IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF NEW YORK

SAFE HAVEN HOME CARE, INC., EVERGREEN HOMECARE SERVICE OF NY INC., ELIM HOME CARE AGENCY, LLC, DHCARE HOMEHEALTH, INC., SILVER LINING HOMECARE AGENCY, AND ANGEL CARE, INC. Plaintiffs, v. UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, XAVIER BECERRA, in his official capacity as Secretary of the United States Department of Health and Human Services, UNITED STATES CENTERS FOR MEDICARE & MEDICAID SERVICES, CHIQUITA BROOKS-LASURE, in her official capacity as Administrator of the U.S. Centers for Medicare and Medicaid Services, NEW YORK STATE DEPARTMENT OF HEALTH, MARY T. BASSETT, in her official capacity as Commissioner of the New York State Department of Health, BRETT R. FRIEDMAN, in his official capacity as Medicaid Director of the New York State Department of Health Defendants.	)	Civil Action No.:

COMPLAINT FOR DECLARATORY AND INJUNCTIVE RELIEF

Plaintiffs are Licensed Home Care Services Agencies ("LHCSAs") providing home care services to Medicaid beneficiaries residing in New York State and bring this complaint for declaratory and injunctive relief against Defendants United States Department of Health and Human Services ("HHS"), United States Centers for Medicare & Medicaid Services ("CMS"),

New York State Department of Health ("NYSDOH"), and associated officials. In support thereof, Plaintiffs state the following:

INTRODUCTION

1. As part of the American Rescue Plan Act, Congress provided additional funding for Medicaid Home and Community-Based Services ("HCBS") during the COVID-19 emergency.

2. New York State's Medicaid Program estimates that this funding represents $2.15 billion of additional federal funds to support Medicaid HCBS in New York.

3. The NYSDOH is tasked with implementing these funds, which must also be matched by equivalent New York State funds. Its spending plan, as well as specific directed-payments it makes under its spending plan, must be pre-approved by Defendant CMS.

4. The NYSDOH's first directed payment request to CMS was to approve $361 million to be distributed among LHCSAs providing Medicaid services in New York.

5. Rather than distribute the funds equitably among providers, however, the NYSDOH decided to give ***all*** the money to 212 specific LHCSAs out of approximately 800 LHCSAs, based solely on one factor—which were the biggest.

6. Some LHCSAs were even big enough to receive multiple awards, as there are 235 awards for the 212 LHCSAs, an average of more than $1.7 million per LHCSA.

7. CMS approved the NYSDOH's request and the funding is set to go out on March 31, 2022 to the managed care plans, to be handed over to the 212 LHCSAs in April.

8. CMS' approval of the NYSDOH's first directed payment is in violation of the Medicaid Statute as the payment is not "made on an actuarially sound basis," *see* 42 U.S.C. § 1396b(m)(2)(A)(iii), and is also contrary to CMS' own regulations which require, among other

things, that directed payments be made "equally, and using the same terms of performance, for a ***class of providers*** proving the service under the contract." 42 C.F.R. § 438.6(c)(2)(ii)(B) (emphasis added).

9. If these funds are distributed as planned, the largest providers in New York—those already winning the market share battle—will be given hundreds of millions of dollars to "fund recruitment, retention, and training for personal care aides, home health aides, and nurses," all but assuring that many smaller providers (who often cater to culturally, racially, and ethnically diverse populations) will be put out of business.

10. This lawsuit seeks to stop that from happening.

JURISDICTION AND VENUE

11. The Court has subject matter jurisdiction under 28 U.S.C. § 1331 as this action arises under the American Rescue Plan Act, Pub. L. No. 117-2, the Medicaid Statute, Title XIX of the Social Security Act, 42 U.S.C. § 1396 *et seq*., the Administrative Procedure Act ("APA"), 5 U.S.C. §§ 702 and 706, and the Declaratory Judgment Act, 28 U.S.C. §§ 2201-02. The Court has personal jurisdiction over all Defendants because they are exercising their challenged official duties in this District.

12. Venue is proper in this Court under 28 U.S.C. § 1391(b) and (e).

PARTIES

13. Plaintiffs are home care services agencies that are licensed pursuant to New York Public Health Law § 3605.

14. Plaintiff Safe Haven Home Care, Inc. is a LHCSA, located at 105-26 Flatlands 1st Street, Brooklyn, New York 11236. It was organized as a corporation in the State of New York

in October of 2008, and it provides services in the following counties: Bronx, Kings, New York, Queens, and Richmond.

15. Plaintiff Evergreen Homecare Service of NY Inc. is a LHCSA, located at 149th Pl, Flushing, New York 11354. It was organized as a corporation in the State of New York in May of 2014 and it provides services in the following counties: Bronx, Kings, New York, Queens, Richmond, and Westchester.

16. Plaintiff Elim Home Care Agency, LLC is a LHCSA, located at 4131 163rd St Fl 1, Flushing, New York 11358. It was organized as a corporation in the State of New York in January of 2013 and it provides services in the following counties: Bronx, Kings, Nassau, and Queens.

17. Plaintiff DHCare Homehealth, Inc. is a LHCSA, located at 172-15 Hillside Ave, Jamaica, NY 11432. It was organized as a corporation in the State of New York in October of 2014 and it provides services in the following counties: Bronx, Kings, Nassau, New York, Queens, and Richmond.

18. Plaintiff Silver Lining Home Care Inc. is a LHCSA, located at 1115 Avenue U, Brooklyn, New York 11223. It was formed as a corporation in the State of New York in October of 2012, and it provides services in the following counties: Bronx, Kings, Nassau, New York, Queens, and Richmond.

19. Plaintiff Angel Care, Inc. is a LHCSA, located at 1580 Dahill Road, 2nd Floor, Brooklyn, New York 11204. It was organized as a corporation in the State of New York in February of 2010, and it provides services in the following counties: Bronx, Kings, Nassau, New York, Queens, and Richmond.

20. Defendant United States Department of Health and Human Services is a federal cabinet-level department tasked with administering federal healthcare statutes. It is headquartered at 200 Independent Avenue, S.W., Washington, DC, 20201.

21. Defendant Xavier Becerra is Secretary of HHS and is sued in his official capacity. Secretary Becerra's office is maintained at HHS headquarters in Washington, DC.

22. Defendant United States Centers for Medicare & Medicaid Services is an agency within HHS that is responsible for administration of the Medicare and Medicaid programs. It is headquartered at 7500 Security Boulevard, Baltimore, Maryland, 21244.

23. Defendant Chiquita Brooks-Lasure is Administrator of CMS and is sued in her official capacity. Administrator Brooks-Lasure's office is maintained at CMS headquarters in Baltimore, Maryland.

24. Defendant New York State Department of Health is the single-state agency in New York responsible for administering New York's Medicaid program. It is headquartered at Corning Tower, Empire State Plaza, Albany, NY 12237.

25. Defendant Mary T. Bassett is the Commissioner of the NYSDOH and is sued in her official capacity. Commissioner Bassett maintains her office at NYSDOH's headquarters in Albany, NY.

26. Defendant Brett R. Friedman is the Medicaid Director of the NYSDOH and is sued in his official capacity. Director Friedman maintains his office at NYSDOH's headquarters in Albany, NY and submitted NYSDOH's request to CMS for approval of NYSDOH's first directed payment.

STATUTORY & REGULATORY OVERVIEW

American Rescue Plan Act

27. Signed into law on March 11, 2021, the American Rescue Plan Act of 2021 ("ARPA"), Pub. L. No. 117-2, provided $1.9 trillion in federal funding for a range of programs to address the public health and economic crisis created by the COVID-19 pandemic.

28. Section 9817 of ARPA is titled "Additional Support for Medicaid Home and Community-Based Services During the Covid-19 Emergency" and provides for a ten percent increase in the Federal Medical Assistance Percentage ("FMAP") with respect to expenditures for HCBS between April 1, 2021 and March 31, 2022 (the "Improvement Period"). This includes services such as home health care, personal care, case management, rehabilitation, and others.

29. Increased FMAP funds must be used by the State to supplement, as opposed to supplant, existing State funding for HCBS, and must be used to implement or supplement the implementation of one or more activities to enhance, expand, or strengthen HCBS under the State Medicaid program. ARPA § 9817(b).

30. The State's enhanced funds are generated during the Improvement Period based on HCBS spending; however, the State may expend these funds at any time prior to March 31, 2024. The NYSDOH has estimated that it will generate $2.15 billion in federal funds from its HCBS spending during the Improvement Period. In addition, the State must use the state funds equivalent to the amount of the enhanced FMAP (*i.e.*, $2.15 billion in State funds) to implement or supplement the implementation of one or more activities to enhance, expand, or strengthen HCBS.

31. The State is required to obtain approval from CMS for its spending plan of ARPA funds, as well as adhere to existing Medicaid spending requirements, such as obtaining pre-approval from CMS for any State directed payments pursuant to 42 C.F.R. § 438.6(c), described further below.

The Medicaid Statute, 42 U.S.C. § 1396, *et seq.*

32. The United States subsidizes health care expenditures for the elderly, disabled, and persons of modest income, principally through the Medicare and Medicaid programs. While the Medicare program is operated by the federal government, the Medicaid program is a federal-state partnership in which the program is operated by the State but is also regulated, overseen, and partially funded by the federal government—specifically Defendants HHS and CMS.

33. States need not join the Medicaid program, but those which do, such as New York State, must comply with a long list of federal statutory and regulatory requirements.

34. Many states, including New York State, operate their Medicaid plans through managed care organizations ("MCOs"). MCOs are health insurance plans or health care systems that contract directly with the State and then, in turn, contract with health care providers to provide an adequate network of services for their Medicaid members. MCOs are typically paid a capitated per-member-per-month fee by the State to cover services for their Medicaid members.

35. Managed Long Term Care ("MLTC") Plans are a type of MCO that cover a range of long-term care services to those who are chronically ill or disabled and wish to stay in their homes or communities. The HCBS described above, and subject to ARPA's enhanced FMAP are among the long-term care services covered by MLTC Plans in New York.

36. Medicaid Advantage Plus ("MAP") plans are another type of MCO that combine Medicaid and Medicare coverage, and likewise cover the range of HCBS subject to ARPA's enhanced FMAP.

37. The Medicaid Statute, as well as regulations implemented by CMS, provide a host of requirements that apply to MCOs, as well as to States that utilize MCOs. One such requirement, found at 42 U.S.C. § 1396b(m)(2)(A)(iii), is that States must make prepaid capitation payments to MCOs "on an actuarially sound basis." This means rates that are projected to cover all reasonable, appropriate, and attainable costs that are required under the terms of the contract between the State and the MCO for the time period and population covered. 42 C.F.R. § 438.4.

38. Because capitated rates paid to the MCOs must be sufficient to cover all reasonable, appropriate, and attainable costs, States are prohibited from making pass-through payments to providers. 42 C.F.R. § 438.6(a).

39. Certain directed payments (*i.e.*, payments in which the State directs the MCO) are permitted, however those payments must meet specific criteria, and be pre-approved by CMS through what is known as a Directed Payment Section 438.6(c) Preprint Application. 42 C.F.R. § 438.6(c). A directed payment which fails to comply with 42 C.F.R. § 438.6(c) is considered a pass-through payment.

40. Directed payments that fail to meet the "special contract provisions as specified in § 438.6" will not be approved as actuarially sound. 42 C.F.R. § 438.4(b)(7).

41. As CMS has explained, "Section 1903(m)(2)(A)(iii) of the Act requires contracts between states and MCOs to provide capitation payments for services and associated administrative costs that are actuarially sound. The underlying concept of managed care and

actuarial soundness is that the state is transferring the risk of providing services to the MCO and is paying the MCO an amount that is reasonable, appropriate, and attainable compared to the costs associated with providing the services in a free market." CMS Final Rule, 81 FR 27498, at 27588, May 6, 2016. As such, states are "prohibited from making a supplemental payment to a provider through a managed care plan, which is referred to as a 'pass-through' payment." *Id*. 27589.

42. CMS provides for limited exceptions at 42 C.F.R. § 438.6(c)(1)(i)-(iii) which permit States to direct MCO payments to providers. One such exception is that the State may require MCOs to "implement value-based purchasing models for provider reimbursement, such as pay for performance arrangement, bundled payments, or other service payment models intended to recognize value or outcomes over volume of services." *Id*. § 438.6(c)(1)(i). Another exception permits the State to direct "a uniform dollar or percentage increase for network providers that provide a particular service under the contract." *Id*. § 438.6(c)(1)(iii)(C). Prior to implementing any such plan, however, the State must obtain written approval from CMS. *Id*. § 438.6(c)(2)(ii). In addition, to obtain CMS approval, a "State must demonstrate, in writing, that the arrangement – (A) Is based on the utilization and delivery of services; [and] (B) Directs expenditures equally, and using the same terms of performance, for a ***class of providers*** providing the service under the contract," among other requirements. *Id*. § 438.6(c)(2)(ii)(A)-(B) (emphasis added).

43. In November 2017, CMS published guidance, a related appendix with examples, and a preprint for states to obtain approval of state directed payments under Section 438.6(c). CMCS Informational Bulletin, "Delivery System and Provider Payment Initiatives under

Medicaid Managed Care Contracts," (Nov. 2, 2017), available at https://www.medicaid.gov/federal-policy-guidance/downloads/cib11022017.pdf.

44. In May 2020, CMS issued specific guidance on Medicaid MCO options for responding to COVID-19, including State directed payments to enhance provider payments. CMCS Informational Bulletin, "Medicaid Managed Care Options in Responding to COVID-19," (May 14, 2020), available at https://www.medicaid.gov/federal-policy-guidance/downloads/cib051420.pdf. CMS reminded States that directed payments must meet the requirements under 42 C.F.R. § 438.6(c)(2) and expounded as to directed payments for a "class of providers." *Id*. It wrote that, "[h]istorically, CMS has deferred to states in defining the provider class for purposes of state directed payment arrangements, ***as long as the provider class is reasonable and identifiable, such as the provider class being defined in the state's Medicaid State Plan***." *Id*. at 6 (emphasis added). CMS further wrote that, "[e]xamples of state directed payments for a target class or classes of providers providing services under the contract could include dental, behavioral health, home health and personal care, pediatric, federally-qualified health centers, and safety-net hospitals." *Id*. Further, "[t]hese payments must be directed equally, using the same terms of performance across a class of providers." *Id*.

45. LHCSAs, for example, would constitute a "class of providers" as they are a class of provider defined by State statute, *see* N.Y. Pub. Health § 3602(13), issued licenses pursuant to N.Y. Pub. Health § 3605, and discussed as a provider class throughout the New York Medicaid State Plan. *See* e.g., State Plan, at TN#18-0047, Attachment 4.19-B; TN#20-0033, Attachment 4.19-B; TN#12-05, Supplement 1 to Attachment 3.1-A; TN#86-7, Attachment 4.11-A. *See also* https://profiles.health.ny.gov/home_care/pages/lhcsa.

46. In January 2021, CMS issued additional guidance on state directed payments in Medicaid managed care. State Medicaid Director Letter #21-001, "RE: Additional Guidance on State Directed Payments in Medicaid Managed Care," (Jan. 8, 2021), available at https://www.medicaid.gov/Federal-Policy-Guidance/Downloads/smd21001.pdf. Once again, CMS stressed that "State directed payments are required under 42 C.F.R. § 438.6(c)(2)(ii)(B) to direct expenditures equally, using the same terms of performance, for a ***class of providers*** providing the service under the contract." *Id*. at 6 (emphasis in original). CMS also noted that states must provide an analysis with the Preprint Application that is specific to the defined provider class, "[f]or example, if the state defined the provider class for a state directed payment as primary care physicians, the analysis of the reimbursement levels would need to be specific to primary care physicians; it should not include all physicians (primary care and specialty physicians)." *Id*. at 7.

47. Finally, in May 2021, CMS issued guidance specific to the implementation of ARPA Section 9817. State Medicaid Director Letter #21-003, "RE: Implementation of American Rescue Plan Act of 2021 Section 9817: Additional Support for Medicaid Home and Community-Based Services during the COVID-19 Emergency," (May 13, 2021), available at https://www.medicaid.gov/Federal-Policy-Guidance/Downloads/smd21003.pdf. CMS once again reminded States that directed payments must be made in accordance with 42 C.F.R. § 438.6(c). *Id*. at 8-9.

FACTUAL ALLEGATIONS

48. On July 8, 2021, the NYSDOH submitted to CMS its initial spending plan for use of its ARPA Section 9817 enhanced FMAP funding. New York State Department of Health Spending Plan for Implementation of American Rescue Plan Act of 2021, Section 9817 (July 8,

2021), available at https://www.health.ny.gov/health_care/medicaid/redesign/hcbs/enhanced_funding/docs/2021-07-08_hcbs_spending_plan.pdf. Its largest category of proposed funding represented $623 million in state funds equivalent (*i.e.*, $1.246 billion total) to "Transform the Long-Term Care Workforce and Achieve Value-Based Payment (VBP) Readiness." *Id*. at 7-9. The NYSDOH explained that it intended "to leverage a significant portion of additional FMAP to increase the capacity and quality of its HCBS workforce, such that both this workforce, and the licensed home services agencies (LHCSAs) or consumers working in conjunction with fiscal intermediaries (FIs), are able to implement evidence-based care interventions, promote quality, and participate effectively in value-based payment (VBP) arrangements." *Id*. at 7.

49. Further, "[p]ayment of the funds would tie to the utilization and delivery of qualifying community-based long-term services and supports (CBLTSS) services by eligible providers, but would be further conditioned on providers that develop the following workforce transformation programs and strategies that assist in workforce capacity building and VBP readiness [workforce retention strategies, training programs, innovative technology, diversity, effective care management, and PPP stockpiles]." *Id*. at 8-9. The "initiatives implemented during this period would support the growing need for HCBS by ensuring improved workforce capacity, skill-level, and quality." *Id*. at 9.

50. Eligible provider classes were listed by the NYSDOH as "LHCSAs, FIs, Adult Day Health Care providers, and Social Adult Day Care Providers." *Id*. at 8. The plan also contemplated tracking for "efficiency metrics that would allow providers to access additional funding based on their progress in implementing and expending funding through this program." *Id*. at 9. Finally, MCOs "will be instructed to monitor and report to DOH on improvements in

quality outcomes against established long-term care quality metrics contained in the State's managed care quality strategy" and the NYSDOH proposed "an evaluation structure that is based on pay-for-reporting in the first six-month period and then pay-for-performance standards in subsequent contract periods." *Id*.

51. On August 25, 2021, CMS notified the NYSDOH of a partial approval to its FMAP spending plan, including approval of NYSDOH's proposal for transforming the long-term care workforce and achieving VBP readiness. New York State Department of Health First Quarterly Report: Spending Narrative for Implementation of American Rescue Plan Act of 2021, Section 9817, (Oct. 18, 2021), available at https://health.ny.gov/health_care/medicaid/redesign/hcbs/enhanced_funding/docs/quarterly_rpt_narrative.pdf., at 9. The NYSDOH memorialized this approval in its first quarterly report to CMS on October 18, 2021, and further wrote that it would submit its Section 438.6(c) Preprint in October or early November 2021 to CMS. *Id*. The NYSDOH also notified CMS that it had increased its proposal of $623 million in state funds equivalent to $722.5 million (or $1.445 billion total) for this category of funding. *Id*. at 9.

52. On or about November 17, 2021, the NYSDOH provided a webinar for providers entitled "Long-Term Care Workforce and Value-Based Payment Readiness Implementation Directed Payment Preprint Process Overview," available at http://leadingageny.org/home/assets/File/November%20Policy%20and%20Planning%20Meeting_Directed%20Payment_11_17_21.pdf.

53. On the webinar, the NSYDOH provided an overview of its Section 438.6(c) Preprint, which it had submitted to CMS on November 15, 2021. *Id*. at 9.

54. Unlike its July 8, 2021 initial spending plan proposal to CMS, which asked for, and received approval by CMS, of a long-term care workforce and VBP readiness plan that would be equally available to LHCSAs, FIs, Adult Day Health Care providers, and Social Adult Day Care Providers, the NYSDOH's November presentation announced—via webinar—that ***all*** funding under the long-term care workforce and VBP readiness plan ($1.461 billion) would go to approximately 250 LHCSAs out of the approximately 800 LHCSAs providing Medicaid services in New York. *Id*. at 2-4.

55. The "provider class" was defined by the NYSDOH as "[o]nly LHCSAs with managed care revenue* [2019 MLTC and MAP revenue] that meets or exceeds the revenue threshold [66th percentile] in their respective regions." *Id*. at 4. In other words, only the largest ***one-third*** of LHCSAs based on 2019 revenue would receive ***any*** funding. The already larger LHCSAs, however, would receive average awards, in two directed payments, of approximately ***$5,844,000*** ($1.461 billion divided by 250) which could be used for workforce retention, training programs, innovative technologies, diversity initiatives, care management, and PPE stockpiles. *Id*. at 8.

56. In addition, the previously described mechanism of MCO monitoring and reporting to the NYSDOH on improvements in quality outcomes was eliminated, as well as any pay-for-reporting or pay-for-performance concept. *Id*. at 6-7. Now, providers need not earn the money at all, they would simply be given it and required to report quarterly on actual and projected spending. *Id*. at 7.

57. In short, the NYSDOH's plan had changed radically and would have devastating impacts on smaller LHCSAs throughout New York State. Not only would the smaller LHCSAs throughout New York not even have ***an opportunity*** for funding, they would see their already

larger competitors receive an influx of cash for recruiting, training, technology, and other competitive advantages.

58. Importantly, the NYSDOH's new plan had lost any resemblance to a lawful directed payment plan under 42 U.S.C. § 438.6(c), as it no longer had any "value or outcome" focus, *id.* § 438.6(c)(1)(i), nor did it "[d]irect expenditures equally, and using the same terms of performance, for a class of providers providing the service under the contract," *id.* § 438.6(c)(2)(ii)(B).

59. In January 2022, the NYSDOH provided another webinar with similar information to the November presentation, along with new FAQs. "Long Term Care Workforce and Value-Based Payment Readiness Implementation Provider Webinar," (Jan. 2022), available at https://nyshcp.org/common/Uploaded%20files/Public%20Policy/DSRIP-VBP-MRT/LTC%20Workforce%20VBP%20Slides.pdf.

60. The NYSDOH explained that there were "212 unique LHCSAs included in the eligible provider class for this current directed payment" and, because "[s]ome LHCSAs met the eligibility criteria in multiple regions, [this] result[ed] in a total of 235 potential awards." *Id*. at 17. The NSYDOH also stated that award amounts among the 235 potential awards "were calculated based on each agency's managed care utilization during the first six months of SFY22 (4/1/2021 – 9/30/21), limited to personal care services provided to Medicaid enrollees in MLTCP and MAP plans." *Id*. In other words, awardees need not do anything to earn the award amounts—they were calculated based on the volume of personal care services already provided during the first six months of SFY22. In addition, even among the 212 LHCSAs receiving awards, they were not provided equally as the largest of the larger LHCSAs would get a bigger share of the available pie.

61. On February 15, 2022, the NYSDOH released its second quarterly report which described changes to its ARPA spending plan, including those discussed above. New York State Department of Health Second Quarterly Report: Spending Narrative for Implementation of American Rescue Plan Act of 2021, Section 9817, (Feb. 15, 2022), available at https://health.ny.gov/health_care/medicaid/redesign/hcbs/enhanced_funding/docs/2nd_quarterly_rpt_narrative.pdf. The NYSDOH confirmed that the eligible "provider class" for transforming long-term care workforce and VBP readiness were "LHCSAs that fall into the top third of providers in their designated regions based on 2019 utilization and that contract with MLTCPs and MAPs: these providers offer home care services such as personal care services." *Id*. at 12, 15. The NYSDOH's purported justification for the new "provider class" was "to maximize the impact of these funds on quality of care for Medicaid members by ensuring that the funds are adequate to enable meaningful and innovative workforce recruitment and retention initiatives and are available to LHCSAs providing the greatest number of hours of service in each region." *Id*. at 12.

62. Based on information and belief, the actual reason that the NYSDOH seeks to cut the majority of LCHSAs out of funding eligibility is because it wants the number of LHCSA providers in New York to shrink. This has been a priority of the NYSDOH for several years. *See e.g.*, "Managed Long Term Care Rate Development" (Mar. 22, 2018), at 11, available at https://hca-nys.org/wp-content/uploads/2018/03/DOH-HCA-Presentation-03-22-18.pdf ("Limit the number of LHCSA . . . that Contract with MLTC Plans"). More recently, the NYSDOH has announced a LHCSA Request for Offer ("RFO") that is anticipated to be implemented on May 1, 2022, and will likely result in further efforts by the NYSDOH to eliminate providers. "MTR II Executive Summary of Proposals", (Mar. 19, 2020), at 12, available at

https://health.ny.gov/health_care/medicaid/redesign/mrt2/docs/2020-03-19_executive_summary_of_proposals.pdf ("the State would issue a request for proposals to limit the number of licensed home care services agencies (LHCSAs) authorized to participate in the State's Medicaid program."); 2022-23 Executive Budget Briefing and Questions and Answers," (Feb. 2022), at 4, available at https://www.health.ny.gov/health_care/medicaid/redesign/2022/docs/2022-23_exec_budget_presentation.pdf.

63. The NYSDOH has taken similar actions already for the Consumer Directed Personal Assistance Program ("CDPAP"), which provides similar home health care services, however, permits consumers more flexibility in choosing their caregivers. There, the NYSDOH issued an RFO on December 18, 2019, and announced awards in early 2021 for only 68 of the approximately 450 Fiscal Intermediaries state-wide providing services under the CDPAP. *See* "New York State Fiscal Intermediaries for the Consumer Directed Personal Assistance Program, Request for Offers #20039," available at https://www.health.ny.gov/funding/rfo/20039/. The lawfulness of the NYSDOH's CDPAP RFO is currently being challenged.

64. It further appears that the NYSDOH is utilizing the enhanced ARPA funds as a mechanism to disadvantage smaller providers in the upcoming LHCSA RFO. In a presentation last month led by Defendant Director Friedman, the NYSDOH explained that it was "refining" the LHCSA RFO by "pre-qualifying" a selection of LHCSAs by service area based on their ability to "participate in value-based payment (VBP) arrangements with MMCOs," the very subject of the first directed payment. 2022-23 Executive Budget Briefing and Questions and Answers," (Feb. 2022), at 13, available at

https://www.health.ny.gov/health_care/medicaid/redesign/2022/docs/2022-23_exec_budget_presentation.pdf.

65. Based on information and belief, in March of 2022, CMS ***approved*** the NYSDOH's Section 438(c) Preprint application for a first directed payment of approximately $361 million, to be awarded only to the largest one-third of LHCSAs in New York.

66. Based on information and belief, the NYSDOH plans to pay approximately $361 million to the MCOs on March 31, 2022, to be distributed to the largest one-third of LHCSAs in April.

67. Based on information and belief, the NYSDOH has not yet posted CMS' approval, or the NYSDOH's final Section 438.6(c) Preprint application, on its website, available at https://www.health.ny.gov/health_care/medicaid/redesign/hcbs/enhanced_funding/.[1]

68. Based on information and belief, however, CMS has approved the NYSDOH's unlawful "provider class," as well as its improper pass-through payment structure.

69. CMS' approval is in clear violation of its regulations, *see* 42 C.F.R. § 438.6(c)(1)(i)-(iii), (c)(2)(ii)(B), § 438.4(b)(7), as well as its various guidance documents discussing those regulations. Among other problems, the so-called "provider class" is not "reasonable and identifiable, such as existing in the State's Medicaid Plan," nor is it analogous to ***any*** other example given in CMS guidance, *i.e.*, primary care, specialty physicians, dental, behavioral health, home health and personal care, pediatric, federally-qualified health centers, or safety-net hospitals.

[1] Plaintiffs have submitted a request under the N.Y. Freedom of Information Law for these materials, however the NYSDOH has not yet provided them.

70. Finally, because CMS' approval permits an improper pass-through payment by the NYSDOH, it runs afoul of the actuarially sound requirements contained in the Medicaid Statute, 42 U.S.C. § 1396b(m)(2)(A)(iii).

CAUSES OF ACTION

COUNT I

VIOLATION OF THE ADMINISTRATIVE PROCEDURE ACT – EXCEEDING STATUTORY AUTHORITY

71. Plaintiffs incorporate and reallege paragraphs 1-70.

72. CMS' approval of the NYSDOH's first directed payment of $361 million is "in excess of statutory jurisdiction, authority, or limitations" afforded to CMS. 5 U.S.C. § 706(2)(C).

73. CMS has no statutory authority to approve a State-directed payment that fails to comply with actuarially soundness requirements in the Medicaid Statute. 42 U.S.C. § 1396b(m)(2)(A)(iii).

74. The NYSDOH's first directed payment also fails to meet CMS' regulations, including at 42 C.F.R. § 438.6(c)(1)(i)-(iii), (c)(2)(ii)(B), and § 438.4(b)(7).

COUNT II

VIOLATION OF THE ADMINISTRATIVE PROCEDURE ACT – AGENCY ACTION NOT IN ACCORDANCE WITH LAW

75. Plaintiffs incorporate and reallege paragraphs 1-74.

76. CMS' approval of the NYSDOH's first directed payment of $361 million is not in accordance with law.

77. The NYSDOH's first directed payment plan is in violation of the Medicaid Statute. 42 U.S.C. § 1396b(m)(2)(A)(iii).

COUNT III

VIOLATION OF THE ADMINISTRATIVE PROCEDURE ACT – ARBITARY AND CAPRICIOUS AGENCY ACTION

78. Plaintiffs incorporate and reallege paragraphs 1-77.

79. CMS' approval of the NYSDOH's Section 438.6(c) Preprint Application is arbitrary and capricious.

80. CMS failed to comply with its regulation requiring that the plan "[d]irects expenditures equally, and using the same terms of performance, for a class of providers providing the service under the contract." 42 C.F.R. § 438.6(c)(2)(B).

81. CMS also approved a directed payment plan in violation of 42 C.F.R. § 438.6(c)(1)(i)-(iii).

82. CMS further approved a directed payment plan in violation of 42 C.F.R. § 438.4(b)(7).

83. CMS also ignored its sub-regulatory guidance discussing Section 438.6(c) Preprint requirements.

COUNT IV

VIOLATION OF CMS REGULATIONS AND MEDICAID STATUTE

84. Plaintiffs incorporate and reallege paragraphs 1-83.

85. CMS has no statutory authority to approve a State-directed payment that fails to comply with actuarially soundness requirements in the Medicaid Statute. 42 U.S.C. § 1396b(m)(2)(A)(iii).

86. CMS' approval of the NYSDOH's first directed payment of $361 million is not in accordance with law or regulation.

87. By issuing its first directed payment, the NYSDOH, via Defendants Commissioner Bassett and Director Friedman, will be engaged in violation of CMS' regulations, 42 C.F.R. § 438.6(c)(1)(i)-(iii).

88. In addition, by issuing its first directed payment, the NYSDOH, via Defendants Commissioner Bassett and Director Friedman, will be engaged in violation of the Medicaid Statute, 42 U.S.C. § 1396b(m)(2)(A)(iii).

REQUESTED RELIEF

Plaintiffs respectfully request that this Court:

A. Issue an order and judgment finding that Defendants HHS, CMS, Secretary Becerra, and Administrator Chiquita Brooks-Lasure violated the APA in approving the NYSDOH's first directed payment because such action was in excess of statutory authority, arbitrary and capricious, an abuse of discretion, and otherwise not in accordance with law.

B. Enjoin Defendants NYSDOH, Commissioner Bassett, and Medicaid Director Friedman from issuing the first directed payment.

C. Issue an order requiring Defendants NYSDOH, Commissioner Bassett, and Medicaid Director Freidman to resubmit a revised Section 438.6(c) Preprint Application to CMS with a plan that directs expenditures equally, and using the same terms of performance, for all LHCSAs providing Medicaid HCBS.

D. Award costs and attorneys' fees pursuant to any applicable statute or authority; and

E. Grant such other and further relief as justice warrants.

Dated: March 18, 2022

Respectfully submitted,

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