

**IN THE UNITED STATES DISTRICT COURT  
FOR THE DISTRICT OF CONNECTICUT**

|  |   |                            |
|--|---|----------------------------|
| CONNECTICUT ASSOCIATION                  | : |                            |
| OF HEALTH CARE FACILITIES, INC.,         | : |                            |
|  | : |                            |
| Plaintiff,                               | : |                            |
|  | : | CASE NO. 3:10-CV-136 (RNC) |
| v.                                       | : |                            |
|  | : | February 16, 2010          |
| M. JODI RELL, in her official capacity   | : |                            |
| as Governor of the State of Connecticut, | : |                            |
|  | : |                            |
| Defendant.                               | : |                            |

**MEMORANDUM OF LAW IN SUPPORT OF  
PLAINTIFF'S MOTION FOR A PRELIMINARY INJUNCTION**

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**PRELIMINARY STATEMENT**

Plaintiff Connecticut Association of Health Care Facilities, Inc. (“CAHCF”) is a not-for-profit trade association that represents over 100 nursing facilities in Connecticut. When family and friends are unable or unwilling to do so, these nursing facilities, and their thousands of employees, provide life-sustaining care to Connecticut’s most frail and elderly citizens, the majority of whom are Medicaid beneficiaries.

CAHCF reluctantly brought this suit on behalf of its members because Connecticut’s recently amended payment methodology for Medicaid-participating nursing facilities cuts already-deficient Medicaid payments by almost 10 percent, in violation of federal law. Specifically, section 32 of Connecticut Public Act 09-5 (“Section 32”) sets payment rates based solely on state budgetary considerations. Indeed, Section 32 sets Medicaid payment rates without considering the costs incurred to deliver care, without considering the reasons that such costs are incurred, and without considering the federal standards governing Medicaid payments.

Because federal law requires States to use methods and procedures that assure Medicaid payments are consistent with efficiency, economy, quality of care, and equality of access, the Supremacy Clause of the United States Constitution instructs that Connecticut’s conflicting payment methodology cannot stand. Pursuant to Rule 65(a) of the Federal Rules of Civil Procedure, CAHCF asks this Court to preliminarily enjoin Defendant M. Jodi Rell (“Governor Rell”) from implementing Section 32.

CAHCF possesses a substantial likelihood of success on the merits of its Supremacy Clause claims. The law of the Second Circuit is well established and unambiguous: a state Medicaid payment methodology that conflicts with federal law is null and void. Several recent appellate rulings from outside the Second Circuit have preliminarily enjoined budget-driven payment

systems similar to the one at issue here. As in those cases, the legislative record here demonstrates that, in violation of federal law, the Connecticut General Assembly did not consider any cost studies, did not make any attempt to relate Medicaid payments to the cost of care, and did not determine whether the payment rates produced by Section 32 assured that Medicaid payments are consistent with efficiency, economy, quality of care, and equality of access. Instead, Section 32 was enacted for the sole purpose of reducing state spending, a clear violation of federal law.

Preliminary injunctive relief is warranted because CAHCF members will suffer irreparable harm if such relief is denied. Pecuniary harm constitutes irreparable harm where, as here, the Eleventh Amendment precludes this Court from awarding retroactive money damages should CAHCF ultimately succeed on the merits of its legal claims. Each day Section 32 is allowed to operate, many CAHCF members lose thousands of dollars that cannot be compensated by a later money damages award from this Court, further weakening Connecticut's fragile long-term care industry.

The value of these lost dollars cannot be measured in monetary terms alone, however, for these dollars are the resources that allow nursing facilities to deliver care and services, to pay caregivers, to secure necessary equipment, and to maintain their physical plants. This is not empty rhetoric based merely on CAHCF's opinion. In 2001, the General Assembly's own Legislative Program Review and Investigations Committee ("LPRI Committee") issued a report severely criticizing the State's payment methodology. Addressing the payment system's failure to pay for care based on current costs, the LPRI Committee concluded: "Providing inadequate inflationary increases and rebasing costs less frequently impact[s] the industry's ability to attract qualified staff, and, without reducing the size of the industry, will eventually pose a serious threat to the quality of resident care as inflation forces homes to reduce spending on critical needs." Legis.

Program Review & Investigations Comm., Conn. Gen. Assem., *Nursing Home Medicaid Rate-Setting System 29* (2001) (“LPRI Rep.”) (App. 2:323a);<sup>1</sup> *see also id.* at 2 (finding that “cost containment in Connecticut, and more recently the flat rate increases, have contributed to Connecticut nursing facilities’ financial problems”) (App. 2:296a).

The financial condition of Connecticut’s nursing facilities has been precarious for years, as evidenced by the numerous bankruptcies and state receiverships that have plagued the industry. As the LPRI Committee noted, the “[f]inancial stability of the nursing home industry has been a concern in Connecticut for some time.” *Id.* at 43 (App. 2:337a). Writing in 2001, the committee found that “[b]ankruptcies in Connecticut have become a major problem with more than 20 percent of facilities bankrupt or in receivership since 1999.” *Id.* at 48 (emphasis in original) (App. 2:342a). Little has changed since then. Between 2002 and late 2009, 22 nursing facilities closed, and in late 2009 another sixteen were in receivership or bankruptcy. *See* Michael P. Starkowski, Comm’r, Conn. Dep’t of Soc. Servs., *Presentation to the Long-Term Care Financial Managers Association* at 23-25 (Oct. 8, 2009) (App. 3:496a-98a). The significant payment cut effected by Section 32 has and will continue to exacerbate this dire situation.

For these reasons, the Court should issue an order preliminarily enjoining Governor Rell from implementing Section 32. Because this case involves the enforcement of public interests arising out of a federal health and welfare statute, the Court should also waive Rule 65(c)’s security requirement.

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<sup>1</sup> References to “App.” are to CAHCF’s four-volume Appendix of Exhibits, which is continuously paginated and contains factual evidence in support of CAHCF’s motion. The number following “App.” refers to the volume number; the number following the colon refers to the precise page on which the cited material appears. The above reference to “App. 2:323a,” for example, is to material found in volume 2 of the Appendix of Exhibits at page 323a.

## STATEMENT OF THE CASE

### **A. The Medicaid Program Generally**

Medicaid is a cooperative federal-state program authorized by Title XIX of the Social Security Act, 42 U.S.C. §§ 1396-1396v (the “Medicaid Act”). If a State agrees to be bound by, and to comply with, the provisions of the Medicaid Act, federal matching funds will be paid to the State so that it may furnish medical care to needy individuals. *See* 42 U.S.C. § 1396. Although a State’s participation in Medicaid is voluntary, once a State chooses to participate, it must comply with various federal statutes and regulations. *Wilder v. Va. Hosp. Ass’n*, 496 U.S. 498, 502 (1990). Connecticut has chosen to participate in the Medicaid program and has designated the Connecticut Department of Social Services (“DSS”) as the “single State agency” responsible for administering the State’s Medicaid program under 42 U.S.C. § 1396a(a)(5). Conn. Gen. Stat. § 17b-2(8).

In order to participate in the Medicaid program, a State must submit a state plan for medical assistance (“State Plan”) to the Centers for Medicare & Medicaid Services (“CMS”), which administers Medicaid on behalf of the Secretary of Health and Human Services. *See* 42 U.S.C. §§ 1396, 1396a. If the State Plan is accepted by CMS, the State is eligible to be reimbursed by the Federal Government for a specified percentage of the amounts expended by the State as medical assistance under the State Plan. §§ 1396b(a)(1), 1396d(b). Historically, the Federal Government has paid approximately 50 percent of the total cost of Connecticut’s Medicaid program; however, that percentage was recently increased to over 60 percent under federal stimulus legislation. *See, e.g.*, Implementation of Section 5001 of the American Recovery and Reinvestment Act of 2009, 75 Fed. Reg. 5325, 5327 (Feb. 2, 2010).

Although States are afforded some discretion in deciding what types of services to provide, participating States must provide nursing facility services. 42 U.S.C. §§ 1396a(a)(10)(A),

1396d(a)(4)(A). States make payments directly to providers. 42 C.F.R. § 430.0. Although States are also afforded some discretion in setting payment rates, the federal statute principally at issue here commands that a State Plan must

provide such methods and procedures relating to . . . the payment for[] care and services available under the [State Plan] . . . as may be necessary . . . to assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the [State Plan] at least to the extent that such care and services are available to the general population in the geographic area.

42 U.S.C. § 1396a(a)(30)(A) (App. 1:2a).

**B. Connecticut’s Payment System For Medicaid-Participating Nursing Facilities**

Attachment 4.19-D to the State Plan contains the methods and standards a State uses in setting payment rates for nursing facility services. *See* Conn. State Plan Excerpts (App. 3:539a-58a). However, Connecticut’s payment methodology for Medicaid-participating nursing facilities is also codified in state statute. On the surface, that statutory payment methodology appears complex. Appearances are deceiving, however.

As explained below, Connecticut’s payment methodology has one overarching and controlling component known as the Stop Gain. The Stop Gain displaces and nullifies the cost-based, facility-specific per diem rate produced by a statutory formula that, at least in theory, was designed to pay per diem rates that take into account the actual cost of providing efficient, economical and quality care to Medicaid beneficiaries.<sup>2</sup>

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<sup>2</sup> As an ad hoc task force comprised of members of the General Assembly, health care professionals and union representatives concluded in 2002: “[W]hile the current Medicaid reimbursement system in Connecticut was soundly conceived when first implemented a decade ago, the cumulative effect of stop-gain/stop-loss ceilings, infrequent rebasing, and a highly discretionary Interim Rate process” have divorced the current payment system from the actual costs of delivering care. *Final Report of the Ad Hoc Task Force on Nursing Home Costs in Connecticut* at 8 (Feb. 15, 2002) (“Task Force Rep.”) (App. 2:368a).

**1. The Stop Gain Renders The Cost-Based Payment Calculation Meaningless**

DSS calculates a cost-based, facility-specific per diem rate that, in theory, is to be paid for each day of care provided. *See* Conn. Gen. Stat. § 17b-340 (App. 1:3a). Each nursing facility's per diem rate is calculated annually. § 17b-340(a). The annual rate year is July 1 through June 30, which coincides with the State's fiscal year. *See id.*

By December 31 of each year, nursing facilities must submit a report detailing the costs they incurred to provide care in the preceding October 1 through September 30 time period. *Id.* Reported expenditures must be organized into five cost categories: (1) "Direct," which includes nursing personnel salaries and related fringe benefits; (2) "Indirect," which includes professional fees, dietary, housekeeping, laundry personnel costs and expenses and supplies related to patient care; (3) "Administrative and General" ("A&G"), which includes maintenance, utilities and plant operation expenses, as well as salaries and related fringe benefits for administrative and maintenance personnel; (4) "Property," which, rather than actual interest and depreciation costs, means a "fair rental value" allowance; and (5) "Capital-Related," which includes such things as property taxes, insurance expenses, equipment leases and equipment depreciation. § 17b-340(f)(1).<sup>3</sup>

Not all costs are "allowable," however. For example, bad debt expense is not allowable, nor are most advertising costs. Conn. Agencies Regs. § 17-311-52(i). On average, "unallowable" costs constitute two or three percent of facilities' total costs. Lubarsky Decl. ¶ 12 (App. 4:871a).

In addition, state law provides that facility costs in the Direct, Indirect and A&G cost categories are limited by certain ceilings, which are established as percentages of statewide median

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<sup>3</sup> The LPRI Committee found that "staff salaries and benefits . . . account for more than 75 percent of facilities' costs." LPRI Rep. at 15 (App. 2:309a). Nursing staff salaries and benefits alone constitute "more than 50 percent of all facilities' costs." *Id.*

costs. Costs in excess of these ceilings are not reimbursed. *See* Conn. Gen. Stat. § 17b-340(f)(3). For costs within the Direct category, the statutory ceiling is 135 percent of the median allowable cost of the facility's peer grouping. *Id.*<sup>4</sup> Costs in the Indirect category are subject to a statutory ceiling that is 115 percent of the statewide median allowable cost. *Id.* Finally, for the A&G category, the statutory ceiling is 100 percent of the statewide median allowable cost. *Id.* After application of all ceilings, the costs that, in theory, should be used to calculate a facility's per diem rate may be further reduced. For rate-computation purposes, costs are divided by the higher of reported total resident days for the year or the number of days equal to an assumed facility occupancy rate of 95 percent of licensed capacity. § 17b-340(f)(14).

Importantly for present purposes, state law instructs that DSS must "rebase" nursing facilities' allowable costs "no less frequently than every four years." § 17b-340(f)(8). As explained by the LPRI Committee: "Rebasing is an element of the reimbursement system that periodically assesses and updates the actual costs of operating a nursing home and reflects those costs in computation of the [nursing home's] Medicaid rate. A cost year is selected as a base year and allowable costs are established; those costs are inflated forward from that base cost year to the appropriate rate year(s)." LPRI Rep. at 19 n.5 (App. 2:313a). "A primary reason for recalculating nursing home rates," the committee explained, "is to update facilities' allowable costs with their expenses. Thus, infrequent rebasing limits costs by preventing facilities with low reimbursement

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<sup>4</sup> Peer groupings are established using two criteria: (1) state licensure type, meaning chronic and convalescent nursing home ("CCNH") versus rest home with nursing supervision ("RHNS"); and (2) location, meaning Fairfield County versus non-Fairfield County. *See* Conn. Gen. Stat. § 17b-340(f)(2). For example, a CCNH located in Fairfield County is theoretically allowed higher costs in the Direct cost category because wages are assumed to be higher in Fairfield County. Similarly, a CCNH located in Fairfield County is theoretically allowed higher costs than an RHNS in the same county because it is more expensive to staff a facility in order to provide the higher CCNH level of care.

rates from making significant improvements in staffing or operations, by capping rates at the prior year's rate plus some inflation factor—even if costs remain below established cost ceilings. In addition, inflating costs forward for too many years ignores valid reasons for cost increases—such as increasing direct care staffing in response to changes in resident acuity.” *Id.* at 28-29 (App. 2:322a-23a).

## 2. The Stop Gain

The cost-based payment rate calculated for each nursing facility as described above is rendered meaningless by a single component of section 17b-340. That component, the Stop Gain, is an overarching and absolute cap on nursing facilities' per diem rates applied across-the-board to all nursing facilities. The Stop Gain is the focus of CAHCF's motion for a preliminary injunction.

The Stop Gain is established annually as part of the state budgetary process. *See* LPRI Rep. at 25 (App. 2:319a). For example, until recently, the Stop Gain stated, in relevant part: “For the fiscal year ending June 30, 2009, rates in effect for the period ending June 30, 2008, shall remain in effect until June 30, 2009 . . . .” Conn. Gen. Stat. § 17b-340(f)(4) (App. 1:8a). In other words, for state fiscal year (“FY”) 2009, Connecticut decided during the state budgetary process that most nursing facilities would be paid the same per diem rate they were paid the previous year, regardless of increases in the costs of providing efficient, economical and quality care to Medicaid beneficiaries. In years prior to FY 2009, the General Assembly had set the Stop Gain at varying percentages allowing small annual rate increases. *See id.*; *see also* Office of Certificate of Need & Rate Setting, Conn. Dep't of Soc. Servs., *Overview of Nursing Facility Rate Setting* at 4 (Oct. 2009) (table listing previous years' Stop Gain percentages) (“DSS Overview”) (App. 3:471a).

As the LPRI Committee and others have explained, because of the Stop Gain, “not all facilities with allowable costs are actually reimbursed based on those costs because the overriding feature of the rate-setting system is the stop gain/stop loss on the prior year's rate. Thus, even

though facilities may be below the maximum ceilings in any of the cost categories, once the stop gain provision is applied to the computed rate, allowable costs may not be reimbursed if those costs grew at a faster rate than the stop gain.” LPRI Rep. at 22 (emphasis omitted) (App. 2:316a); *see also id.* at 25 (“In recent years, the rate-setting system has been superceded [sic] by a single system component—the stop gain provision.”) (App. 2:319a). Other state entities have similarly noted the controlling effect of the Stop Gain. *See, e.g.,* Office of Legis. Research, Conn. Gen. Assem., *OLR Major Issues*, Rep. No. 2010-R-0029 at 17 (Jan. 20, 2010) (finding that the “complex rate formula has been rendered moot in recent years as the legislature has either appropriated flat rates or frozen them altogether”) (App. 2:397a); Office of Legis. Research, Conn. Gen. Assem., *Nursing Homes*, Rep. No. 2008-R-0020 at 6 (Jan. 16, 2008) (“While the structure for limiting the costs the state will allow remains in statute, the legislature has essentially rendered it moot by appropriating in recent years flat increases to homes and allowing DSS to grant them interim rates.”) (App. 2:394a); Univ. of Conn. Health Ctr., *Connecticut Long-Term Care Needs Assessment, Part II: Rebalancing Long-Term Care Systems in Connecticut and Recommendations* 30 (June 2007) (“UConn Study”) (noting the Stop Gain’s inherent flaws) (App. 2:387a); Task Force Rep. at 8 (App. 2:368a) (same).

The Stop Gain has been noted to have three principle yet interrelated effects. First, facilities are not reimbursed based on their allowable costs as determined by the cost-based payment methodology contained in section 17b-340. *See* LPRI Rep. at 26 (App. 2:320a). Second, the Stop Gain “has eliminated the relationship between facilities’ allowed costs and the Medicaid rate ultimately issued,” *id.* at 25-26 (emphasis omitted) (App. 2:319a-20a), such that the “current system does *not* adequately reflect the actual costs of wages, benefits and staffing,” Task Force Rep. at 8 (emphasis in original; internal quotations omitted) (App. 2:368a); *see also* UConn Study

at 30 (App. 2:387a). Third, the Stop Gain is “fundamentally unfair” because, after the Stop Gain has been applied over “multiple years, the cumulative effect of the loss is even greater, weakening the relationship between a facility’s costs and the rate it receives.” LPRI Rep. at 23 (emphasis omitted) (App. 2:317a).<sup>5</sup>

### 3. The Shadow Rate System: Interim Rates

Connecticut law allows the Commissioner of DSS discretion to increase Medicaid payment rates to individual nursing facilities and pay financially troubled facilities so-called “interim rates,” but only if the Commissioner can do so “within available appropriations.” Conn. Gen. Stat. § 17b-340(a). The Commissioner may grant a nursing facility’s request for an interim rate only if (1) the rate increase is necessary to avoid a nursing facility filing a petition for bankruptcy, (2) the facility has been placed in state receivership, or (3) there has been substantial deterioration in the facility’s financial condition that may be expected to adversely affect resident care and the continued operation of the facility. *Id.* If one or more of the foregoing conditions is met, the Commissioner must then determine whether the “continued operation of the facility is in the best interest of the state.” *Id.*

Unfortunately, dire financial conditions have caused a significant percentage of Connecticut nursing facilities to seek interim rates. According to the General Assembly’s Office of Legislative Research: “As the nursing home industry faces more bankruptcies, receiverships, and closures in part due to the inadequacy of Medicaid reimbursements (a new study suggests that

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<sup>5</sup> The impact of the Stop Gain is significant and long-standing. For example, based on cost reports submitted by facilities over a four-year period, the LPRI Committee in 2001 found that “almost all facilities would have had direct care costs fully allowed if a stop gain provision were not applied. Over three-quarters of facilities would have indirect care costs fully allowed. Since the administrative and general cost category is set at the median, half of the facilities have costs allowed, while half are disallowed.” LPRI Rep. at 22 (App. 2:316a). As discussed above, the Stop Gain continues to have the same detrimental effect today.

Medicaid under-funds Connecticut nursing homes an average of \$12.40 per patient per day), the state has looked to interim rates to help homes cover their costs.” OLR Nursing Homes Rep. at 2 (App. 2:390a).<sup>6</sup>

By way of illustration, there are approximately 238 nursing facilities in Connecticut. DSS Overview at 1 (App. 3:468a). According to DSS, 16 facilities obtained interim rates in FY 2008. Gary M. Richter, Dir., Office of Certificate of Need & Rate Setting, Conn. Dep’t of Soc. Servs., *Presentation to the Long-Term Care Financial Managers Association* at 13 (Nov. 12, 2009) (App. 3:532a). In FY 2009, however, the number of facilities granted interim rates jumped to 41. *Id.* DSS has already approved at least seven interim rate requests in FY 2010, and there are at least 26 additional interim rate requests currently pending. *Id.* Thus, “in any discussion involving adequate Medicaid reimbursement in Connecticut, it is important to remember interim rate increases have become so common, that case-by-case review has replaced a systemic approach to rate setting.” LPRI Rep. at 26 (App. 2:320a).<sup>7</sup>

**C. The State Has Long Recognized Fundamental Flaws In Its Own Payment Methods And Procedures**

The State cannot seriously contend that its Medicaid payment system bears any real relationship to nursing facility costs or that its payment methods and procedures satisfy the Medicaid

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<sup>6</sup> This report also notes that a DSS representative stated that “most of the increases are granted to homes that can show that their costs have increased more than the rate increases the legislature grants.” OLR Nursing Homes Rep. at 7 (App. 2:395a). “DSS has granted over 160 interim rates” since rates were last rebased, the report finds, “in some instances to the same home in different rate years. The additional overall cost of granting these rates is expected to exceed \$50 million in FY 08.” *Id.* at 6-7 (App. 2:394a-95a).

<sup>7</sup> This is not a new problem. In 2007, the UConn Study found that “[n]early half (45 percent) of facilities in the state have received such individual adjustments since 1998, and it is typical for [DSS] to issue 30 to 50 interim rates annually related to major capital projects, ownership changes and hardship situations (DSS, 2006).” UConn Study at 30 (App. 2:387a).

Act's payment criteria of efficiency, economy, quality of care and equality of access. The State also is in no position to deny that Connecticut's Medicaid payment system for nursing facilities, and the Stop Gain in particular, are, to use the words of the LPRI Committee, "fundamentally unfair." LPRI Rep. at 26 (App. 2:320a). Indeed, for almost ten years, the State itself has documented in meticulous detail the fundamental flaws of its own payment system.

In 2001, for example, the LPRI Committee conducted an in-depth investigation of the efficacy and equity of the State's payment methods and procedures. Among other things, the committee found that Connecticut's payment methodology had been superseded "by a single system component—the stop gain provision." LPRI Rep. at 25 (App. 2:319a). The Stop Gain had "evolved into a flat percent increase with specific percent increases established through the state budget process and applied to all facilities' prior year's rates." *Id.* As a result, the committee found that "*adoption of flat percent increases for rate reimbursement has eliminated the relationship between facilities' allowed costs and the Medicaid rate ultimately issued.*" *Id.* at 25-26 (emphasis in original) (App. 2:319a-20a). As the LPRI Committee succinctly explained:

Under Connecticut's rate-setting system, facilities submit cost reports, and a two-step process determines allowable costs to compute rates. First, DSS excludes costs not allowed under the Medicaid program, and then disallows costs above the cost ceilings in three of the five categories (direct care, indirect care, and administrative and general) in which costs are arrayed. The costs are then used to calculate per diem Medicaid rates. *However, since FY 00, the stop gain provision has made this calculation pointless, since a flat rate increase percentage is merely applied to the prior year's rate to yield the new per diem issued to a facility. In other words, the rate ultimately established has no connection to the costs submitted by the facility.*

*Id.* at 26 (emphasis added) (App. 2:320a); *see also id.* at 20 (describing the Stop Gain as the "dominant provision" in Connecticut's statutory payment methodology that "supercedes [sic] all others [and] caps facilities' per-diem Medicaid rate increases from year to year to specified statutory percentages") (App. 2:314a).

On the heels of the LPRI Committee Report, leaders of the General Assembly created an Ad Hoc Task Force on Nursing Home Costs (“Task Force”), which was comprised of members of the General Assembly, as well as health care professionals and union representatives. Chaired by Bruce C. Vladeck—the former Administrator of what is now CMS, the federal agency that oversees Medicaid—the Task Force independently reached the same conclusions as the LPRI Committee. The Task Force concluded that, “while the current Medicaid reimbursement system in Connecticut was soundly conceived when first implemented a decade ago, the cumulative effect of stop-gain/stop-loss ceilings, infrequent rebasing, and a highly discretionary Interim Rate process have undermined the operational effectiveness of that system. Specifically, in terms of the Task Force’s charge, it was agreed that the current system does *not* ‘adequately reflect the actual costs of wages, benefits and staffing.’” Task Force Rep. at 8 (emphasis in original) (App. 2:368a).

A few years later, a state-funded study conducted by the University of Connecticut discussed the flaws in the State’s payment methodology that had been identified by the LPRI Committee and the Task Force, but never fixed. The UConn Study also concluded that the consequences of Connecticut’s flawed payment methodology had been greatest “for those facilities that serve primarily Medicaid-pay residents. These nursing homes are less able to shift un-reimbursed Medicaid costs onto other sources (Medicare and private payers) due to increasing numbers of Medicaid-only residents, lower Medicare reimbursement rates, and declining numbers of private pay residents associated with increased community-based long-term care alternatives (BDO Seidman, 2003).” UConn Study at 31 (App. 2:388a).

The Supreme Court of Connecticut made similar findings last year. In *St. Joseph’s Living Center, Inc. v. Town of Windham*, 966 A.2d 188 (Conn. 2009), the Court was asked to decide whether a town properly denied a nursing facility’s application for a property tax exemption.

Finding that the nursing facility's Medicaid participation "relieve[d] the state of a burden it otherwise would be compelled to bear," *id.* at 211, the Court held that the nursing facility "clearly undertakes a 'financial burden' by virtue of the fact—which the trial court expressly recognized—that reimbursement under the Medicaid program 'does not fully [compensate] the [nursing facility] for actual patient care costs.' This funding gap relieves the state of having to shoulder the entire financial burden of caring for the indigent elderly." *Id.* at 213 (quoting trial court's unpublished ruling). "The fact that the [nursing facility] may pass on some of this shortfall to private paying patients in the form of higher rates," the Court concluded, "is insignificant in light of the uncertain number of such patients and the fact that these higher rates merely hasten the pace at which such patients spend down their assets and become reliant on the Medicaid program themselves." *Id.* (footnotes omitted).

Similar findings have also been made by the Office of Legislative Research ("OLR"), which is a nonpartisan office of the General Assembly that provides research, policy analysis and assistance in the development of legislation. Just last month, for example, OLR concluded that Connecticut's "complex rate formula has been rendered moot in recent years as the legislature has either appropriated flat rates or frozen them altogether." OLR Major Issues Rep. at 17 (App. 2:397a); *see also* OLR Nursing Homes Rep. at 6 ("While the structure for limiting the costs the state will allow remains in statute, the legislature has essentially rendered it moot by appropriating in recent years flat increases to homes and allowing DSS to grant them interim rates.") (App. 2:394a).

**D. Section 32 Cut Nursing Facility Payments By Almost Ten Percent Based Solely On State Budgetary Considerations**

As the LPRI Committee acknowledged, the Stop Gain's across-the-board percentage has been established each year as part of the state budgetary process, which for present purposes has

two primary components. First, the Governor recommends to the General Assembly a biennial budget bill and certain other bills to implement subjects covered by the budget. *See* Office of Fiscal Analysis, Conn. Gen. Assem., *State Budget Process* (App. 2:408a). Second, the General Assembly considers those bills, amends them as it sees fit, and, if the bills are passed, sends them to the Governor for her signature. *See id.*

As a rule, the Stop Gain is extended—or, perhaps more accurately, imposed—on a year-to-year basis. The Stop Gain for FY 2010 and FY 2011 was most recently imposed by Section 32. The legislative record documenting the process through which Section 32 became law demonstrates beyond any doubt that, in violation of federal law, state budgetary considerations were once again the sole motivating factor behind the Stop Gain’s extension. Indeed, rather than set payment rates based on the considerations required by federal law—i.e., efficiency, economy, quality of care, and equality of access—Section 32’s legislative history dispositively proves that those factors were wholly ignored in favor of the State’s own pecuniary interests.

**1. Governor Rell’s Proposed Budget Bill (House Bill 6365) And Proposed Budget-Implementer Bill For Medicaid (Senate Bill 843)**

On February 4, 2009, Governor Rell’s proposed budget for the FY 2010-2011 biennium was introduced as House Bill 6365. *See* H.R. 6365, 2009 Gen. Assem., Jan. Sess. § 1 (Conn. Feb. 4, 2009) (appropriating approximately \$4 billion for the State’s Medicaid program) (App. 1:21a). That same day, Governor Rell’s proposed bill implementing the Medicaid-related aspects of her budget was introduced as Senate Bill 843. Using language virtually identical to what eventually became law eight months later, Senate Bill 843 would have extended FY 2009’s zero percent rate cap into FY 2010-2011. *See* S. 843, 2009 Gen. Assem., Jan. Sess. § 16 (Conn. Feb. 4, 2009) (App. 1:98a-99a). Governor Rell’s proposal, however, was the functional equivalent of a 10 percent rate cut, as her own budget document explained:

Under current statute, DSS is required to rebase nursing home rates no more than once every two years and no less than once every four years. Since nursing home rates were last rebased in FY2006, the Current Services budget includes a rate increase of 9.64% in FY2010 to reflect the rebasing of rates at a cost of \$113.7 million in FY2010 and \$127.6 million in FY2011 . . . . Legislation is being proposed to eliminate these increases over the biennium.

Conn. Office of Policy & Mgmt., *FY 2010-FY 2011 Biennium Governor's Budget* at 518 (Feb. 4, 2009) (App. 1:23a).

The sole reason given for the rate cut was to reduce state spending. *See, e.g.*, Office of Fiscal Analysis, Conn. Gen. Assem., Synopsis of the Governor's 2010-2011 Biennial Budget at 8 (Feb. 5, 2009) (App. 1:25a) (concluding that Governor Rell's proposal to nullify rate increases otherwise due nursing facilities because of statutorily required rebasing would reduce state spending by \$115.3 million in FY 2010 and \$166.4 million in FY 2011). No mention was made of the Medicaid Act's efficiency, economy, quality and access criteria.

## **2. The Appropriations Committee Hearing On House Bill 6365**

Testimony relating to Governor Rell's proposed cut to nursing facilities' payment rates was presented on February 18, 2009, before the General Assembly's Appropriations Committee. That testimony confirmed the perilous financial condition of the State's long-term care industry. For example, Nancy Shaffer, the State's own Long-Term Care Ombudsman, testified as follows:

In the State of Connecticut we currently have ten skilled nursing facilities that are in state receivership. There are also six skilled nursing facilities in bankruptcy. A nursing home closed in December 2008 and two homes are awaiting the DSS Commissioner's decision regarding their request to close. In less than one month, 27 skilled nursing facilities face union activity. And by all accounts there are other facilities facing the prospect of closing in the very near future. As the State Ombudsman I am currently the Court appointed Patient Care Ombudsman in six bankrupt homes; and until recently also the Patient Care Ombudsman in four other homes.

These are perilous times. They are challenging, difficult times for the Connecticut long term care industry and that translates into significantly critical times for long term care residents. . . .

Tr. of Appropriations Comm. Hr'g, Conn. Gen. Assem., Regarding H.R. 6365 at 70 (Feb. 18, 2009) (App. 1:27a).

Written testimony submitted to the Appropriations Committee used equally blunt terms. CAHCF, for example, explained to the Appropriations Committee:

5 facilities are currently in bankruptcy and 10 are being run by the State under the receivership program with little likelihood of finding a buyer. With this record number of facilities in receivership the State of CT is now the 5th largest provider in CT! Since the first of this year three (3) nursing homes have closed or announced they will be closing very soon. That is an historic record of closures in such a short time frame. A sickening record when you know the heartbreak and devastating toll it takes on the residents in those facilities when they are forced out of their home because their nursing home is no longer financially viable and closes.

Nursing Homes received a zero increase [in FY 2009] at a time of record increases in expenses. These closures are a direct result of inadequate funding. And the more poor people you care for the more at risk you are of being forced to close!

The Governor's budget zero funds nursing home care for the next two years and eliminates a statutorily required cost of living increase to rates that we receive once every 4 years so the Medicaid program can try to keep pace with the costs of providing care. The Governor's budget estimates nursing homes have experienced a 9.64% increase in expenses while trying to operate with a zero % increase in rates and expected to deliver top notch care. . . .

Written Testimony of CAHCF at 1-2 (Feb. 18, 2009) (App. 1:34a); *see also* Written Testimony of the Conn. Ass'n of Not-For-Profit Providers For the Aging, Inc. (Feb. 18, 2009) (App. 1:64a); Written Testimony of the Service Employees Int'l Union (Feb. 18, 2009) (App. 1:67a). No effort was made by the Appropriations Committee to relate the proposed payment cut to efficiency, economy, quality of care, or equality of access.

### **3. The Human Services Committee Hearing On Senate Bill 843**

A few weeks later, the General Assembly's Human Services Committee held a public hearing on Governor Rell's proposed implementation of her Medicaid-related budget. *See* Tr. of Hr'g Before the Human Servs. Comm., Conn. Gen. Assem., Regarding S. 843 (Mar. 3, 2009) ("Mar. 3, 2009 Hr'g Tr.") (App. 1:100a). During that hearing, the following colloquy took place between

Representative Toni E. Walker, co-chair of the Human Services Committee, and the chief rate-setting official for DSS, Gary M. Richter:

REP. WALKER: How many beds do we have basically for the state of Connecticut for—for nursing homes? How many beds do we have now?

GARY RICHTER: Approximately 28,000 beds.

REP. WALKER: About 28,000[]?

GARY RICHTER: And we pay for—we have an average of—I think we're about a little under 18,000 are Medicaid cases. . . .

REP. WALKER: Okay the next question I have is how many of them are in receivership right now that are in jeopardy?

GARY RICHTER: Right now we have ten facilities in receivership.

. . .

REP. WALKER: So the question then I go to is that section 16 [of Senate Bill 843] which talks about the rebasing of the rate—the increase—we have a very fragile industry here and for a variety of reasons; costs, our reimbursement rates, I mean some obviously some other issues that have happened in there but this impact is not—is this going to impact the number of nursing homes that are going to end up closing also? Have we looked at that long-term?

GARY RICHTER: Well I think there's going to be pressure on the whole system. Clearly an increase would probably avoid problems for some homes. We do have a safety valve in the statute related to interim rates for facilities in financial distress.

And when those facilities come to [DSS] we evaluate the situation. Whether there's adequate bed supply in the area, physical condition of the building, so forth and so on. We can't give grants—we can grant rate relief and we have done that this year.

REP. WALKER: I just see a perfect storm coming here. Baby boomers are aging. People are having many more illnesses and they're ending up in nursing homes or they need long-term care. . . . [H]ere we have the fragile industry sort of shaking in their boots because they're not sure whether they're going to make it day to day.

So I just think that we need to look at this whole process that we're doing for long-term care and for [the] elderly because I think we're going to end up in an emergency state within the next year or two. . . .

Mar. 3, 2009 Hr'g Tr. at 64-65 (App. 1:101a-03a).

Nevertheless, the Human Services Committee eventually approved Governor Rell's proposed extension of the Stop Gain. *See* S. 843, 2009 Gen. Assem., Jan. Sess. § 2 (Conn. Mar. 19, 2009) (App. 1:112a). That doing so would cut otherwise payable nursing facility rates almost 10 percent was well documented, as was the fact that the extension of the Stop Gain was driven solely by state budgetary considerations. *See, e.g.*, Human Servs. Comm., Conn. Gen. Assem., J. Favorable Rep. Regarding S. 843 at 2-4 (Apr. 1, 2009) (statement of Claudette J. Beaulieu, Dep'y Comm'r for Programs, DSS) ("The budget includes a proposal to eliminate the rebasing of nursing home rates that would have resulted in a 9.64% increase in FY 2010 and a 3% inflationary adjustment in FY 2011 resulting in savings of \$115.3 million in FY 2010 and \$166.4 million in FY 2011.") (App. 1:116a); Office of Fiscal Analysis, Conn. Gen. Assem., Substitute S. 843 (File No. 461) at 28 (Apr. 6, 2009) (App. 1:137a). At the same time, a report produced by the Human Services Committee explained that the Connecticut Commission on Aging, an independent state agency, had testified that Governor Rell's proposal "does not provide sufficient Medicaid reimbursement rates to providers across the continuum of long-term care, threatening the very existence of services across the spectrum." Joint Favorable Report at 12 (statement of Deb Polun, Leg. Dir., Conn. Comm'n on Aging) (App. 1:125a).

Meanwhile, on April 2, 2009, the Appropriations Committee approved an amended version of Governor Rell's proposed budget bill. *See* H.R. 6365, 2009 Gen. Assem., Jan. Sess. § 1 (Conn. Apr. 2, 2009) (App. 1:83a). That same day, the General Assembly's Office of Fiscal Analysis issued a report explaining that the extension of the Stop Gain was the equivalent of a 10 percent rate cut. *See* Office of Fiscal Analysis, Conn. Gen. Assem., 2009 Appropriations Committee JF Report at 237-38 (Apr. 2, 2009) (App. 1:90a-91a). No mention was made of the costs that nursing facilities must incur to provide care or of the Medicaid Act's payment criteria.

**4. The May 18, 2009 “Informational Forum” Before The Appropriations, Aging, Human Services, And Public Health Committees**

On May 18, 2009, the Appropriations, Aging, Human Services, and Public Health Committees held a “Joint Informational Forum on Nursing Home Funding” at which the committees heard from representatives of DSS and CAHCF, among others. Testifying on behalf of DSS, Mr. Richter explicitly acknowledged that the State’s system for paying Medicaid-participating nursing facilities is entirely budget-driven, explaining: “Every year, we set the rates for the homes based on the formula and then, every home gets a computation based on the formula and statute and regulation. And then, at the end, we say ‘okay, well, what did the legislature allow for an increase [referring to the Stop Gain]?’” Video Recording of May 18, 2009 Forum at 01:59:14-01:59:34.<sup>8</sup>

Mr. Richter went on to explain to the several committees:

I don’t envy your job. Why have we limited these expenses? I think you, for example, Representative Walker, you have said it’s not just nursing homes. It’s other service areas that have been capped. Our fee schedules, have, uh, you know you’ve heard from providers. I think legislators had to make a choice. Are we going to add coverage, expand coverage to more areas, more eligible groups, uh, under our option? Provide more services for the uninsured? Can’t do everything. Plus, you have demands from not just the Department of Social Services, you’ve had demands from DCF, Corrections, everything else. And this is what’s, uh, you’ve been able to do in the nursing home area.

*Id.* at 02:00:55-02:01:34.

**5. The State Budget Impasse And DSS’s June 1, 2009 Notice**

With no further legislative action taken on the Stop Gain legislation and with the General Assembly scheduled to adjourn on June 3, 2009, Governor Rell announced that she had proposed a second budget containing “deeper cuts and no tax increases.” Press Release, Governor Rell Delivers Second ‘No-Tax’ Budget of Legislative Session (May 28, 2009) (App. 3:441a). Three

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<sup>8</sup> Available at [http://ctnv1.ctn.state.ct.us/A/app\\_5-18-09.wmv](http://ctnv1.ctn.state.ct.us/A/app_5-18-09.wmv).

days later, DSS started the process of implementing Governor Rell's "deeper cuts" by causing a notice to be published in newspapers throughout Connecticut, stating, in relevant part:

**Changes to Medicaid State Plan**

Based upon the Governor's [second] Recommended Budget for SFY 2010 and actions to date by the General Assembly, it is anticipated that the Medicaid State Plan will be amended to reduce nursing facility and [intermediate care facility for the mentally retarded ("ICF/MR")] rates by approximately 2.4% and 1%, respectively, effective July 1, 2009. While a final budget and related implementing legislation have not yet been adopted and budget development is ongoing, public notice is required at this time under federal regulations. With no changes to the current Medicaid State Plan or state statutes, it is projected that July 1, 2009 nursing facility and ICF/MR rates would increase by an average of 9.6% and 4.7%, respectively.

**Fiscal Information**

The expected revisions to nursing facility and ICF/MR rate setting will result in Medicaid savings of approximately \$152 million in SFY 2010. . . .

Conn. Dep't of Soc. Servs., Notice of Proposed Changes to the Medicaid State Plan Governing Payments to Nursing Facilities (June 1, 2009) (App. 3:559a).

On June 30, 2009, FY 2009 ended without an approved appropriations act for FY 2010. That same day, Governor Rell signed the first in what would become a series of similarly worded Executive Orders providing temporary funding in the absence of an approved state budget. *See* Exec. Order No. 28 (Conn. June 30, 2009) (App. 3:458a); Exec. Order No. 31 (Conn. July 30, 2009) (App. 3:461a); Exec. Order No. 31A (Conn. Aug. 11, 2009) (App. 3:464a); Exec. Order No. 33 (Conn. Sept. 1, 2009) (App. 3:466a).

**6. The Final Budget Bill (House Bill 6802)**

On August 31, 2009, new budget legislation (House Bill 6802) was introduced in both the House and the Senate. No public hearings were held on House Bill 6802, and the House and Senate passed House Bill 6802 the same day it was introduced. On September 1, 2009, Governor Rell issued a press release announcing that House Bill 6802 would become law without her

signature. *See* Press Release, Governor Rell: Budget Will Become Law Without Her Signature—and Without Pork-Barrel Spending (Sept. 1, 2009) (App. 3:454a). One week later, House Bill 6802 became law and was designated Public Act 09-3, June Special Session, 2009. Entitled “An Act Concerning Expenditures and Revenue for the Biennium Ending June 30, 2011,” Public Act 09-3 appropriated approximately \$4 billion for the State’s Medicaid program. *See* Pub. Act No. 09-3, 2009 Gen. Assem., June Sp. Sess. § 1 (Conn. Sept. 8, 2009) (App. 1:251a).

### **7. The Final Budget-Implementer Bill For Medicaid (House Bill 7005)**

On September 24, 2009, a new bill (House Bill 7005) was introduced and passed by the House implementing the Medicaid-related aspects of the new budget. Like Governor Rell’s original budget-implementer bill (Senate Bill 843), section 32 of House Bill 7005 extended the Stop Gain into FY 2010-2011 by adding the following italicized language to section 17b-340(f)(4) of the Connecticut General Statutes:

*For the fiscal years ending June 30, 2010, and June 30, 2011, rates in effect for the period ending June 30, 2009, shall remain in effect until June 30, 2011, except any facility that would have been issued a lower rate for the fiscal year ending June 30, 2010, or the fiscal year ending June 30, 2011, due to interim rate status or agreement with the department, shall be issued such lower rate. The Commissioner of Social Services shall add fair rent increases to any other rate increases established pursuant to this subdivision for a facility which has undergone a material change in circumstances related to fair rent, except for the fiscal year ending June 30, 2010, and the fiscal year ending June 30, 2011, such fair rent increases shall only be provided to facilities with an approved certificate of need . . . .*

H.R. 7005, 2009 Gen. Assem., Sept. Sp. Sess. § 32 (Conn. Sept. 24, 2009) (App. 1:258a). The legislative record demonstrates that legislators understood section 32 of House Bill 7005 imposed a rate cut of almost 10 percent on payments otherwise due nursing facilities, the sole purpose of which was to reduce state spending. *See* Tr. of H.R. Proceedings on H.R. 7005 at 4, 2009 Gen. Assem., Sept. Sp. Sess. (Conn. Sept. 24, 2009) (statement of Rep. Walker) (explaining in response to questioning by a fellow legislator that the rate cut imposed by Section 32 was “about 9 percent,

but if you note in the fiscal note, the savings is 122 million in FY10 and 181 million in FY11”) (App. 1:262a).

The Senate passed House Bill 7005 shortly thereafter. No comments were made regarding the significant cuts to Medicaid reimbursement for nursing facilities. *See* Tr. of S. Proceedings on H.R. 7005, 2009 Gen. Assem., Sept. Sp. Sess. (Conn. Oct. 2, 2009).<sup>9</sup>

On October 5, 2009, Governor Rell signed House Bill 7005, which became Public Act 09-5. With this official action, the statutory section at the heart of CAHCF’s motion for a preliminary injunction—Section 32—became law. *See* Pub. Act No. 09-5, 2009 Gen. Assem., Sept. Sp. Sess. § 32 (Conn. Oct. 5, 2009) (App. 1:281a). Nowhere in the process had state officials identified the costs that efficiently and economically operated nursing facilities incur, nor had anyone sought to relate the payment cut to efficiency, economy, quality of care, or equality of access, as required by the Medicaid Act.<sup>10</sup>

#### **E. Representative Harm To CAHCF Members Caused By Section 32**

Section 32’s extension of the Stop Gain into FY 2010-2011 has caused and will continue to cause significant harm. CAHCF’s Appendix of Exhibits includes illustrative testimony from several nursing facilities.

As explained in that testimony, on November 17, 2009, DSS mailed form letters to many Medicaid-participating nursing facilities. *See* Ex. A & B to Sinicariello Decl. (App. 4:666a,

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<sup>9</sup> Available at <http://www.cga.ct.gov/2009/trn/S/2009STR01002-R00-TRN.htm>.

<sup>10</sup> DSS forwarded to CMS a proposed state plan amendment implementing Section 32 shortly before its enactment. *See* Letter from Michael P. Starkowski, Comm’r, Conn. Dep’t of Soc. Servs., to Nat’l Institutional Reimbursement Team, Ctrs. for Medicare & Medicaid Servs. (Sept. 30, 2009) (App. 3:561a). DSS made no effort to justify the rate cut imposed by Section 32 in terms of costs incurred by nursing facilities or based on consideration of the Medicaid Act criteria. To CAHCF’s knowledge, CMS has taken no final action on DSS’s proposed state plan amendment.

693a); Ex. A to Liistro Decl. (App. 4:724a); Ex. A to Murphy Decl. (App. 4:754a); Ex. A to Thivierge Decl. (App. 4:784a); Ex. A & B to Phelps Decl. (App. 4:815a, 842a). Attached to each letter was a facility-specific document entitled “State of Connecticut Long-Term Care Facility Rate Computation Report” (“Rate Computation Report”). Among other things, the Rate Computation Report lists two different per diem rates. The first page of the Rate Computation Report lists the facility’s “[s]tate rate for 7/1/2009 through 6/30/2010” (“Stop-Gain Rate”)—the per diem rate DSS actually pays the facility as a result of Section 32’s extension of the Stop Gain. *See, e.g.*, Ex. A to Sinicariello Decl. (App. 4:666a). The second page of the Rate Computation Report lists the “[c]alculated rate for 7/1/2009 through 6/30/2010” (“Calculated Rate”)—the per diem rate DSS determined it would have pay the facility if the Stop Gain had not trumped the cost-based methodology found in section 17b-340. The Calculated Rate is based on the facility’s Medicaid-allowable costs, whereas the Stop-Gain Rate is, as the State itself has said, completely divorced from those costs. *See, e.g.*, Ex. A to Sinicariello Decl. (App. 4:666a). Each facility’s Rate Computation Report contains dozens of pages of detailed cost data as reported by the facility. *See, e.g.*, Ex. A & B to Sinicariello Decl. (App. 4:667a-91a, 694a-719a). However, the Stop Gain renders that cost data completely irrelevant, producing rates that are a combined \$385,180.38 less per month for the seven facilities. *See* App. 4:868a (table combining financial figures from facilities’ declarations).

There is no doubt that most Connecticut nursing facilities can demonstrate similar impact. It is, for example, incontrovertible that nursing facilities, like all businesses, are impacted by inflation. Using the index utilized by the State, inflation has caused cost increases of approximately 5.51 percent since payment rates were last rebased. *See* Lubarsky Decl. ¶ 19 (App. 4:874a). Yet, since FY 2009, the Stop Gain has frozen payment rates at FY 2008 levels. *See*

Conn. Gen. Stat. § 17b-340(f)(4). Moreover, the State itself determined that the aggregate impact of the Stop Gain is over \$200 million for FY 2010-2011. *See* Tr. of Sept. 24, 2009 H.R. Proceedings at 4 (App. 1:262a).

**F. CAHCF's Complaint For Declaratory And Injunctive Relief**

On January 28, 2010, CAHCF commenced this action on behalf of its members by filing a seven-count Complaint for Declaratory and Injunctive Relief against Governor Rell, who is sued in her official capacity only. *See* Compl. ¶ 14. As is relevant here, CAHCF's complaint alleges that Connecticut's payment system for Medicaid-participating nursing facilities conflicts with federal law. *See id.* ¶¶ 173-84.<sup>11</sup>

**STANDARD OF REVIEW**

In order to obtain a preliminary injunction affecting government action taken pursuant to a statutory scheme, a movant must demonstrate (1) a substantial likelihood of success on the merits and (2) irreparable harm in the absence of an injunction. *VIP of Berlin, LLC v. Town of Berlin*, \_\_\_ F.3d \_\_\_, No. 09-2950-cv, 2010 WL 252292, at \*4 (2d Cir. Jan. 25, 2010) (App. 2:427a); *Lynch v. City of New York*, 589 F.3d 94, 98 (2d Cir. 2009). In addressing the substantial-likelihood-of-success element, a State's interpretation of federal law is not entitled to judicial deference; instead, the Court applies a *de novo* standard of review. *See Turner v. Perales*, 869 F.2d 140, 141 (2d Cir. 1989) (per curiam).

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<sup>11</sup> CAHCF's complaint also asserts causes of action under 42 U.S.C. § 1983, constitutional takings claims, and a claim for relief under the Declaratory Judgment Act, 28 U.S.C. § 2201. *See* Compl. ¶¶ 185-207. Those other claims for relief are not at issue here because they do not serve as the basis for CAHCF's request for a preliminary injunction.

## ARGUMENT

### I. CAHCF HAS A SUBSTANTIAL LIKELIHOOD OF SUCCESS ON THE MERITS OF ITS SUPREMACY CLAUSE CLAIMS

#### A. The Supremacy Clause Preempts A State Statute That Conflicts With The Medicaid Act

The Supremacy Clause nullifies a state statute that conflicts with the Medicaid Act. Such was the holding of *Catholic Medical Center of Brooklyn & Queens, Inc. v. Rockefeller*, 430 F.2d 1297 (2d Cir. 1970) (per curiam). In *Catholic Medical Center*, several hospitals sued after New York enacted a nine-month rate freeze on Medicaid payments. Among other things, the hospitals argued that the state law was preempted because it conflicted with the Medicaid Act's earlier reasonable-cost requirement. See *Catholic Med. Ctr. of Brooklyn & Queens, Inc. v. Rockefeller*, 305 F. Supp. 1256, 1258-59 (E.D.N.Y. 1969). A three-judge district court concluded that the state statute was preempted by the Medicaid Act. See *Catholic Med. Ctr. of Brooklyn & Queens, Inc. v. Rockefeller*, 305 F. Supp. 1268, 1271 (E.D.N.Y. 1969). The Second Circuit affirmed the district court's decision in a per curiam opinion adopting the district court's previous opinions. See *Catholic Medical Center*, 430 F.2d at 1298 (finding it "unnecessary to spell out" the legal questions in dispute because the court of appeals was affirming the "declaratory judgment below [based] on the two reasoned opinions of the district court").

*Catholic Medical Center's* holding remains good law. See, e.g., *Pharm. Soc'y of the State of N.Y., Inc. v. N.Y. Dep't of Soc. Servs.*, 50 F.3d 1168, 1172 (2d Cir. 1995) (recognizing that Medicaid Act can preempt contrary state statute). Persuasive authorities from outside the Second Circuit are to the same effect. In particular, recent litigation in the Ninth Circuit has confirmed the ability of Medicaid providers to bring suit under the Supremacy Clause in order to enjoin a state Medicaid reimbursement scheme that conflicts with 42 U.S.C. § 1396a(a)(30)(A). See *Indep. Living Ctr. of S. Cal., Inc. v. Shewry*, 543 F.3d 1050, 1065 (9th Cir. 2008) (finding that Medicaid

providers could sue under the Supremacy Clause to challenge California's 10 percent across-the-board cut in Medicaid reimbursement paid to various provider-types) ("*Independent Living I*"), *cert. denied sub nom. Maxwell-Jolly v. Indep. Living Ctr. of S. Cal., Inc.*, 129 S. Ct. 2828 (2009); *see also Cal. Pharm. Ass'n v. Maxwell-Jolly*, 563 F.3d 847, 853 (9th Cir. 2009) (granting emergency motion for an injunction pending appeal and enjoining California's across-the-board reduction in Medicaid reimbursement for certain hospital services); *Wash. Health Care Ass'n v. Dreyfus*, No. C09-5395-RBL, 2009 WL 2432005, at \*1 (W.D. Wash. July 13, 2009) (granting temporary restraining order enjoining Washington State from implementing state statute cutting Medicaid reimbursement for nursing facilities where cut was driven entirely by state budgetary concerns) (App. 2:437a); *Wash. State Pharm. Ass'n v. Gregoire*, No. C09-5174-BHS, 2009 WL 1259632, at \*1 (W.D. Wash. Mar. 31, 2009) (enjoining similar state cuts with respect to pharmaceuticals) (App. 2:439a).

## **B. Section 32 Conflicts With The Medicaid Act**

The Medicaid Act requires that a State Plan

provide such methods and procedures relating to . . . the payment for[] care and services available under the [State Plan] . . . as may be necessary . . . to assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the [State Plan] at least to the extent that such care and services are available to the general population in the geographic area.

42 U.S.C. § 1396a(a)(30)(A). To comply with § 1396a(a)(30)(A), a State must "set [Medicaid] reimbursement rates 'that bear a reasonable relationship to efficient and economical [providers'] costs of providing quality services, unless the [State] shows some justification for rates that substantially deviate from such costs.'" *Indep. Living Ctr. of S. Cal., Inc. v. Maxwell-Jolly*, 572 F.3d 644, 651 (9th Cir. 2009) ("*Independent Living II*") (quoting *Orthopaedic Hosp. v. Belshe*, 103 F.3d 1491, 1496 (9th Cir. 1997)). To satisfy this substantive standard, the State "must rely on

responsible cost studies . . . that provide reliable data as a basis for its rate setting.” *Id.* at 651-52 (quoting *Orthopaedic Hospital*, 103 F.3d at 1496).<sup>12</sup> Even if a State reviews responsible cost studies before setting payment rates, the State bears the burden of justifying any payment rate that substantially deviates from the cost of an efficient facility economically providing quality care. *Orthopaedic Hospital*, 103 F.3d at 1500.

Moreover, federal appellate courts are in agreement that a State violates § 1396a(a)(30)(A) if the State’s decision to reduce Medicaid reimbursement rates is based solely on state budgetary considerations. *See, e.g., Independent Living II*, 572 F.3d at 656; *Orthopaedic Hospital*, 103 F.3d at 1499 n.3; *Ark. Med. Soc’y v. Reynolds*, 6 F.3d 519, 531 (8th Cir. 1993) (“[T]he state may not ignore the Medicaid Act’s requirements in order to suit budgetary needs.”); *see also Ohio Hosp. Ass’n v. Ohio Dep’t of Human Servs.*, 579 N.E.2d 695, 699 (Ohio 1991) (finding that Medicaid rate cuts “implemented solely for budgetary reasons” violate § 1396a(a)(30)(A)); *Tallahassee Mem’l Reg’l Med. Ctr. v. Cook*, 109 F.3d 693, 704 (11th Cir. 1997) (“[B]udgetary constraints alone can never be [a] sufficient” basis for setting Medicaid rates because, “[i]f a state could evade the requirements of the [Medicaid] Act simply by failing to appropriate sufficient funds to meet them, it could rewrite the Congressionally imposed standards at will.”); *Ala. Nursing Home Ass’n v. Harris*, 617 F.2d 388, 396 (5th Cir. 1980) (“Inadequate state appropriations do not excuse noncompliance [with the Medicaid Act].”); *cf. Minnesota v. Ctrs. for Medicare & Medicaid Servs.*, 495 F.3d 991, 996 (8th Cir. 2007) (affirming administrative decision rejecting State’s request for federal approval to amend Medicaid payment methodology where State provided

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<sup>12</sup> The requirement that payment rates must be based upon a consideration of the factors mandated by the Medicaid Act is long standing. *See, e.g., Ark. Med. Soc’y v. Reynolds*, 819 F. Supp. 816, 822-23 (E.D. Ark.) (collecting cases), *aff’d*, 6 F.3d 519, 529-30 (8th Cir. 1993) (same).

“unsupported assertions” that its amendment met § 1396a(a)(30)(A)’s efficiency, economy, and quality-of-care requirements).

**1. Section 32 Conflicts With The Procedural Requirement of 42 U.S.C. § 1396a(a)(30)(A)**

CAHCF has a substantial likelihood that it will succeed on its claim that Section 32 conflicts with the procedural requirement of § 1396a(a)(30)(A). *See* Compl. ¶¶ 173-80. The legislative record demonstrates that, before enacting Section 32, the General Assembly: (1) did not identify the costs that efficiently and economically operating nursing facilities incur; (2) did not consider responsible cost studies to assure that payments to Medicaid-participating nursing facilities would bear a reasonable relationship to efficient and economical facilities’ costs of providing quality care; and (3) did not consider objective data relating to efficiency, economy, quality of care or access, as required by § 1396a(a)(30)(A). Without such data, Connecticut could not have complied with its legal obligation under § 1396a(a)(30)(A) to use “methods and procedures” that “assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area.” *See Independent Living II*, 572 F.3d at 652-57.

The legislative record clearly demonstrates that state budgetary considerations were the sole reason for Section 32’s enactment. Rather than acting to fulfill § 1396a(a)(30)(A)’s mandate, Connecticut did the opposite by extending the Stop Gain into FY 2010-2011 in order to reduce state spending by \$115.3 million and \$166.4 million, respectively. *See* 2009 Appropriations Committee JF Report at 237-38 (App. 1:90a-91a); Joint Favorable Report at 2-3 (App. 1:116a-17a).

Section 32's extension of the Stop Gain assured that the federal statutory considerations of efficiency, economy, quality of care and access would *not* be considered by the State when it set payment rates because Section 32 nullifies the complex statutory calculation that is based on cost data reported by nursing facilities. The State's own documents prove this point. *See, e.g.*, OLR Major Issues Rep. at 17 (finding that Connecticut's "complex rate formula" has been rendered "moot" by the Stop Gain) (App. 2:397a); LPRI Rep. at 25-26 (finding that the Stop Gain has rendered the State's complex statutory calculation "pointless" because the Stop Gain has "eliminated the relationship between facilities' allowed costs and the Medicaid rate ultimately issued") (App. 2:319a-20a); Task Force Rep. at 8 (concluding that application of the Stop Gain means that Connecticut's payment system does not adequately reflect the actual costs of wages, benefits and staffing) (App. 2:368a); UConn Study at 31 (noting the Stop Gain's inherent flaws) (App. 2:387a). As explained by expert economic testimony submitted in support of CAHCF's motion, the Stop Gain is the "most fundamentally flawed" component of Connecticut's payment system because it "limits changes in reimbursement rates despite findings by the State of increased costs as measured by its own costing methodology." Harris Decl. ¶ 21 (App. 4:902a-03a).

Unfortunately, Connecticut is not the only State to have recently disregarded its legal obligations under § 1396a(a)(30)(A), as federal courts have recently enjoined California and Washington State from implementing similar revisions to their Medicaid payment methodologies. In *Independent Living II*, for example, the Ninth Circuit recently affirmed a district court decision preliminarily enjoining application of a California statute imposing a 10 percent across-the-board cut in Medicaid reimbursement for various types of providers. *See* 572 F.3d at 649. In doing so, the court of appeals examined the legislative record that accompanied the state statute and concluded that the rate cut had been enacted solely to reduce state spending. *See id.* at 652. As a

result, the Ninth Circuit agreed that the plaintiffs possessed a substantial likelihood of succeeding on their claim that the state statute was preempted by § 1396a(a)(30)(A). *See id.* at 657; *see also Santa Rosa Mem'l Hosp. v. Maxwell-Jolly*, No. 08-5173 SC, 2009 WL 3925498, at \*5 (N.D. Cal. Nov. 18, 2009) (granting motion for a preliminary injunction after finding that Medicaid rate cut for hospitals was based solely on state budgetary considerations) (App. 2:421a).

Similarly, a district court recently entered a temporary restraining order precluding Washington State from implementing revisions to a statutory device analogous to the Stop Gain. *See Washington Health Care Ass'n*, 2009 WL 2432005, at \*1 (App. 2:437a). Reimbursement rates for nursing facilities in Washington State are calculated on a facility-specific basis using a facility's costs. In 2009, however, Washington State enacted a rate reduction of approximately 10 percent by amending its so-called "budget dial." *See* 2009 Wash. Sess. Laws ch. 4, § 205(2). The budget dial, like the Stop Gain, is a statutory device that automatically limits reimbursement rates for nursing facilities so that total state spending does not exceed amounts appropriated by the state legislature. *See* Wash. Rev. Code § 74.46.421. The district court in *Washington Health Care Ass'n* issued a temporary restraining order precluding the State from implementing its statute after finding that the plaintiffs possessed a substantial likelihood of success on their claim that the statute conflicted with § 1396a(a)(30)(A). *See* 2009 WL 2432005, at \*1 (App. 2:437a).

As in *Independent Living II* and *Washington Health Care Ass'n*, the legislative record at issue here demonstrates beyond any doubt that Section 32's extension of the Stop Gain was the functional equivalent of a 10 percent rate cut, the sole purpose of which was to reduce state spending. *See, e.g.*, Tr. of Sept. 24, 2009 H.R. Proceedings at 4 (statement of Rep. Walker) (explaining in response to questioning that the rate cut imposed by Section 32 was "about 9 percent, but if you note in the fiscal note, the savings is 122 million in FY10 and 181 million in

FY11”) (App. 1:262a); Joint Favorable Report at 2 (statement of Dep’y DSS Comm’r Beaulieu (explaining that by extending the Stop Gain, Governor Rell’s proposal would “eliminate the rebasing of nursing home rates that would have resulted in a 9.64% increase in FY 2010 and a 3% inflationary adjustment in FY 2011 resulting in savings of \$115.3 million in FY 2010 and \$166.4 million in FY 2011”) (App. 1:116a). The legislative record also clearly demonstrates that, before making this drastic cut, the General Assembly had no responsible cost studies or objective data allowing it to assure that Medicaid-participating nursing facilities’ payment rates would bear a reasonable relationship to efficient and economical facilities’ costs of providing quality care, nor did the General Assembly consider objective data relating to efficiency, economy, quality of care or access, as required by § 1396a(a)(30)(A).

Therefore, like the plaintiffs in *Independent Living II* and *Washington Health Care Ass’n*, CAHCF possesses a substantial likelihood that it will succeed on its claim that Section 32 conflicts with the procedural requirement of § 1396a(a)(30)(A). *See also Arkansas Medical Society*, 6 F.3d at 529-31 (holding State violated § 1396a(a)(30)(A) by establishing payment rates without considering statutory factors).

**2. Section 32 Conflicts With The Substantive Requirement of 42 U.S.C. § 1396a(a)(30)(A)**

CAHCF also possesses a substantial likelihood of succeeding on its claim that Section 32 conflicts with the substantive requirement of § 1396a(a)(30)(A). *See Compl.* ¶¶ 181-84. To comply with § 1396a(a)(30)(A), a State must “set [Medicaid] reimbursement rates ‘that bear a reasonable relationship to efficient and economical [providers’] costs of providing quality services . . . .’” *Independent Living II*, 572 F.3d at 651 (quoting *Orthopaedic Hospital*, 103 F.3d at 1496). Section 32 violates § 1396a(a)(30)(A) because it completely divorces the per diem rates nursing

facilities receive from their Medicaid-allowable costs, which costs have already been limited by ceilings and other cost-control measures imposed by state law.

The State's own studies prove this point. The Stop Gain has "eliminated the relationship between facilities' allowed costs and the Medicaid rate ultimately issued." LPRI Rep. at 25-26 (App. 2:319a-20a). As the LPRI Committee explained:

Under Connecticut's rate-setting system, facilities submit cost reports, and a two-step process determines allowable costs to compute rates. First, DSS excludes costs not allowed under the Medicaid program, and then disallows costs above the cost ceilings in three of the five categories (direct care, indirect care, and administrative and general) in which costs are arrayed. The costs are then used to calculate per diem Medicaid rates. However, since FY 00, the stop gain provision has made this calculation pointless, since a flat rate increase percentage is merely applied to the prior year's rate to yield the new per diem issued to a facility. *In other words, the rate ultimately established has no connection to the costs submitted by the facility.*

*Id.* at 26 (emphasis added) (App. 2:320a); *see also* OLR Nursing Homes Rep. at 6 ("While the structure for limiting the costs the state will allow remains in statute, the legislature has essentially rendered it moot [through the Stop Gain].") (App. 2:394a); UConn Study at 31 (noting the Stop Gain's inherent flaws) (App. 2:387a). Because of the Stop Gain, Connecticut's payment system does not adequately reflect the actual costs of wages, benefits and staffing. Task Force Rep. at 8 (App. 2:368a).

Section 32's legislative history also demonstrates that Connecticut's Medicaid payments do not bear a reasonable relationship to efficient and economical providers' costs of providing quality services. For example, in testimony before several committees, DSS's chief rate-setting official admitted that the State's system for paying Medicaid-participating nursing facilities is entirely driven by state budgetary considerations, explaining: "Every year, we set the rates for the homes based on the formula and then, every home gets a computation based on the formula and statute and regulation. And then, at the end, we say 'okay, well, what did the legislature allow for

an increase [referring to the Stop Gain]?” Video Recording of May 18, 2009 Forum at 01:59:14-01:59:34 (statement of Mr. Richter).

Although the State’s own studies and Section 32’s legislative history demonstrate that Connecticut’s Medicaid payments do not bear a reasonable relationship to efficient and economical providers’ costs of providing quality services, that conclusion is further supported by application of the definition of efficiency and economy historically used by the State to validate its own payment methodology. In 1994, Connecticut assured the Federal Government that the payment methodology then in effect, which included a Stop Gain that allowed annual rate increases of up to 6 percent, paid the reasonable costs incurred by efficiently and economically operated nursing facilities. *See* Conn. State Plan Excerpts at TN 94-011 (App. 3:553a-55a). The Federal Government relied on DSS’s assurances to approve Connecticut’s use of the payment methodology then in effect. *See id.*

In its assurances, DSS defined efficiency and economy, saying that the “median is the standard by which efficient facilities are measured” and that “an economically operated facility’s rate should not have increased in total by more than 6% over the previous year’s rate . . . .” *Id.* (App. 3:554a). Stated differently, DSS justified its payment methodology by arguing that “efficient” facilities are those whose Medicaid-allowable costs are at or below the statewide median, whereas facilities whose Medicaid-allowable costs are above the statewide median are inefficient. *See id.* Because roughly 50 percent of all facilities at that time received payment rates that covered *all* of their Medicaid-allowable costs even after application of the 6 percent Stop Gain, DSS reasoned that its payment system complied with federal law. *See id.* (“With application of the 6% increase limitation provision, 78% [of nursing facilities] receive all of their direct costs, 68%

receive all of their indirect costs, 51% receive all of their administrative and general costs and virtually half of the facilities receive all of their costs.”) (App. 3:555a).<sup>13</sup>

Judged against DSS’s own historical standard for measuring efficiency and economy, Section 32 produces per diem rates that do not bear a reasonable relationship to efficient and economical providers’ costs of providing quality services. As explained by the expert analysis prepared for CAHCF by one of the most well respected and knowledgeable experts in the long-term care industry,<sup>14</sup> there are approximately 116 Medicaid-participating nursing facilities in Connecticut whose Medicaid-allowable costs are at or below the median of all providers. Lubarsky Decl. ¶ 32 (App. 4:879a). Of this group of nursing facilities, which by DSS’s own definition are efficiently operated, Section 32 causes an astounding 81 percent to be paid less than their Medicaid-allowable costs. *Id.* ¶ 33 (App. 4:879a). Moreover, on average these nursing facilities lose \$11.57 *for every day* of care or \$317,700 annually because of caring for Medicaid patients. *Id.* Clearly, payment methods and standards that produce such deficient reimbursement do not assure that payments are consistent with efficiency and economy, as required by § 1396a(a)(30)(A). *See also* Lubarsky Decl. ¶ 43 (explaining that 89 percent of Connecticut nursing facilities are paid on average \$20.92 per patient day, or more than \$550,000 annually, less than their Medicaid-allowable costs) (App. 4:883a).

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<sup>13</sup> To be clear, CAHCF does not adopt DSS’s historical efficiency and economy standard as its own. DSS’s historical standard is used for illustration purposes only.

<sup>14</sup> Connecticut’s analyses of its nursing facility payment system have often relied on the work of CAHCF’s expert. *See, e.g.*, UConn Study at 31 (App. 2:399a); LPRI Rep. at 1 n.1 (App. 2:295a); Office of Legis. Research, Conn. Gen. Assem., *Studies on Adequacy of Medicaid Reimbursements to Nursing Homes*, Rep. No. 2001-R-0728 at 1 (Nov. 8, 2001) (noting that rate-and-cost study performed by CAHCF’s expert “may become a seminal report on the topic”) (App. 2:388a); *see also* Lubarsky Decl. ¶ 7 (App. 4:870a) (discussing preparation of rate-and-cost studies that are used throughout the United States).

In sum, the substantive requirement of § 1396a(a)(30)(A) requires that Medicaid payment rates bear a reasonable relationship to efficient and economical providers' costs of providing quality services. The State and CAHCF's experts agree: Section 32 divorces the per diem rates nursing facilities receive in Connecticut from their Medicaid-allowable costs. As a result, Connecticut's per diem rates do not bear a reasonable relationship to efficient and economical providers' costs of providing quality services. Therefore, CAHCF possesses a substantial likelihood of success on its claim that Section 32 conflicts with the substantive requirement of § 1396a(a)(30)(A).

## **II. CAHCF MEMBERS WILL SUFFER IRREPARABLE HARM IN THE ABSENCE OF A PRELIMINARY INJUNCTION**

To satisfy the irreparable-harm requirement, the movant must demonstrate that, absent a preliminary injunction, "they will suffer an injury that is neither remote nor speculative, but actual and imminent, and one that cannot be remedied if a court waits until the end of trial to resolve the harm." *Faiveley Transp. Malmö AB v. Wabtec Corp.*, 559 F.3d 110, 118 (2d Cir. 2009). Such a showing is easily made in this case.

The injury to CAHCF's members is actual and imminent. The rate cut imposed by Section 32 was made effective immediately upon enactment. *See* Pub. Act No. 09-5, 2009 Gen. Assem., Sept. Sp. Sess. § 32 (Oct. 5, 2009) (App. 1:277a). On November 17, 2009, DSS mailed letters to many Medicaid-participating nursing facilities that include Rate Computation Reports detailing how Section 32 disregards a facility's Medicaid-allowable costs. With respect to just the seven illustrative facilities discussed above, for example, Section 32 has caused those facilities to receive a combined \$385,180.38 less per month than they would have received had Section 32 not been enacted. *See* App. 4:868a.

While such an amount may not appear significant in the abstract, it must be remembered that the rate cut imposed by Section 32 comes at a time when Connecticut's long-term care industry is already struggling to survive. As the State's own Long-Term Care Ombudsman explained after describing the significant number of nursing facilities that have recently been forced into bankruptcy or state receivership: "These are perilous times. They are challenging, difficult times for the Connecticut long term care industry and that translates into significantly critical times for long term care residents." Feb. 18, 2009 Hr'g Tr. at 70 (App. 1:27a); *see also* Mar. 3, 2009 Hr'g Tr. at 64-65 (statement of DSS's Mr. Richter) (conceding that extending the Stop Gain into FY 2010-2011 would put "pressure on the whole system. Clearly an increase would probably avoid problems for some homes") (App. 1:102a); *id.* at 65 (statement of Rep. Walker) ("I just see a perfect storm coming here. Baby boomers are aging. People are having many more illnesses and they're ending up in nursing homes or they need long-term care. . . . [H]ere we have the fragile industry sort of shaking in their boots because they're not sure whether they're going to make it day to day.") (App. 1:102a).

Moreover, the State itself admits that the Stop Gain will cost Connecticut nursing facilities over \$200 million in FY 2010-2011. *See* Tr. of Sept. 24, 2009 H.R. Proceedings at 4 (App. 1:262a). Further, the 89 percent of Connecticut nursing facilities who are paid less than the cost of service will, on average, each lose over \$555,000 solely on care provided to Medicaid patients. Lubarsky Decl. ¶¶ 29, 32 (App. 4:906a-07a). Even the 94 arguably most efficiently operated nursing facilities will each lose \$317,700 serving Medicaid patients. *Id.* ¶ 33.

Apart from whatever additional bankruptcies and state receiverships Section 32 will cause, the financial harm to CAHCF members constitutes irreparable harm because it cannot be remedied at a later date. For example, in *United States v. New York*, 708 F.2d 92 (2d Cir. 1983) (per cu-

riam), the Second Circuit was asked to review a district court's decision granting a preliminary injunction against state officials. In affirming the district court's irreparable-harm holding, the court of appeals explained that, "in deciding whether a federal plaintiff has an available remedy at law that would make injunctive relief unavailable, federal courts may consider only the available *federal* legal remedies." *See id.* at 93. There, as here, the Eleventh Amendment precluded the plaintiffs from seeking money damages from the State in federal court, and thus it did not matter that the plaintiffs' losses were pecuniary in nature. *See id.*

The Ninth Circuit recently applied these Second Circuit principles in granting preliminary injunctive relief to Medicaid providers who brought a Supremacy Clause challenge similar to this one. In *California Pharmacists Ass'n*, hospitals appealed a ruling that they were not entitled to a preliminary injunction stopping California from reducing Medicaid reimbursement. The district court had denied the hospitals relief because, inasmuch as their injury was only pecuniary, the hospitals had failed to demonstrate irreparable harm. *See* 563 F.3d at 849. In granting an emergency injunction to stop the rate cuts while the Ninth Circuit considered the merits of the hospitals' appeal, the court of appeals found that the hospitals had demonstrated they were likely to suffer irreparable harm. *See id.* at 850-52. Relying on the Second Circuit's decision in *United States v. New York*, *see id.* at 852 n.2, the Ninth Circuit held: "Because the economic injury doctrine rests only on ordinary equity principles precluding injunctive relief where a remedy at law is adequate, it does not apply where, as here, the [hospitals] can obtain no remedy in damages against the [S]tate because of the Eleventh Amendment," *id.* at 852.

As in *United States v. New York* and *California Pharmacists Ass'n*, the Eleventh Amendment prohibits this Court from awarding CAHCF members money damages should the Court ultimately decide that Connecticut's payment system conflicts with federal law. Therefore, as in

*United States v. New York and California Pharmacists Ass'n*, CAHCF members face the threat of imminent irreparable harm justifying preliminary injunctive relief.<sup>15</sup>

### III. THE COURT SHOULD WAIVE RULE 65'S SECURITY REQUIREMENT

Rule 65(c)'s security requirement may be waived in cases involving enforcement of public interests arising out of the Medicaid Act. *See Pharmaceutical Society*, 50 F.3d at 1174-75 (affirming district court's decision to waive Rule 65's security requirement in challenge brought by trade association representing pharmacists who alleged that certain state statutes conflicted with the Medicaid Act and deprived them of full compensation). The reasoning of *Pharmaceutical Society* applies with equal force here. Therefore, in granting CAHCF's motion for a preliminary injunction, the Court should waive Rule 65's security requirement.

### CONCLUSION

For the foregoing reasons, CAHCF respectfully requests that the Court enter an order (1) preliminarily enjoining Governor Rell and her agents from implementing Section 32; (2) instructing Governor Rell and her agents to immediately begin using the payment methodology contained in section 17b-340 of the Connecticut General Statutes that existed prior to the enactment of Section 32, unless the use of that methodology would produce facility-specific per diem rates less than the per diem rates produced by Section 32, in which event such facilities should

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<sup>15</sup> The Second Circuit's standard for awarding preliminary injunctive relief does not require a court to balance the equities or to consider the public interest. *See, e.g., VIP of Berlin*, 2010 WL 252292, at \*4. However, even if this Court were to consider these additional factors, the balance of the equities tips in CAHCF's favor and the public interest favors issuing a preliminary injunction. *See, e.g., Independent Living II*, 572 F.3d at 658-59 (rejecting State's argument that budget crisis controlled balance-of-equities and public-interest inquiries, explaining: "A budget crisis does not excuse ongoing violations of federal law, particularly when there are no adequate remedies available other than an injunction."); *California Pharmacists Ass'n*, 563 F.3d at 852-53 (finding it "would not be equitable or in the public's interest to allow the state to continue to violate the requirements of" § 1396a(a)(30)(A) because the "interest of preserving the Supremacy Clause is paramount").

receive the higher per diem rate produced by Section 32; and (3) waiving the security requirement of Rule 65(c).<sup>16</sup>

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Respectfully submitted,

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<sup>16</sup> By seeking relief tailored in this fashion, CAHCF does not concede that the underlying payment methodology nullified by Section 32 complies with federal law. *See, e.g.*, Harris Decl. ¶¶ 29-53 (explaining fundamental flaws in several components of underlying payment methodology) (App. 4:906a-19a). Instead, CAHCF has focused its motion on the single component of Connecticut's payment system (i.e., the Stop Gain as extended by Section 32) that most obviously conflicts with federal law. Furthermore, CAHCF's proposed order (App. 4:947a) has been drafted to ensure that, for those few nursing facilities that receive higher rates because of the Stop Gain, CAHCF's motion maintains the *status quo ante* in order not to harm any such facility.