly/daily reimbursement for service delivery.

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 ($28.7 million).

Effective on or after April 1, 2019 and thereafter, current provisions for certified home health agency administrative and general costs reimbursement limits are extended.

There is no additional estimated annual change to gross Medicaid expenditures as a result of this extension.

Effective on or after April 1, 2019 and thereafter, the total reimbursable state assessment on each residential health care facility's gross receipts received from all patient care services and other operating income on a cash basis for inpatient or health-related services, including adult day service, but excluding gross receipts attributable to payments received pursuant to Title XVII of the federal Social Security Act (Medicare), at six percent.

The extent to which a facility is reimbursed for the additional cost of the assessment is dependent upon Medicaid volume of services.

Appendix V
2019 Title XIX State Plan
Second Quarter Amendment
Responses to Standard Funding Questions

APPENDIX V
LONG TERM CARE SERVICES
State Plan Amendment #19-0033

CMS Standard Funding Questions (NIRT Standard Funding Questions)

The following questions are being asked and should be answered in relation to all payments made to all providers under Attachment 4.19-D of the state plan.

1. **Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by States for services under the approved State plan. Do providers receive and retain the total Medicaid expenditures claimed by the State (includes normal per diem, supplemental, enhanced payments, other) or is any portion of the payments returned to the State, local governmental entity, or any other intermediary organization? If providers are required to return any portion of payments, please provide a full description of the repayment process. Include in your response a full description of the methodology for the return of any of the amount or percentage of payments that are returned and the disposition and use of the funds once they are returned to the State (i.e., general fund, medical services account, etc.)**

   Response: Providers do retain the payments made pursuant to this amendment. However, this requirement in no way prohibits the public provider, including county providers, from reimbursing the sponsoring local government for appropriate expenses incurred by the local government on behalf of the public provider. The State does not regulate the financial relationships that exist between public health care providers and their sponsoring governments, which are extremely varied and complex. Local governments may provide direct and/or indirect monetary subsidies to their public providers to cover on-going unreimbursed operational expenses and assure achievement of their mission as primary safety net providers. Examples of appropriate expenses may include payments to the local government which include reimbursement for debt service paid on a provider's behalf, reimbursement for Medicare Part B premiums paid for a provider's retirees, reimbursement for contractually required health benefit fund payments made on a provider's behalf, and payment for overhead expenses as allocated per federal Office of Management and Budget Circular 2 CFR 200 regarding Cost Principles for State, Local, and Indian Tribal Governments. The existence of such transfers should in no way negate the legitimacy of these facilities' Medicaid payments or result in reduced Medicaid federal financial participation for the State. This position was further supported by CMS in review and approval of SPA 07-07C when an on-site audit of these transactions for New York City's Health and Hospitals Corporation was completed with satisfactory results.

2. **Section 1902(a)(2) provides that the lack of adequate funds from local sources will not result in lowering the amount, duration, scope, or quality of care and services available under the plan. Please describe how the state share of each type of Medicaid payment (normal per diem, supplemental, enhanced, other) is funded. Please describe whether the state share is from appropriations from the legislature to the Medicaid agency, through intergovernmental transfer agreements (IGTs), certified public expenditures (CPEs), provider taxes, or any other mechanism used by the state to provide state share. Note that, if the appropriation is not to the Medicaid agency, the source of the state share would necessarily be derived through either an IGT or CPE. In this case, please identify the agency to which the funds are appropriated. Please provide an estimate of total expenditure and State share amounts for each type of Medicaid payment. If any of the non-federal share is being provided using IGTs or CPEs, please fully describe the matching arrangement including when the state agency receives the transferred amounts from the local government entity transferring the funds. If CPEs are used, please describe the methodology used by the state to verify that the total expenditures being certified are eligible for Federal matching funds in accordance with 42 CFR 433.51(b). For any payment funded by CPEs or IGTs, please provide the following:**
   - **(i) a complete list of the names of entities transferring or certifying funds;**
   - **(ii) the operational nature of the entity (state, county, city, other);**
   - **(iii) the total amounts transferred or certified by each entity;**
   - **(iv) clarify whether the certifying or transferring entity has general taxing authority; and,**
   - **(v) whether the certifying or transferring entity received appropriations (identify level of appropriations).**

Response: Payments made to service providers under the provisions of this SPA are funded through a budget appropriation received by the State agency that oversees medical assistance (Medicaid), which is the Department of Health.

The source of the appropriation is the Medicaid General Fund Local Assistance Account, which is part of the Global Cap. The Global Cap is funded by General Fund and HCRA resources.

There have been no new provider taxes and no existing taxes have been modified.

3. **Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State plan. If supplemental or**

enhanced payments are made, please provide the total amount for each type of supplemental or enhanced payment made to each provider type.

Response: No additional payments are included as part of the Amendment.

4. **Please provide a detailed description of the methodology used by the state to estimate the upper payment limit (UPL) for each class of providers (State owned or operated, non-state government owned or operated, and privately owned or operated). Please provide a current (i.e. applicable to the current rate year) UPL demonstration. Under regulations at 42 CFR 447.272, States are prohibited from setting payment rates for Medicaid inpatient services that exceed a reasonable estimate of the amount that would be paid under Medicare payment principals.**

   Response: The 2019 Nursing Home UPL is currently under CMS review.

5. **Does any governmental provider receive payments that in the aggregate (normal per diem, supplemental, enhanced, other) exceed their reasonable costs of providing services? If payments exceed the cost of services, do you recoup the excess and return the Federal share of the excess to CMS on the quarterly expenditure report?**

   Response: Effective January 1, 2012, the rate methodology included in the approved State Plan for non-specialty nursing facility services for the operating component of the rate is a blended statewide/peer group price adjusted for case mix and wage equalization factor (WEF). Specialty nursing facilities and units are paid the operating rate in effect on January 1, 2009. The capital component of the rate for all specialty and non-specialty facilities is based upon a cost-based methodology. We are unaware of any requirement under current federal law or regulation that limits individual provider payments to their actual costs.

ACA Assurances:

1. **Maintenance of Effort (MOE). Under section 1902(gg) of the Social Security Act (the Act), as amended by the Affordable Care Act, as a condition of receiving any Federal payments under the Medicaid program during the MOE period indicated below, the State shall not have in effect any eligibility standards, methodologies, or procedures in its Medicaid program which are more restrictive than such eligibility provisions as in effect in its Medicaid program on March 10, 2010.**

   MOE Period.
   - **Begins on: March 10, 2010, and**
   - **Ends on: The date the Secretary of the Federal Department of Health and Human Services determines an Exchange established by a State**

under the provisions of section 1311 of the Affordable Care Act is fully operational.

Response: This SPA complies with the conditions of the MOE provision of section 1902(gg) of the Act for continued funding under the Medicaid program.

2. **Section 1905(y) and (z) of the Act provides for increased FMAPs for expenditures made on or after January 1, 2014 for individuals determined eligible under section 1902(a)(10)(A)(i)(VIII) of the Act. Under section 1905(cc) of the Act, the increased FMAP under sections 1905(y) and (z) would not be available for States that require local political subdivisions to contribute amounts toward the non-Federal share of the State's expenditures at a greater percentage than would have been required on December 31, 2009.**

   Prior to January 1, 2014 States may potentially require contributions by local political subdivisions toward the non-Federal share of the States' expenditures at percentages greater than were required on December 31, 2009. However, because of the provisions of section 1905(cc) of the Act, it is important to determine and document/flag any SPAs/State plans which have such greater percentages prior to the January 1, 2014 date in order to anticipate potential violations and/or appropriate corrective actions by the States and the Federal government.

   Response: This SPA would [ ] / would not [✓] violate these provisions, if they remained in effect on or after January 1, 2019.

3. **Please indicate whether the State is currently in conformance with the requirements of section 1902(a)(37) of the Act regarding prompt payment of claims.**

   Response: The State does comply with the requirements of section 1902(a)(37) of the Act regarding prompt payment of claims.

Tribal Assurance:

Section 1902(a)(73) of the Social Security Act the Act requires a State in which one or more Indian Health Programs or Urban Indian Organizations furnish health care services to establish a process for the State Medicaid agency to seek advice on a regular ongoing basis from designees of Indian health programs whether operated by the Indian Health Service HIS Tribes or Tribal organizations under the Indian Self Determination and Education Assistance Act ISDEAA or Urban Indian Organizations under the Indian Health Care Improvement Act.

IHCIA Section 2107(e)(I) of the Act was also amended to apply these requirements to the Children's Health Insurance Program CHIP.

Consultation is required concerning Medicaid and CHIP matters having a direct impact on Indian health programs and Urban Indian organizations.

a) **Please describe the process the State uses to seek advice on a regular ongoing basis from federally recognized tribes Indian Health Programs and Urban Indian Organizations on matters related to Medicaid and CHIP programs and for consultation on State Plan Amendments waiver proposals waiver extensions waiver amendments waiver renewals and proposals for demonstration projects prior to submission to CMS.**

b) **Please include information about the frequency inclusiveness and process for seeking such advice.**

c) **Please describe the consultation process that occurred specifically for the development and submission of this State Plan Amendment when it occurred and who was involved.**

Response: Tribal consultation was performed in accordance with the State's tribal consultation policy as approved in SPA 17-0065, and documentation of such is included with the original submission. To date, no feedback has been received from any tribal representative in response to the proposed change in this SPA.

Appendix VI
2019 Title XIX State Plan
Second Quarter Amendment
Responses to Standard Access Questions

APPENDIX VI
LONG TERM CARE SERVICES
State Plan Amendment 19-0033

<u>CMS Standard Access Questions</u>

The following questions have been asked by CMS and are answered by the State in relation to all payments made to all providers under Attachment 4.19-D of the state plan.

1. **Specifically, how did the State determine that the Medicaid provider payments that will result from the change in this amendment are sufficient to comply with the requirements of 1902(a)(30)?**

   <u>Response:</u> This amendment seeks to rationalize the case mx reimbursement system. This will be accomplished through a change from a census-based case mix calculation to a system which will use all valid MDS assessments filed during a six-month period.

2. **How does the State intend to monitor the impact of the new rates and implement a remedy should rates be insufficient to guarantee required access levels?**

   <u>Response:</u> The State has various ways to ensure that access levels in the Medicaid program are retained and is currently not aware of any access issues, particularly since there is excess bed capacity for both hospitals and nursing homes. Additionally, hospital and nursing home providers must notify and receive approval from the Department's Office of Health Systems Management (OHSM) in order to discontinue services. This Office monitors and considers such requests in the context of access as they approve/deny changes in services. Finally, providers cannot discriminate based on source of payment.

   For providers that are not subject to an approval process, the State will continue to monitor provider complaint hotlines to identify geographic areas of concern and/or service type needs. If Medicaid beneficiaries begin to encounter access issues, the Department would expect to see a marked increase in complaints. These complaints will be identified and analyzed in light of the changes proposed in this State Plan Amendment.

   Finally, the State ensures that there is adequate provider capacity for Medicaid Managed Care plans as part of its process to approve managed care rates and plans. Should the necessary access to services be compromised, the State would be alerted and would take appropriate action to ensure retention of access to such services.

3. **How were providers, advocates and beneficiaries engaged in the discussion around rate modifications? What were their concerns and how did the State address these concerns?**

Response: This change was enacted by the State Legislature as part of the negotiation of the 2019-2020 Budget. The impact of this change was weighed in the context of the overall State Budget. The legislative process provides opportunities for all stakeholders to lobby their concerns, objections, or support for various legislative initiatives.

4. **What action(s) does the State plan to implement after the rate change takes place to counter any decrease to access if the rate decrease is found to prevent sufficient access to care?**

   Response: Should any essential community provider experience Medicaid or other revenue issues that would prevent access to needed community services, per usual practice, the State would meet with them to explore the situation and discuss possible solutions, if necessary.

5. **Is the State modifying anything else in the State Plan which will counterbalance any impact on access that may be caused by the decrease in rates (e.g. increasing scope of services that other provider types may provide or providing care in other settings)?**

   Response: Over the course of the past three years, the State has undertaken a massive reform initiative to better align reimbursement with care. When fully implemented, the initiative will invest over $600 million in the State's ambulatory care system (outpatient, ambulatory surgery, emergency department, clinic and physicians) to incentivize care in the most appropriate setting. The State has also increased its physician reimbursement schedule to resemble Medicare payments for similar services, thus ensuring continued access for Medicaid beneficiaries. While some of these initiatives are outside the scope of the State Plan, they represent some of the measures the State is taking to ensure quality care for the State's most vulnerable population.

EXHIBIT E

RICHARD N. GOTTFRIED
75TH ASSEMBLY DISTRICT

CHAIR
COMMITTEE ON HEALTH

NEW YORK STATE ASSEMBLY

822 LEGISLATIVE OFFICE BUILDING, ALBANY, NY 12248
TEL: 518-455-4941 FAX: 518-455-5939

250 BROADWAY, RM. 2232, NEW YORK, NY 10007
TEL: 212-312-1492 FAX: 212-312-1494

E-MAIL: GottfriedR@nyassembly.gov

COMMITTEES:
RULES
HEALTH
HIGHER EDUCATION
MAJORITY STEERING

CHAIR
MANHATTAN DELEGATION

September 9, 2019

Paul Francis
Deputy Secretary for Health
The Capitol
Albany, NY 12224

Robert Mujica
Director of the Budget
The Capitol
Albany, NY 12224

Dear Paul and Robert:

The enacted budget for SFY 2019-20 created a Residential Health Care Facility Case Mix Adjustment Workgroup to offer recommendations regarding the proposed "patient driven" payment model in revising the minimum data set and rate promulgation processes. I am concerned to hear from representatives of stakeholders that efforts of the workgroup have been ignored.

It is my understanding that the Workgroup has offered useful suggestions for modernizing the case mix method, including a temporary method using the most recent quarterly average of all Minimum Data Sets (MDS) until January of 2020 in order to allow a transition to the Resource Utilization Groupings (RUGS) IV classification system used by Medicare, which would provide greater consistency for both the Department and the industry. Their concern is that in rejecting their proposal, the Department is worsening the fiscal outlook faced by an industry which is already paid 20% less than the actual cost of providing care.

Particularly among the non-profit and county-run facilities, it is essential that the Department protect vulnerable safety net providers. It will do us no good to achieve score-card savings if we endanger the safety and care of our elderly in the process. A decent society provides what is needed when it is needed. We need our nursing homes to be safe, well regulated, and adequately funded to meet this obligation.

Very truly yours,

Richard N. Gottfried
Chair, Assembly Committee on Health

EXHIBIT "F"

NEW YORK
STATE
SENATE
ALBANY, NEW YORK 12247

September 11, 2019

Robert Mujica, Director
Division of the Budget
State Capitol
Albany, New York 12210

Dear Mr. Mujica:

We write to express our concern about the impact of administrative rate changes to residential health care facilities. As part of the 2019-20 enacted state budget, the Governor agreed, at the Legislature's request, to establish the Residential Health Care Facilities Case Mix Adjustment Workgroup ("Workgroup") before implementation of rate changes to these facilities. These rate changes seek to save the state approximately $122.8 million (or a $245.6 million gross cut to nursing homes). While savings to the state's Medicaid spending is critical in ensuring a balanced budget, we ask that you delay the implementation of these cuts pending further review in conformity with the Legislature's intent in reviewing and implementing these changes.

As you know, the Workgroup was charged with reviewing data to "seek to promote a higher degree of accuracy in the minimum data set data, and target abuses," as was the administration's articulated intent for making the methodology change. It is our understanding that the Workgroup members never received the case mix data or related analyses to review. Instead, the Department announced at the Workgroup's first meeting their intent to move forward with the methodology initially proposed, resulting in severe cuts to nursing home rates without the required analyses, review and Workgroup input mandated by law.

Given the lack of detail surrounding the methodology and implementation, individual nursing homes are rightfully concerned. We are told the cut will drive the average nursing home operating margin in New York from -1.3 percent (2017) to -3.2 percent and increase the overall percentage of nursing homes with negative operating margins from 41 percent currently to an estimated 56 percent following the cuts. Clearly, the state does not want to see nursing homes close, reduce staffing levels and/or compromise quality. Earlier this year the Governor used a portion of the Transformation Fund to support salary enhancements for nursing homes. The Executive recognized that this sector could not increase salaries without an infusion of funding since the reimbursement rate for nursing homes is based on 2007 costs that have not seen any Medicaid inflation adjustment over the course of the last 10 years. To now assume, months later, that this same sector can withstand a $245.6 million gross reduction in funding without a careful

and systemic look at the methodology and effects is unrealistic and dangerous. This is precisely why the Legislature demanded the Workgroup and its charge be enshrined in statute.

The $122.8 million in state administrative Medicaid savings to be achieved through the new rate methodology requires a State Plan Amendment (SPA), which we understand was filed with CMS on June 28th, immediately following the final Workgroup meeting. Again, the administration moved forward without the statutorily required Workgroup's analysis and input. Pursuing this particular SPA, as opposed to others filed over the last few years that have yet to be implemented and for which the state also assumed savings, raises questions. Those SPAs filed much earlier could be pursued to accomplish savings and provide the necessary, appropriate and required time to ensure the proposed changes to the case mix/acuity methodology is carefully considered.

Recommendations were issued by the Workgroup in late June, without the benefit of having first received and reviewed the data and related analyses from the Department, as required by law. However, even without the required information, the Workgroup's recommendations raised alarms about the magnitude of the retroactive cut and the Department's failure to follow the letter and intent of the law. Again, the objective of the Workgroup was to "promote a higher degree of accuracy in the minimum data set data, and target abuses" – that is, facilities who may be "gaming the system" through false inflation of utilization – not to disrupt patient care or threaten the financial vulnerability of all nursing homes.

We urge you to reconvene the Workgroup, provide the necessary and required data and analyses, and allow for a complete and thorough review of the impacts. Until this activity occurs, any administrative action should be delayed to conform with the budget agreement. It is critically important that the final methodology that is administratively imposed by the Department does not create unnecessary and unintended consequences that could undermine our most fragile nursing homes.

Senator Gustavo Rivera, 33rd District,
Chair, Senate Health Committee

Liz Krueger, 28th District,
Chair, Senate Finance Committee

Senator Anna Kaplan, 7th District

Senator Todd Kaminsky, 9th District

Senator James Sanders, Jr., 10th District

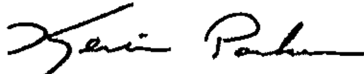
Senator John C. Liu, 11th District

Senator Leroy Comrie, 14th District

Senator Joseph Addabbo, 16th District

Senator Simcha Felder, 17th District

Senator Julia Salazar, 18th District


Senator Kevin Parker, 21st District

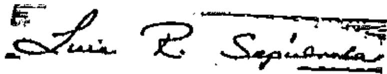
Senator Andrew Gounardes, 22nd District

Senator Velmanette Montgomery, 25th District

Senator Brad Hoylman, 27th District

Senator José M. Serrano, 29th District

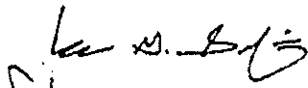
Senator Robert Jackson, 31st District


Senator Luis R. Sepulveda, 32nd District

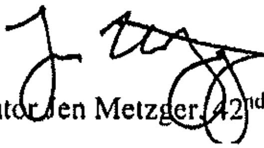
Senator Alessandra Biaggi, 34th District

Senator Jamaal T. Bailey, 36th District

Senator Shelley Mayer, 37th District


Senator James Skoufis, 38th District

Senator Peter Harckham, 40th District


Senator Jen Metzger, 42nd District

Senator Rachel May, 53rd District

Senator Timothy M Kennedy, 60th District

Cc: Commissioner Howard A. Zucker, M.D., J.D.

EXHIBIT “G”

Department of Health

ANDREW M. CUOMO
Governor

HOWARD A. ZUCKER, M.D., J.D.
Commissioner

SALLY DRESLIN, M.S., R.N.
Executive Deputy Commissioner

October 9, 2019

Dear Administrator:

This letter provides you with information regarding your Residential Health Care Facility reimbursement rates effective July 1, 2019. The all-inclusive rate sheets are provided on Health Commerce System, via the Healthcare Financial Data Gateway.

The July 1, 2019 rates have been updated to include a case mix adjustment which was calculated using all assessment data submitted to Centers for Medicare and Medicaid Services for the time period August 8, 2018 through March 31, 2019. Please note no discharge or tracking Minimum Data Sets were used, and no default scores were assigned to any assessments.

The payment for July 1, 2019 rates will be made in cycle 2200 with a check release date of 11/6/2019. If you have any questions regarding the rates, please send an email to nfrates@health.ny.gov and we will respond to your inquiry.

Sincerely,

Michael Ogborn
Medicaid Chief Financial Officer
Office of Health Insurance Programs