

SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF BRONX

MARY McKINNEY and MECHLER HALL
COMMUNITY SERVICES, INC.,

Plaintiffs,

-against-

THE COMMISSIONER OF THE NEW YORK STATE
DEPARTMENT OF HEALTH; THE NEW YORK
STATE DEPARTMENT OF HEALTH; and THE
STATE OF NEW YORK

Defendants.

Index No.

VERIFIED COMPLAINT

Plaintiffs Mary McKinney and Mechler Hall Community Services, Inc., by their attorneys from New York Lawyers for the Public Interest, Inc. and Chadbourne & Parke LLP, allege as follows:

NATURE OF THE ACTION

1. Plaintiffs Mary McKinney and Mechler Hall Community Services, Inc. bring this declaratory judgment action seeking an order declaring the Commission on Health Care Facilities in the 21st Century, Enabling Legislation (“Enabling Legislation”) invalid and enjoining its implementation. (2005 N.Y. Sess. Laws page no. 689-94, § 2) (McKinney) (added as Part K of Chapter 58 of the Laws of 2005) (hereinafter “Enabling Legis.”) (annexed to the Affirmation of Thomas E. Bezanson and Amanda Masters as Exhibit 4) Such relief is warranted because the Enabling Legislation constitutes an unconstitutional delegation of

legislative lawmaking authority by the New York State Legislature (the “Legislature”) to the Executive Department in violation of the separation of powers and Article III, Section 1 of the Constitution of the State of New York. Article III, Section 1 provides that “[t]he legislative power of this state shall be vested in the senate and assembly.” N.Y. Const. art. III, § 1.

2. More specifically, in violation of the separation of powers, the Enabling Legislation empowered the unelected members of the New York State Commission on Health Care Facilities in the 21st Century, chaired by Stephen Berger (the “Berger Commission”), with broad and unfettered authority to dramatically reshape the distribution of health care throughout New York State. The Enabling Legislation authorized the Berger Commission to adopt its own standards in lieu of those enumerated by the Legislature and mandates that the Berger Commission’s “recommendations” shall be implemented by the Commissioner of Health “notwithstanding any contrary provision” of law.

3. The Berger Commission’s “recommendations” now have the force of law. The Enabling Legislation provided that unless a “majority of the members of each house of the legislature vote[d] to adopt a concurrent resolution rejecting the recommendations” by December 31, 2006, the Commissioner of Health would be required to implement the Berger Commission’s recommendations. (Enabling Legis. § 9) The Legislature failed to take any action before December 31. As a result, hospitals and nursing homes will be closed or downsized, patient relationships with hospitals will change, patient access to health care will be severely burdened, and funds that could have provided patient care will be diverted to hospital and nursing home closings and downsizings.

4. The “recommendations” issued by the Berger Commission to close or downsize 57 hospitals across the State will also require the expenditure of substantial New York State revenues in order to implement the Berger Commission’s recommendations to be implemented by the Commissioner of Health.

5. Pursuant to N.Y. C.P.L.R. § 3001 (McKinney 2005) and N.Y. State Fin. Law § 123-b (McKinney 2001), Plaintiffs respectfully ask this Court to declare the Enabling Legislation unconstitutional and to enjoin permanently the Commissioner of Health from implementing its provisions. Pursuant to N.Y. C.P.L.R. §§ 6301, 6311 and N.Y. State Fin. Law § 123-e, Plaintiffs also seek a preliminary injunction and temporary restraining order enjoining the Commissioner of Health from implementing the Berger Commission’s recommendations because Plaintiffs will be irreparably harmed without intervention by the Court.

6. Beginning January 1, 2007, the Commissioner of Health is obligated to begin the process of closing and/or downsizing fifty-seven hospitals throughout the State, including New York Westchester Square Medical Center (“WSMC”). Once the process begins, we can reasonably expect that the dismantling of WSMC will proceed swiftly. Staff who have been worried about the impending closure will likely begin to leave, and patients will no longer be referred. If this process is allowed to proceed, Plaintiffs will be irreparably harmed by the pervasive and widespread effects of this unconstitutional legislation, the practical consequences of which cannot be undone through later judicial order or compensated for by monetary relief. This Court must therefore act now to halt this unconstitutional delegation of power.

PARTIES AND VENUE

7. Plaintiff Mary McKinney is a 64 year old resident of the Bronx who relies on New York Westchester Square Medical Center for treatment of multiple serious medical conditions. New York Westchester Square Medical Center was selected for closure by the Berger Commission.

8. Plaintiff Mechler Hall Community Services, Inc. is a not-for-profit corporation located in the Parkchester area of the Bronx which is dedicated to improving the health and well-being of its senior citizen members.

9. Defendant Commissioner of the New York State Department of Health is responsible for the operation and administration of the New York State Department of Health. N.Y. Pub. Health Law § 206 (McKinney 2002). The Commissioner of Health has a principal place of business at Corning Tower, Albany, New York and has offices at 90 Church Street, New York, New York.

10. Defendant New York State Department of Health is the agency created by the State of New York that licenses, supervises, and enforces the laws and regulations applicable to health care facilities, including hospitals and nursing homes. N.Y. Pub. Health Law § 201 (McKinney 2002).

11. Defendant State of New York (the “State”) enacted the Enabling Legislation creating the Commission on Health Facilities in the 21st Century in the Executive Department. (Enabling Legis. § 2)

12. Based upon the foregoing, venue is properly placed before this Court pursuant to N.Y. C.P.L.R. § 503 (McKinney 2005) and N.Y. State Fin. Law § 123-c (McKinney 2001).

FACTUAL BACKGROUND

A. Unconstitutional Delegation of Legislative Powers to the Berger Commission

1. The Berger Commission Will Set Policy in the Area of New York's Health Care System

13. On April 13, 2005, the State of New York enacted the Enabling Legislation, which provided for the creation of the Berger Commission, a body “charged with examining the system of general hospitals and nursing homes in New York State and recommending changes to the system.” (Enabling Legis. § 2(a)) This broad delegation vested the Berger Commission with the power to direct hundreds of millions of dollars of State expenditures and dramatically reshape the distribution of health care facilities throughout the State, without requiring any review, much less accountability, by the Legislature.

14. As a central component of this sweeping mandate, the Enabling Legislation tasked the Berger Commission with issuing recommendations “relating to facilities to be closed and facilities to be resized, consolidated, converted, or restructured.” (Enabling Legis. § 8) The Enabling Legislation authorized the Berger Commission to arrive at these recommendations by assessing the need for and availability of health care resources within a given region, the “economic impact” of closing and downsizing facilities “on the state, regional and local economics,” as well as the financial status of facilities, including the amount of capital debt

carried by each. (Enabling Legis. § 5) However, the Legislature provided no meaningful guidelines as to how the Berger Commission was to weigh these competing, disparate interests. (See ¶¶ 21-25 infra)

15. The Enabling Legislation provided that the Berger Commission would be comprised of eighteen statewide members and thirty-six regional members (six regional members shall be appointed to each of six established regions); approval of any matter required “the affirmative vote of a majority of the members voting thereon.” (§ 2) Significantly, none of the statewide or regional members were approved by vote of the Legislature.

16. A majority of the Berger Commission’s members was appointed by the Executive. Twelve of the eighteen statewide members were appointed by Governor Pataki. Of the remaining six statewide members, two were appointed by the temporary president of the senate, two were appointed by the speaker of the assembly, one was appointed by the minority leader of the senate, and one was appointed by the minority leader of the assembly. (Enabling Legis. § 2(b)) Additionally, the Enabling Legislation empowered Governor Pataki to appoint two of the six members for each region. (§ 7)

**2. The Berger Commission’s Recommendations
Became Law on January 1, 2007, Without Bicameral
Legislative Approval**

17. The Berger Commission submitted a Final Report containing its final recommendations to Governor Pataki and the Legislature on November 28, 2006. See Commission on Health Care Facilities in the 21st Century, Final Report (Dec. 2006), available at <http://www.nyhealthcarecommission.org> (follow “Download the final report” hyperlink, then

follow “Full Report” hyperlink) (hereinafter, “Final Report”) (excerpts annexed to the Affirmation of Thomas E. Bezanson and Amanda Masters as Exhibit 6) As mandated by the Enabling Legislation, the Berger Commission’s Final Report included “specific recommendations for facilities to be closed and specific recommendations for facilities to be resized, consolidated, converted, or restructured.” (§ 8(e))

18. On or around December 5, 2006, less than two weeks after the Final Report was submitted, Governor Pataki approved the Berger Commission’s recommendations in their entirety. Pursuant to the Enabling Legislation, Governor Pataki then transmitted the Final Report with his written approval to the Commissioner of Health and transmitted his approval to the Legislature. (Enabling Legis. § 9(b))

19. By the terms of the Enabling Legislation, the Commissioner of Health is now required to implement the Berger Commission’s recommendations because the Legislature failed to reject the recommendations by December 31, 2006. The Enabling Legislation provided that the recommendations would not take effect only if “a majority of the members of *each house* of the legislature vote[d] to adopt a concurrent resolution rejecting the recommendations of the commission . . . *in their entirety* by December 31, 2006.” (Enabling Legis. § 9(b)(ii)) (emphasis added) The Legislature declined to stage a vote on the recommendations. As a result of this legislative inaction, the Berger Commission’s “recommendations” regarding the distribution of hospitals and nursing care facilities have the force of law.

20. Although the Enabling Legislation provides that Sections 2-8 shall be deemed repealed on December 31, 2006, the force and effect of this legislation survives in

Section 9, which governs and requires the implementation of the Berger Commission's recommendations. (Enabling Legis. § 11)

3. The Enabling Legislation Grants the Berger Commission the Power to Adopt its Own Standards That Will be Binding on the New York State Department of Health

21. The Enabling Legislation contains a number of provisions that empowered the Berger Commission with extraordinarily broad policy making authority without providing for any meaningful limitations on that authority.

22. Certain Enabling Legislation provisions, for example, provided the Berger Commission with unlimited discretion in the formulation of its recommendations. The Enabling Legislation mandated that the Berger Commission's recommendations be made in light of "factors submitted pursuant to section five of this act *and additional factors established by the commission*" (§ 2(a); see also § 5(a)(ix) (emphasis added)) Nowhere does this legislation provide any guidance as to how the Berger Commission was to develop these "additional standards" or how any considered standard should be weighed or applied. In fact, the Enabling Legislation did not even require that these additional standards be consistent with those enumerated in Section 5.

23. In accordance with these provisions, the Berger Commission adopted its own standards and framework to derive its recommendations. The Berger Commission created an "Analytic Framework" (the "Framework") that purported to apply twenty-five metrics to assess six criteria in an analysis aimed at classifying hospitals as high, medium or low priority for rightsizing. (Final Report at 69) Though the six criteria resemble factors provided in Section 5

of the Enabling Legislation, the twenty-five metrics used to assess the criteria were developed without Legislative participation. Moreover, the Legislature provided no guidance on how the Berger Commission was to balance the fundamental interests addressed by these disparate criteria, allowing the Berger Commission to balance the interest addressed by “Service to Vulnerable Populations” against the interests addressed by “Viability” as it saw fit. (Final Report at 68-70)

24. The Berger Commission used this amorphous framework within its larger, undefined decision-making process to obscure the bases for its recommendations. For example, literature provided by the Berger Commission states that the Framework “starts and advances Commission deliberations” but that the ratings produced from the Framework were subject to additional deliberation before recommendations were issued. (Rightsizing Analytic Framework PowerPoint Presentation, available at <http://www.nyhealthcarecommission.org/docs/framework.pdf>) The Berger Commission offered no insight as to what standards or criteria guided these additional deliberation, stating only that “[a]dditional measures [outside of the analytic framework] will be considered during later phase deliberations.” (Id.) Moreover, in its Final Report, the Berger Commission revealed that this “framework was a starting point for focused and continual deliberations and discussions, and was not final determinations of which institutions to rightsize.” (Final Report at 68) The ‘additional measures’ considered by the Berger Commission are not articulated with any meaningful specificity anywhere in the public literature or public meetings.

25. Meaningful assessment of the Framework and the Berger Commission’s decision-making methodology is further precluded by the lack of transparency in the Berger Commission’s deliberations. For example, the Berger Commission claimed that it was not subject to the Open Meetings Law and conducted most of its business in executive sessions beyond the scrutiny of the public. (See Letter from Stephen Berger, Chairman of the Commission on Health Care Facilities in the 21st Century, to Judy Wessler, Commission on the Public’s Health System, and Louis Guida, Committee of Interns and Residents (Jul. 12, 2006) (annexed to the Affirmation of Thomas E. Bezanson and Amanda Masters as Exhibit 5) Further, while the Enabling Legislation calls for “formal public hearings” (§ 8), these hearings were held before Regional Advisory Committees rather than Berger Commission members, and they were not recorded in any manner.

4. The Berger Commission’s Recommendations Function as Lawmaking Because They Will Effectively Repeal Existing Legislation

26. The Enabling Legislation requires the Commissioner of Health to implement the Commission’s recommendations in a manner that effectively repeals existing legislation.

Section 9(a) states that:

“notwithstanding any contrary provision of the law, rule or regulation related to the establishment, construction, approval, suspension or revocation of the operating certificates, closure, resizing, consolidation, conversion or restructuring of the general hospitals or nursing homes identified in the commission’s recommendations, including but not limited to sections 2801-A, 2802, 2805, 2806, and 2806-B of the public health law, the commissioner of health shall take all actions necessary to implement . . . the recommendations of the commission. . . .”

(Enabling Legis. § 9(a)) Article 28 of the New York Public Health Law specifically contains statutes governing “the system of general hospitals and nursing homes” -- the subject area within the jurisdiction of the Berger Commission as stated in the Enabling Legislation. See N.Y. Pub. Health Law §§ 2800-2815 (McKinney 2002). Through Section 9(a), however, the Enabling Legislation purported to allow the “recommendations” of an unelected governmental entity to entirely disregard and supersede these and any other pre-existing statutes and rules passed by the democratically elected Legislature.

27. For example, Section 2806(1) provides that the Commissioner of Health may revoke, suspend, limit or annul a hospital operating certificate, where a hospital

“(a) . . . fail[s] to comply with the provisions of this article or rules and regulations promulgated thereunder; or (b) a general hospital [refuses or fails] to admit or to provide for necessary emergency care and treatment for an unidentified person brought to it in an unconscious, seriously ill or wounded condition.”

N.Y. Pub. Health Law § 2806(1) (McKinney 2002). Where these were once the principal statutory grounds under which a hospital operating certificate could be revoked, the Enabling Legislation purported to empower the Commissioner of Health to effect revocations *in any circumstance* the Berger Commission deemed appropriate. Accordingly, the Final Report prefaces its recommendations by asserting that “the term ‘close’ means that the Commissioner of Health shall revoke the operating certificate of the facility as expeditiously as possible to preserve quality of care.” (Final Report at 86)

28. In the instant case, the Commissioner of Health is tasked with revoking the operating certificate of WSMC on the grounds that it “represents excess capacity in the system.”

(Final Report at 159) This singular and conclusory basis is inconsistent with Public Health Law § 2806(1).

29. Not only does the Enabling Legislation mandate that the Commissioner of Health ignore (and effectively repeal) the required substantive bases for revoking the operating certificates of hospitals and residential health care facilities, Section 9 also authorized the Berger Commission to repeal the procedural safeguards that the Legislature included within Article 28 of the Public Health Law for such revocations. Section 2806 (2) of that Article, for instance, provides that:

“[n]o hospital operating certificate shall be revoked, suspended, limited or annulled without a hearing, except for operating certificates revoked, limited or annulled because of revocation, limitation or annulment of establishment approval.”

N.Y. Pub. Health Law. § 2806(2) (McKinney 2002). Here, although WSMC’s establishment approval has not been revoked, and there has been and will be no revocation hearing, the Commissioner of Health is mandated under Section 9 of the Enabling Legislation to revoke or annul its operating certificate in order to effect the Berger Commission’s recommendations.

The Enabling Legislation now authorizes the Commissioner of Health to disregard the procedural safeguards of Section 2806(6), which provides detailed procedures that the Commissioner of Health must follow whenever the commissioner considers modifying or revoking a hospital operating certificate to restrict the number of beds to those “actually needed.” N.Y. Pub. Health Law § 2806(6)(a) (McKinney 2002). These statutory safeguards require the Commissioner of Health to take community and public comment into account when determining whether a hospital’s services are “actually needed.” Before revoking or modifying

an operating certificate under this subsection, the commissioner “*shall* cause to be published, in a newspaper of general circulation in the geographic area of the facility at least thirty days prior to making such a finding an announcement that such a finding is under consideration and an address to which interested persons can write to make their views known. The commissioner *shall* take all public comments into consideration when making such a finding.” N.Y. Pub. Health Law § 2806(6)(b) (McKinney 2002) (emphasis added). The provision requires the Commissioner of Health to provide a facility 30 days notice in advance of revoking or modifying its operating certificate under this subsection, during which time the facility “may request a public hearing to be held in the county in which the hospital is located.” N.Y. Pub. Health Law § 2806(6)(c) (McKinney 2002) (“In no event shall the revocation, suspension or limitation take effect prior to the thirtieth day after the date of the notice, or prior to the effective date specified in the notice or prior to the date of the hearing decision, whichever is later.”). In this case, the Commissioner of Health is compelled by the Berger Commission to revoke WSMC’s operating certificate because the Berger Commission found that it represented “excess capacity in the system” and ordered it closed. (The Commissioner of Health “shall revoke the operating certificate of the subject facility as expeditiously and necessary as possible.” (Final Report at 86-87))

30. Implementation of the Enabling Legislation will nullify statutory provisions beyond those expressly mentioned in Section 9. For instance, in its Final Report, the Berger Commission authorizes the Commissioner of Health to “take *any action* necessary” to compel a facility’s compliance with its final recommendations, “including but not limited to refusal to act

on any application from the subject facility, [or] refusal to provide *any other consent* requested by the subject facility.” (Final Report at 89) (emphasis added) This unlimited coercive power abrogates statutory provisions of the Public Health Law that require the Commissioner of Health to base her approval or denial of certain applications submitted by hospitals on considerations enumerated by the Legislature. For example, Section 2807-i of the Public Health Law states that when considering certain hospital grant applications, “the commissioner in evaluating proposals pursuant to this section shall give primary consideration to the financial condition of applicants.” N.Y. Pub. Health Law § 2807-i (McKinney 2002). Regardless of this statutory limitation on the discretion of the Commissioner of Health, implementation of the Final Report would allow the Commissioner of Health to completely disregard the financial condition of applicants for Section 2807-i grants, rejecting a facility’s application solely because of its failure to act on the Berger Commission’s recommendations.

B. Unconstitutional Expenditures of State Funds by the Commission

31. In the course of implementing the Berger Commission’s recommendations, the State will cause an unconstitutional disbursement of state funds through both the Federal-State Health Reform Partnership (“F-SHRP”) and the Health Care Efficiency and Affordability Law of New Yorkers (“HEAL NY”). Under each of these programs, the Berger Commission, not the Legislature, will require the State to expend hundreds of millions of dollars to close and downsize hospitals and nursing homes throughout New York. Indeed, the Enabling Legislation required that the Berger Commission’s recommendations set forth the investments necessary to carry out each recommendation (§ 8), and in its Final Report, the Berger Commission estimates

its recommendations will cost \$1.2 billion. (Final Report at 17, 229) These expenditures of State funds give Plaintiffs standing to bring this suit as citizen taxpayers. (See ¶¶ 50-58 *infra*)

1. **The Federal Statutory Scheme: F-SHRP**

32. The Berger Commission’s recommendations play a decisive role in the procurement and disbursement of State and federal funds under F-SHRP.

33. F-SHRP is an agreement under which the State and the federal governments will each contribute funds to “reform initiatives” designed to “rightsize” health care facilities and improve primary care in New York. (F-SHRP Conditions at 1-2 ¶¶ 1-3)¹

34. Under F-SHRP, the federal government will provide the State with \$1.5 billion in matching funds over five years, provided that the State spends \$3 billion on reform initiatives over the same period and complies with certain reporting and savings requirements. (F-SHRP Condition at 9-26 ¶¶ 23-64)

35. A substantial amount of these State and federal funds will be spent implementing the Commission’s recommendations. (F-SHRP Conditions at 9-10 ¶ 26) F-SHRP funds will be used to retire and restructure debt associated with facilities closed and downsized by the Berger Commission; to fund operating costs, such as severance pay and

¹ The citation “F-SHRP Conditions ___ ¶ ___” refers to the Federal-State Health Reform Partnership Medicaid Section 1115 Demonstration, Special Terms and Conditions, Number 11-W-00234/2, available at http://www.health.state.ny.us/health_care/managed_care/appextension/partnership_plan/docs/special_terms_and_conditions.pdf.

pension requirements, at facilities selected by the Berger Commission; and to convert acute care facilities to alternative delivery models at those facilities that the Berger Commission determines are unneeded. (Federal-State Healthcare Reform Partnership (F-SHRP), Proposal at 7-9, April 27, 2005, available at <http://www.aaasc.org/state/documents/Federal-StateHealthcareReformPartnershipProposal.pdf>) The Final Report estimates that its recommendations will require \$350 million for closure costs alone and specifically suggests that if “state funds are to be used, this cost category should be given priority for funding under [F-SHRP], since this cost category is most likely to result in measurable state and federal savings, and the availability of F-SHRP funds is tied to such measures.” (Final Report at 229, 230-31)

36. F-SHRP expressly conditions the release of federal matching funds on the unimpeded and swift enactment of the Berger Commission’s recommendations. For instance, F-SHRP provisions require that by January 31, 2007, the State must submit a report certifying “*that there are no State statutory impediments to implementation of the Commission’s recommendations, the steps taken to implement those recommendations, and a timeline for implementation of these recommendations.*” (F-SHRP Conditions at 16 ¶ 37(a) (emphasis added)) F-SHRP also requires the State to submit a report by July 15, 2008, certifying that “each of the Commission’s recommendations has been acted upon, [and setting forth] a strategy and timeline for full implementation.” (F-SHRP Conditions at 16 ¶ 37(b))

2. The State Statutory Scheme: HEAL NY

37. HEAL NY was enacted, before the Enabling Legislation, to award capital grants “in a manner that will encourage improvement in the operation and efficiency of the

health care delivery system within the state.” N.Y. Pub. Health Law § 2818 (McKinney 2006); N.Y. Pub. Auth. Law § 1680-j (McKinney 2006). The State will disburse a total of \$1 billion in capital grants through HEAL NY. 2006-07 New York Executive Budget Overview at 71-72, available at <http://www.budget.state.ny.us> (follow “Executive Budget Documents” hyperlink; then follow “Executive Budget Overview” hyperlink). To date, the State has advanced \$500 million toward HEAL NY. Id.

38. The Berger Commission’s recommendations will make the policy decisions directing the disbursement of State funds which had been made available through HEAL NY. The Enabling Legislation effectively granted the Berger Commission the power to control the disbursement of HEAL NY funds by requiring the Commissioner of Health to reflect the Berger Commission’s recommendations “in the administration of funds available pursuant to section 2818 of the public health law.” (Enabling Legis. § 9(a)(iv))

39. In addition to recommending uses for HEAL NY funds, the Berger Commission also shapes the criteria used to select the program’s grant recipients. HEAL NY grants are awarded by the Department of Health and the Dormitory Authority of the State of New York using a published list of criteria to evaluate proposals. As amended in April 2006, HEAL NY now states that these criteria “shall be consistent with objectives and determinations of the Commission on Health Care facilities in the Twenty-First Century.” N.Y. Pub. Health Law § 2818 (McKinney 2006).

C. **Imminent Irreparable Harm**

1. **The Commission's Recommendations**

40. In its Final Report, the Berger Commission recommended the closure, downsizing, reconfiguration, or conversion of 57 hospitals, one-quarter of all hospitals in the state. It recommended the outright closure of nine hospitals, five of which serve the people of New York City. Once implemented, the Berger Commission's recommendations will reduce statewide inpatient capacity by more than 4,000 beds, representing 7 percent of the State's total capacity. (Final Report at 11) In 2004, the nine hospitals selected for closure alone had over 47,000 discharges and over 156,000 emergency room visits. (Final Report at 115-93) The Final Report estimates that the cost of implementing the Berger Commission's recommendations will total \$1.2 billion. (Final Report at 229)

2. **Hospital Background**

41. New York Westchester Square Medical Center ("WSMC") is one of the facilities that the Berger Commission selected for closure in its Final Report. (Final Report at 159-160) WSMC is reportedly the lowest cost hospital in the Bronx, with a Medicaid discharge rate of \$4,460. Commission on Health Care Facilities in the 21st Century, New York City Regional Advisory Committee: Recommendations (Nov. 2006), available at <http://www.nyhealthcarecommission.org/docs/final/appendix2-newyorkcityrac.pdf> (excerpts annexed to the Affirmation of Thomas E. Bezanson and Amanda Masters as Exhibit 6). WSMC

has historically been financially sound, generating a small surplus each year, despite reportedly serving over 23,000 emergency room patients.² (Id.) As the Berger Commission’s own Regional Advisory Committee for New York City reported, WSMC’s “primary service area includes parts of Northeast Bronx and Pelham/Throggs Neck neighborhoods which are ‘*stressed*’ and ‘*serious shortage areas*’ for primary care.” (Id.) (emphasis added) The Regional Advisory Committee noted that “there are strong bonds between the patients and the physicians who practice” at WSMC and that “closure could *significantly disrupt access*.” (Id.) (emphasis added) For these reasons, the Regional Advisory Committee recommended that WSMC survive. (Id.)

3. Plaintiffs’ Common Law Standing

(i) Plaintiff Mary McKinney

42. Plaintiff Mary McKinney resides at 880 Colgate Avenue in the Soundview neighborhood of the Bronx. She is 64 years old and has lived in the Soundview neighborhood since 1981.

43. Ms. McKinney suffers from severe asthma, erratic blood pressure, and severe arthritis that prevents her from walking more than a few blocks at a time. She is currently in remission for colon cancer.

² Reportedly, on December 20, 2006, WSMC filed in the U.S. Bankruptcy court for the Southern District of New York for bankruptcy protection while it seeks debtor in possession funding.

44. Ms. McKinney relies on WSMC for treatment of all these conditions. She depends on the emergency room services of WSMC for emergency medical care when she is suffering from a severe asthma attack. Because any one of her asthma attacks can suddenly and without warning become a life-threatening crisis, ready access to WSMC's emergency facilities is crucial to Ms. McKinney. The unpredictable nature of Ms. McKinney's blood pressure condition also forces her to rely on the emergency services of WSMC, as this condition has required stabilization in WSMC's emergency room on multiple occasions over the past ten years. Because of the time it takes ambulances to reach her neighborhood, Ms. McKinney is forced to take a taxi to the WSMC emergency room when one of these conditions arises.

45. Ms. McKinney receives treatment for all her conditions from physicians affiliated with WSMC. Ms. McKinney's internist, whom she must visit every two to three months for her erratic blood pressure, is affiliated with WSMC, maintains offices near WSMC, and often sends Ms. McKinney to WSMC for tests and other procedures. Ms. McKinney has been treated by this internist for the past seven years. Ms. McKinney's colon cancer specialist is also affiliated with WSMC and maintains an office near the hospital. The same is true for Ms. McKinney's asthma doctor.

46. Closure of WSMC will impose significant burdens on Ms. McKinney's access to needed health care. Whereas WSMC is a 15 minute bus ride away from her home, the next closest hospital is 1-2 hours away by bus and 30 minutes away by taxi. This dramatically increased travel time will impose a significant burden on Ms. McKinney, who has limited mobility because of her serious medical conditions, including severe arthritis. The cost of Ms.

McKinney's taxi rides to obtain emergency service will also dramatically increase once WSMC closes. While a taxi ride to WSMC costs less than \$15, the fare to the next closest hospitals ranges from \$40 to \$60.

47. Most significantly, once WSMC closes, Ms. McKinney's physicians may be forced to relocate. Thus, the closure of WSMC may make it impossible for her to maintain her longstanding doctor-patient relationships, particularly if these physicians, displaced by the closure of WSMC, are forced to relocate to a facility far away from Soundview. For Ms. McKinney, an individual with serious medical conditions which require constant care, the closure of WSMC will cause her to suffer an injury-in-fact because it will impose ongoing, significant disruptions to her access to needed health care.

(ii) **Plaintiff Mechler Hall Community Services, Inc.**

48. Plaintiff Mechler Hall Community Services, Inc. ("Mechler Hall") is a not-for-profit corporation that is dedicated to improving the health and well-being of senior citizens in the Parkchester area of the Bronx. Mechler Hall offers a variety of services to its 65-80 senior citizen members, including a hot and nutritious lunch every weekday, aerobics classes, and nutritional counseling.

49. WSMC is the only hospital within Mechler Hall's neighborhood, and many of the senior citizens who are members of Mechler Hall rely on WSMC for needed health care. Many of the Mechler Hall's members have limited mobility and would have great difficulty accessing a hospital outside the neighborhood, particularly during a medical emergency. Many

of the members also have longstanding relationships with physicians and staff at WSMC. The loss of WSMC would significantly burden many of the members' access to health care.

D. Plaintiff Mary McKinney has Standing as a Citizen Taxpayer to Bring this Action for Declaratory and Injunctive Relief

50. Ms. McKinney has standing to challenge the implementation of the Berger Commission's recommendations as a citizen taxpayer under N.Y. State Fin. Law § 123-b (McKinney 2001). Section 123-b states:

“any person, who is a citizen taxpayer, whether or not such person is or may be affected or specially aggrieved by the activity herein referred to, may maintain an action for equitable or declaratory relief, or both, against an officer or employee of the state who in the course of his or her duties has caused, is now causing, or is about to cause a wrongful expenditure, misappropriation, misapplication, or any other illegal or unconstitutional disbursement of state funds.”

51. At all relevant times, Ms. McKinney was a resident of the State of New York, and paid State income and sales taxes.

52. Plaintiffs assert that the implementation of the Berger Commission's recommendations effectuate an unconstitutional delegation of legislative authority. (See ¶¶ 59-69 infra)

53. As discussed above, it will be impossible to implement the Berger Commission's recommendations without the expenditure of substantial State funds. (See ¶¶ 32-39 supra)

54. The Berger Commission's directives will control the disbursement of a significant portion of the \$3 billion of State money the State must invest in “reform initiatives” to be eligible for matching funds under F-SHRP (See ¶ 35 supra)

55. The Berger Commission also has the power, as discussed above, to direct the disbursement of HEAL NY capital grants. (See ¶¶ 37-39) Indeed, the Berger Commission was expressly established to disburse State funds already previously allocated to the HEAL NY capital grant program. 2005 N.Y. Sess. Laws page no. 310-11 (McKinney).

56. The \$3 billion of State expenditures required under F-SHRP and the HEAL NY funds are “State funds” for the purposes of N.Y. State Fin. Law § 123-b (McKinney 2001).

57. The Berger Commission’s recommendations will result in the closing of nine hospitals and the downsizing of many more. The process of hospital closing and downsizing entails the rapid dismantling of services that will have irreversible effects. This is particularly so in this case, as the Enabling Legislation provided for the extremely rapid approval and implementation of the Berger Commission’s recommendations without any deliberative process and legislative approval as required by the Constitution of the State of New York. The Berger Commission’s recommendations and their imminent implementation are sufficient to result in a decrease in patient referrals, an increase in staff departures, and preliminary steps to begin the termination and/or reallocation of hospital services in communities chosen solely by the Berger Commission. Accordingly, Plaintiff McKinney requires an imminent determination of the constitutionality of this legislation.

58. By reason of the foregoing, Ms. McKinney has standing under N.Y. State Fin. Law § 123-b (McKinney 2001) to bring this action for declaratory and injunctive relief.

CLAIM FOR DECLARATORY AND INJUNCTIVE RELIEF

AS AND FOR THE CAUSE OF ACTION

(Delegation of Legislative Lawmaking Power in Violation of
Article III, Section 1 of the New York State Constitution)

59. Plaintiffs repeat and reallege each and every allegation contained in paragraphs 1 through 58 hereof as though fully set forth herein.

60. Article III, Section 1 of the New York State Constitution states that “[t]he legislative power of this state shall be vested in the senate and assembly.” Accordingly, the legislature bears the sole responsibility for making critical policy decisions and is prohibited from delegating its legislative powers.

61. As noted above, the Berger Commission is comprised of unelected officials and its recommendations must be implemented by the Commissioner of Health. At no time was the Legislature obligated to adopt or endorse the Berger Commission’s recommendations. Instead, they became law after a month of legislative inaction.

62. The Enabling Legislation constitutes an unconstitutional delegation of legislative powers for three principal reasons. It impermissibly (i) vested the Commission with legislative, lawmaking powers to enact statewide public policy on issues of immense public concern; (ii) failed to provide sufficient standards to guide the Commission’s recommendations; and (iii) granted the Berger Commission the authority to effectively repeal existing legislation.

63. First, the Enabling Legislation violates Article III, Section 1 because it conferred on the unelected Berger Commission broad and unfettered authority to enact statewide public policy. The comprehensive review of New York’s health care facilities constitutes policy making of the most fundamental kind because it will have expansive and pervasive statewide effects on the State’s health care system. The recommendations were

designed to achieve drastic reductions in the State's hospital and nursing home system and a comprehensive overhaul of the means by which millions of New Yorkers receive their health care. The Enabling Legislation provided the Berger Commission with power over how hundreds of millions of dollars will be spent on a matter of utmost importance to the public's welfare. Accordingly, the Berger Commission's recommendations constitute a profound change in social and economic policy that is properly and exclusively the province of the Legislature. The New York State Legislature may not delegate such legislative functions to any other entity, particularly to an unelected body like the Berger Commission.

64. Second, the Enabling Legislation constitutes an unconstitutional delegation of legislative, lawmaking authority because it provided the Berger Commission with insufficient standards by which to determine its policy recommendations. Sections 2(a) and 5(a)(ix) of the Enabling Legislation provided that the Berger Commission's recommendations were to be developed in light of the factors set forth in Section 5 of the legislation *and* additional factors established by the Berger Commission. The Enabling Legislation provided no guidance, however, regarding how such additional factors were to be determined or how these additional factors were to be weighed against each other. Indeed, the factors enumerated by the Enabling Legislation and adopted in the Framework were so amorphous that it is impossible to determine if they were consistent with the Berger Commission's recommendations. By granting this unfettered discretion, the Legislature disavowed its responsibility to make important policy decisions about what factors must take priority when determining hospital closings and downsizing. Ultimately, Sections 2(a) and 5(a)(ix) set forth an exception that effectively

swallows the Legislature's stated standards, thereby rendering the Enabling Legislation a standardless grant of authority to the Berger Commission. A delegation of this kind is patently unconstitutional.

65. Indeed, the lack of transparency in the Berger Commission's decision-making process only underscores the constitutional infirmity of this delegation of authority. The Berger Commission jettisoned a transparent, decision-making process of employing the Enabling Legislation's enumerated factors (see § 5), in favor of its amorphous Framework and undisclosed additional factors, which were discussed behind closed doors in executive session. The Legislature delegated broad, lawmaking authority to an unelected commission without placing any meaningful limits on such authority or requiring that the decision-making process be transparent and subject to public scrutiny.

66. Nor could any restraint in this provision have been expected, given that Section 9 was designed to sacrifice the Constitution on the alter of political expediency. F-SHRP (and the federal matching funds attached to that program) is conditioned on the submission of two reports by the State on the Commission's work, one of which, due January 31, 2007, must include "certification . . . that there are no State statutory impediments to the implementation of the Commission's recommendations on reconfiguring the State's general hospital and nursing home bed capacity." (F-SHRP Conditions at 16 ¶ 37(a))

67. Finally, the Enabling Legislation also impermissibly vests the Berger Commission and the Commissioner of Health with the power to effectively repeal existing legislation. Section 9 provides that the Commissioner of Health shall implement the Berger

Commission’s recommendations “notwithstanding any contrary provision of the law . . . , including but not limited to sections 2801-A, 2802, 2805, 2806, and 2806-B of the public health law.” Nowhere in Section 9 is any attempt made to temper this provision. Instead, this legislation empowers the unelected Berger Commission with lawmaking authority to effectively repeal statutes carefully crafted and enacted by the democratically elected Legislature.

68. Article 28 of the Public Health Law, cited in the Enabling Legislation, sets forth a number of significant provisions governing hospital operating certificates that protect basic due process rights and require that community input be taken into account before a hospital’s services are deemed unneeded. Should the Legislature desire to repeal these statutes for the purposes of closing WSMC, it must legislate accordingly in order to satisfy its constitutional, lawmaking responsibilities. Article III, Section 1 of the Constitution of the State of New York prohibits the Legislature from delegating to the Berger Commission and Commissioner of Health the lawmaking authority to repeal any Public Health law it so chooses.

69. Individually and collectively, the foregoing reasons demonstrate that the Enabling Legislation is constitutionally infirm. The Legislature has abandoned its responsibility to legislate, and through this delegation to the Berger Commission, it has violated Article III, Section 1 of the Constitution of the State of New York. Accordingly, the Enabling Legislation and the Berger Commission’s recommendations should be annulled as a matter of law, and their implementation should be enjoined.

WHEREFORE, on the basis of the foregoing, Plaintiff demands the following relief jointly and severally against all Defendants:

a. A declaration by this court voiding and annulling the Enabling Legislation on the grounds that such legislation is an unconstitutional delegation of legislative power and cannot be implemented without violating the separation of powers that is central to the New York State Constitution;

b. A temporary restraining order and preliminary injunction enjoining Defendants or their agents from implementing and enforcing the Berger Commission's recommendations as of January 1, 2007, and thereafter during the pendency of this action.

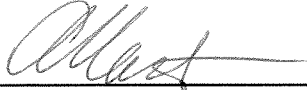
c. A permanent injunction enjoining Defendants or their agents from implementing and enforcing the Berger Commission's recommendations.

c. Costs and reasonable attorney's fees;

d. Such other and further relief as this court may deem appropriate and equitable.

Respectfully submitted,

NEW YORK LAWYERS FOR THE
PUBLIC INTEREST

By  _____

Amanda Masters

Senior Staff Attorney

Attorneys for Plaintiffs

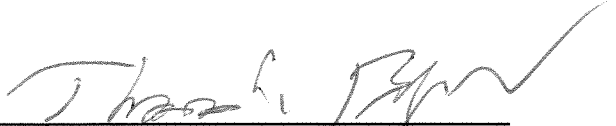
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Dated: January 3, 2007