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 (PCD)
v.	:	April 9, 2010
M. JODI RELL, in her official capacity as Governor of the State of Connecticut,	:	
Defendant.	:	

CONSOLIDATED REPLY IN SUPPORT OF PLAINTIFF'S MOTION FOR A PRELIMINARY INJUNCTION AND OPPOSITION <u>TO DEFENDANT'S MOTION TO DISMISS</u>

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Plaintiff Connecticut Association of Health Care Facilities, Inc. ("CAHCF") respectfully submits this Consolidated Reply in Support of Plaintiff's Motion for a Preliminary Injunction and Opposition to Defendant's Motion to Dismiss.

PRELIMINARY STATEMENT

Rather than address the facts and binding Second Circuit precedent on which this case must be resolved, the overarching message of the briefs filed in this matter by Defendant M. Jodi Rell ("Governor Rell") is that nursing facilities in Connecticut are greedy. For example, Governor Rell repeatedly uses the word "for-profit" as if it is a four-letter word. She contends that CAHCF is an association whose membership is comprised solely of "for-profit" nursing facilities. Def.'s Mem. Opp'n Pl.'s Mot. Prelim. Inj. at 1 [Doc. No. 40] ("Def.'s Opp'n"); Def.'s Mem. Supp. Mot. Dismiss at 1 [Doc. No. 39-1] ("Def.'s Mem.").

Not only is Governor Rell factually incorrect, the proprietary status of CAHCF's members has nothing to do with the legal issues presented by this case. Furthermore, the brief *amicus curiae* filed by the Connecticut Association of Not-For-Profit Providers For the Aging, Inc. ("CANPFA") confirms that, as amended by section 32 of Public Act 09-5 ("Section 32"),[1] the State's illegal payment methodology for Medicaid-participating nursing facilities does not discriminate based on a facility's for-profit or not-for-profit status. *See* CANPFA Br. at 2 [Doc. No. 37]; *see also* Mem. of New England Health Care Employees Union, Dist. 1199, SEIU as

[1] Pub. Act No. 09-5, 2009 Gen. Assem., Sept. Sp. Sess. § 32 (Conn. Oct. 5, 2009) (Pl.'s App. 1:277a-82a). References to "Pl.'s App." are to CAHCF's four-volume appendix of exhibits [Doc. Nos. 15-3 to 15-13] submitted in support of CAHCF's Motion for a Preliminary Injunction. References to "Pl.'s Reply App." are to the one-volume appendix of exhibits submitted in support of this consolidated brief. References to "Def.'s App." are to Governor Rell's appendix of exhibits [Doc. Nos. 40-1 to 40-4] submitted in conjunction with her opposition to CAHCF's Motion for a Preliminary Injunction. Finally, references to "Def.'s Stat. App." are to Governor Rell's statutory and legislative appendix [Doc. Nos. 39-3 to 39-4] submitted in support of her Motion to Dismiss.

Amicus Curiae in Supp. of Pl. at 3 [Doc. No. 31] (arguing that State's illegal payment system "has made a mockery of the Union's rights under federal labor laws to engage in meaningful collective bargaining").

Governor Rell ignores Second Circuit precedent demonstrating that CAHCF is entitled to an order preliminarily enjoining the continued implementation of Section 32. That precedent instructs that Medicaid providers can sue state officials for injunctive relief under the Supremacy Clause, which nullifies any state statute that conflicts with the Medicaid Act. *See Pharmacists 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); *Catholic Med. Ctr. of Brooklyn & Queens, Inc. v. Rockefeller*, 430 F.2d 1297, 1298 (2d Cir. 1970) (per curiam). Second Circuit precedent also provides that, where, as here, the Eleventh Amendment precludes a federal court from awarding retroactive money damages should the movant ultimately succeed on the merits of its legal claims, the risk of pecuniary harm to the movant constitutes irreparable harm. *See United States v. New York*, 708 F.2d 92, 93 (2d Cir. 1983) (per curiam). Governor Rell never mentions *Pharmacists Society*, *Catholic Medical Center* or *United States v. New York*. Try as she might to paint this case as one based on a novel legal theory recently concocted by the Ninth Circuit, the inescapable truth is that CAHCF's motion is well grounded in binding Second Circuit precedent.

Connecticut has promised to comply with federal law in order to receive billions of dollars in federal Medicaid funds. The provision of federal law at issue in CAHCF's motion instructs that the State must "*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 for medical assistance ("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) (emphases added) (Pl.'s App. 1:2a). Existing precedent and appellate briefs recently filed by the Centers for Medicare & Medicaid Services ("CMS") confirm that the actual cost of providing quality care is the essential predicate for establishing a Medicaid payment system that "assure[s] . . . 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." *Id.* Governor Rell's contention that cost is completely irrelevant and that States have unfettered discretion to set payment rates has been repeatedly rejected by the judiciary and CMS.

Contrary to Governor Rell's inaccurate rhetoric, CAHCF has never asked this Court to impose a payment system that would "reimburse each facility's full costs." Def.'s Opp'n at 1. CAHCF recognizes that § 1396a(a)(30)(A)'s plain language allows a state payment system to include reasonable incentives to promote efficiency and economy. Section 32, however, conflicts with § 1396a(a)(30)(A) because, by precluding the rebasing of rates as otherwise required by state law, Section 32 renders moot the underlying payment methodology contained in section 17b-340 of the Connecticut General Statutes. By mooting that process in favor of a payment system based solely on state budgetary concerns, Section 32 assures that Medicaid payments bear no relationship to nursing facilities' costs of providing quality care, to efficiency or to economy. Governor Rell does not refute this essential fact, nor can she given the record of state-sponsored studies that have repeatedly found that Connecticut's payment rates are completely divorced from the cost of providing quality care. Governor Rell makes no effort to address these studies, nor does she make any effort to rebut the expert testimony submitted by CAHCF.

The Court should grant CAHCF's motion and deny Governor Rell's Motion to Dismiss.

ARGUMENT

I. THE COURT SHOULD GRANT CAHCF'S MOTION FOR A PRELIMINARY INJUNCTION

A. CAHCF Has Demonstrated A Substantial Likelihood Of Success On The Merits Of Its Supremacy Clause Claims

1. Governor Rell's *Ex parte Young* Argument Has No Merit

"In determining whether the doctrine of *Ex parte Young* avoids an Eleventh Amendment bar to suit," the Supreme Court has explained that a court "need only conduct a straightforward inquiry into whether the complaint alleges an ongoing violation of federal law and seeks relief properly characterized as prospective." *Verizon Md. Inc. v. Pub. Serv. Comm'n of Md.*, 535 U.S. 635, 645 (2002) (internal quotations and brackets omitted). CAHCF's complaint easily satisfies this "straightforward inquiry." *See* Compl. ¶ 14. Governor Rell makes no argument to the contrary. Instead, she claims that CAHCF should have sued some other state official she chooses not to name. According to Governor Rell, CAHCF "challenges the constitutionality of a state law" that Governor Rell "has no *specific* duty to enforce." Def.'s Mem. at 2 (emphasis added). For this reason alone, Governor Rell contends that CAHCF's motion should be denied, Def.'s Opp'n at 1 n.1, although she suggests that CAHCF "can cure the Eleventh Amendment defect by filing an amended complaint naming a proper defendant," Def.'s Mem. at 5.

Governor Rell's *Ex parte Young* argument is without merit. The Court in *Ex parte Young* explained that, "[i]n making an officer of the State a party defendant in a suit to enjoin the enforcement of an act alleged to be unconstitutional," the state officer need only have "*some* connection with the enforcement of the act" in question. *Ex parte Young*, 209 U.S. 123, 157

(1908) (emphasis added). Whether this connection "arises out of general law, or is specially created by the act itself, is not material so long as it exists." *Id.*

Although the Second Circuit appears not to have decided this exact issue, it has decided multiple Medicaid-related cases similar to this one in which a governor was named as a defendant, all without noting any *Ex parte Young* jurisdictional problem. *See, e.g.*, *Conn. Hosp. Ass'n v. Weicker*, 46 F.3d 211 (2d Cir. 1995); *Catholic Medical Center*, 430 F.2d 129; *see also Wilder v. Va. Hosp. Ass'n*, 496 U.S. 498 (1990). Furthermore, this Court's decision in *Reynolds v. Blumenthal*, No. 3:04-cv-218 (PCD), 2006 WL 2788380 (D. Conn. Sept. 26, 2006) (Pl.'s Reply App. 56a-66a), counsels that Governor Rell's *Ex parte Young* argument should be rejected.

In *Reynolds*, a disgruntled former power plant employee sued various state officials. The plaintiff claimed that he was entitled to injunctive relief under *Ex parte Young*; however, the relief the plaintiff sought was an injunction instructing that the plaintiff be reinstated to his former job, something the state officials had no authority to do. *See id.* at *8 (Pl.'s Reply App. 63a). This Court explained that, under the doctrine of *Ex parte Young*, "federal courts may 'enjoin state officials to conform future conduct to the requirements of federal law.'" *Id.* at *7 (quoting *Rosie D. v. Swift*, 310 F.3d 230, 234 (1st Cir. 2002)) (Pl.'s Reply App. 62a). "For the *Ex parte Young* exception to apply, however, a plaintiff seeking prospective injunctive relief must be seeking such relief from a state official who has a direct connection to, or responsibility for, the alleged illegal action." *Id.* (Pl.'s Reply App. 63a). Because the plaintiff failed to demonstrate the requisite connection or responsibility, this Court granted the state officials' motion to dismiss. *Id.* at *9 (Pl.'s Reply App. 63a).

Unlike the state officials in *Reynolds*, Governor Rell undoubtedly has a direct connection to, or responsibility for, the alleged illegal actions at issue in this case. As detailed by CAHCF's

complaint (¶¶ 77-168) and in CAHCF's moving brief (at 14-22), the alleged illegal actions in this case include Governor Rell's use of the state budgetary process to amend the Stop Gain in order to ensure that the State's payment system bears no reasonable relationship to the cost of providing quality nursing facility services in an economic and efficient manner. *See also* Office of Fiscal Analysis, Conn. Gen. Assem., *State Budget Process* (explaining that governor is catalyst for state budgetary process) (Pl.'s App. 2:408a). Moreover, the state agency responsible for the day-to-day operation of Connecticut's Medicaid program, the Connecticut Department of Social Services ("DSS"), is an Executive Branch agency directly responsible to, and under the direction of, Governor Rell. *See* Conn. Gen. Stat. §§ 3-1 ("The supreme executive power of the state shall be vested in the Governor. [S]he may, personally or through any authorized agent, . . . take any proper action concerning[] any matter involving the enforcement of the laws of the state."), 17b-1(a) (explaining that Commissioner of DSS "shall be appointed by the Governor").

As such, Governor Rell cannot be heard to complain that in her role as governor, she has no direct connection to, or responsibility for, the alleged illegal actions in this case, nor is there any question that in her role as the State's chief executive officer, she has the unquestioned authority to implement the relief requested by CAHCF's motion. *See Luckey v. Harris*, 860 F.2d 1012, 1015-16 (11th Cir. 1988) (finding that governor was proper party defendant under *Ex parte Young* because governor was constitutionally "charged with executing the laws faithfully"); Conn. Const. art. IV, § 12 ("[The governor] shall take care that the laws be faithfully executed.").

Accordingly, the Court should reject Governor Rell's *Ex parte Young* argument.[2]

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[2] Contemporaneously with the filing of this consolidated response, CAHCF has filed an unopposed motion under Rule 21 to add Michael P. Starkowski, in his official capacity as Commissioner of Social Services, as a defendant in this action to ensure that the Court's consideration of this issue will not affect the Court's ability to grant preliminary injunctive relief (continued)

2. CAHCF's Supremacy Clause Claims Rest On Second Circuit Precedent, Which Governor Rell Ignores Completely

"[W]hen the state law stands as an obstacle to the accomplishment and execution of the full purposes and objectives of Congress," the Supremacy Clause provides that the state law is null and void. *P. Capital Bank v. Connecticut*, 542 F.3d 341, 351 (2d Cir. 2008) (internal citations and quotations omitted). Despite Governor Rell's intimations, neither this legal concept nor its application to cases implicating the Medicaid Act are recent inventions of the Ninth Circuit. As CAHCF's moving brief explained in detail (at 26), the law of this Circuit instructs that the Supremacy Clause preempts a state statute when the state statute conflicts with the Medicaid Act's provision specifying the required contents of State Plans, of which § 1396a(a)(30)(A) is one part. *See Catholic Medical Center*, 430 F.2d 1297; *cf. Pharmacists Society*, 50 F.3d at 1172.

Governor Rell makes no effort to distinguish *Catholic Medical Center* or *Pharmacists Society*. Instead, she uses two strategies in an attempt to confuse the issue, both of which should be rejected.

First, Governor Rell cites a concurring opinion written by Justice Kennedy, arguing that CAHCF must show that Section 32 and § 1396a(a)(30)(A) are "in 'irreconcilable' conflict such that the Connecticut law 'directly contradict[s]' one of Medicaid's 'primary objectives as conveyed with clarity in the federal legislation.'" Def.'s Opp'n at 12 (quoting *Gade v. Nat'l Solid Waste Mgmt. Ass'n*, 505 U.S. 88, 110 (1992) (Kennedy, J., concurring)) (brackets supplied by Governor Rell). That, however, is not the applicable standard for conflict preemption.

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in a timely manner. As explained more fully in that motion, there can be no doubt that Commissioner Starkowski is a proper party defendant under *Ex parte Young*.

As demonstrated by *Catholic Medical Center* and *Pharmacists Society*, the Supremacy Clause preempts a state statute that stands as an obstacle to the accomplishment and execution of the full purposes and objectives of Congress, even when the federal statute in question happens to be the Medicaid Act. *See Catholic Medical Center*, 430 F.2d 1297; *Pharmacists Society*, 50 F.3d at 1172. Moreover, even if Justice Kennedy's concurrence in *Gade* did represent the applicable legal standard, Section 32 and § 1396a(a)(30)(A) *are* in irreconcilable conflict because Section 32 directly contradicts one of the primary objectives expressed by § 1396a(a)(30)(A)'s plain language: namely, that in order to receive federal funds, a State must assure that its Medicaid payments are consistent with efficiency, economy, quality of care and equality of access, something Section 32 precludes.

Second, Governor Rell cites the Supreme Court's decision in *New York State Department of Social Services v. Dublino*, 413 U.S. 405 (1973), for the proposition that, "[i]n the context of a cooperative federal-state program such as Medicaid," state law "cannot be preempted absent a 'direct and unambiguous' instruction from Congress." Def.'s Opp'n at 12-13 (quoting *Dublino*, 413 U.S. at 413-14). *Dublino* is readily distinguishable from this case. The *Dublino* Court was asked to decide whether a state statute that supplemented the federal requirements for persons seeking certain welfare benefits was implicitly preempted because the federal statute contained no such requirements. *See* 413 U.S. at 406-07. In finding that the state statute was not pre-empted, the Court explained that, at the time of the federal statute's enactment, dozens of States had already enacted requirements similar to the ones being challenged. *See id.* at 414. "If Congress had intended to pre-empt state plans and efforts in such an important dimension of" the federal-state welfare program in question, the Court held that "such intentions would in all likelihood have been expressed in direct and unambiguous language." *Id.* at 414.

Here, in contrast, the federal statute in question expresses "in direct and unambiguous language" what States must do in order to receive federal Medicaid funds: "[a] State plan for medical assistance *must* . . . *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) (emphasis added). Therefore, unlike the federal statute at issue in *Dublino*, which was completely silent on whether the State had a particular legal duty to act or refrain from acting, the federal statute at issue here expressly instructs the State how it "must" act in order to receive federal funds.[3]

The Second Circuit precedent that Governor Rell fails to address teaches that § 1396a(a)(30)(A) provides a basis for the Supremacy Clause challenge here. *See Catholic Medical Center*, 430 F.2d at 1298 (affirming district court's conclusion that state statute was preempted by former provision of the Medicaid Act, 42 U.S.C. § 1396a(a)(13)(D) (Supp. IV 1969), which commanded that State Plans "must . . . provide . . . for payment of the reasonable cost . . . of inpatient hospital services provided under the plan"); *Pharmacists Society*, 50 F.3d at 1172 (holding that, "to the extent that the State's co-payment system results in the reduction of [Medicaid] payments to pharmacists as a result of non-payment of co-payments, it is preempted by" a provision of the Medicaid Act, 42 U.S.C. § 1396r-8(e), which requires that, in order to receive federal funds, a State "may not reduce the payment" for certain pharmaceuticals); *accord*

[3] Another Supreme Court decision that Governor Rell relegates to a footnote (Def.'s Opp'n at 13 n.4) is also distinguishable. *See Nw. Cent. Pipeline Corp. v. State Corp. Comm'n*, 489 U.S. 493, 509 (1989) (holding that federal statute did not preempt state regulation because state regulation governed "a field that Congress expressly left to the States"). As in *Catholic Medical Center* and *Pharmacists Society*, the mandatory language of § 1396a(a)(30)(A) instructs that ensuring Medicaid payments are consistent with efficiency, economy, quality of care and access is *not* a field that Congress expressly left to the States.

Lankford v. Sherman, 451 F.3d 496, 510 (8th Cir. 2006) ("While Medicaid is a system of cooperative federalism, the same [conflict preemption] analysis applies; once the state voluntarily accepts the conditions imposed by Congress, the Supremacy Clause obliges it to comply with federal requirements."); *Planned Parenthood of Houston & Se. Tex. v. Sanchez*, 403 F.3d 324, 337 (5th Cir. 2005) (explaining that, in the context of conflict preemption, "State participation in federal funding programs is voluntary, but once a state has accepted federal funds, it is bound by the strings that accompany them").

Amazingly, in spite of *Catholic Medical Center*, Governor Rell argues that, "while courts on occasion have entertained Medicaid preemption challenges to state laws and actions *not* embodied in a state plan, there is no basis for such a challenge when the state law has been or will be reviewed and approved (or not) as part of the state plan." Def.'s Mem. at 21-22. Governor Rell's argument simply disregards the law of this Circuit. *Catholic Medical Center* specifically endorsed a preemption challenge to a state statute even though the state statute was to be implemented through a State Plan amendment. *See Catholic Med. Ctr. of Brooklyn & Queens, Inc. v. Rockefeller*, 305 F. Supp. 1268, 1269 (E.D.N.Y. 1969) (discussing correspondence between federal authorities and state officials regarding State Plan amendment seeking to implement state statute being challenged), *aff'd per curiam*, 430 F.2d at 1298. Not even the district court decision Governor Rell cites supports her argument. *See Minn. Pharmacists Ass'n v. Pawlenty*, --- F. Supp. 2d ---, Civil No. 09-2723, 2010 WL 561473, at *17 (D. Minn. Feb. 10, 2010) (finding that, although CMS approval of proposed State Plan amendment being challenged weighed against granting preliminary injunction on Supremacy Clause claim, that underlying legal claim was valid and would be allowed to proceed despite State's motion for judgment on the pleadings) (Pl.'s Reply App. 51a).

Accordingly, CAHCF's Supremacy Clause claims are well grounded in the law of the Second Circuit, which Governor Rell ignores completely. Her arguments based on *Dublino* and Justice Kennedy's concurrence in *Gade* should therefore be rejected.

The same must be said of Governor Rell's reliance on *Seminole Tribe of Florida v. Florida*, 517 U.S. 44 (1996). In *Seminole Tribe*, the Court cautioned that, "where Congress has prescribed a detailed remedial scheme for the enforcement against a State of a statutorily created right, a court should hesitate before casting aside those limitations and permitting an action against a state officer based upon *Ex parte Young*." 517 U.S. at 74. According to Governor Rell, "this case is governed by *Seminole Tribe*, and the congressional determination that the Medicaid Act does not confer concrete, definitive rights on providers to challenge their rates should be respected." Def.'s Mem. at 21.

This case calls for no hesitation under *Seminole Tribe*. Every appellate court that has decided the issue has found that the reasoning of *Seminole Tribe* does *not* apply in the Medicaid Act context. *See Antrican v. Odom*, 290 F.3d 178, 190 (4th Cir. 2002) (holding that "the Medicaid Act does not provide the type of detailed remedial scheme that would supplant an *Ex parte Young* action"); *Westside Mothers v. Haveman*, 289 F.3d 852, 862 (6th Cir. 2002) (holding that the Medicaid Act provision allowing reduction of funds to noncompliant States "is not a detailed 'remedial' scheme sufficient to show Congress's intent to preempt an action under *Ex parte Young*"); *see also Rosie D. v. Swift*, 310 F.3d 230, 237 (1st Cir. 2002) (rejecting similar argument). Even apart from this weight of authority is the fact that Governor Rell makes no effort to demonstrate that the Medicaid Act's review provisions are in anyway similar to those at issue in *Seminole Tribe*, where the federal statute in question greatly limited judicial review of disputes between tribes and States related to gaming compacts—so much so that federal courts

could not order States to do anything against their will. *See* 517 U.S. at 49-50, 73-74. Accordingly, Governor Rell's *Seminole Tribe* argument should be rejected.

3. Recent Ninth Circuit Decisions Preliminarily Enjoining State Statutes Similar To Section 32 Are Not "An Aberration," But Are Based On Second Circuit Precedent

In its moving brief (at 30-31), CAHCF explained that several recent decisions from the Ninth Circuit have preliminarily enjoined budget-driven payment systems similar to the one at issue here. The weight of that authority has only grown since CAHCF filed its moving brief. *See, e.g.*, *Cal. Pharmacists Ass'n v. Maxwell-Jolly*, 596 F.3d 1098, 1106-07 (9th Cir. 2010) ("*California Pharmacists II*") (holding that if state legislature is responsible for setting Medicaid payment rates, the state legislature must study the "statutory factors of efficiency, economy, quality of care, and access to care *prior to* setting or adjusting payment rates") (Pl.'s Reply App. 13a), *petition for cert. filed*, --- U.S.L.W. --- (U.S. Mar. 24, 2010) (No. 09-1158); *Dominguez v. Schwarzenegger*, 596 F.3d 1087, 1097-98 (9th Cir. 2010) (affirming district court's finding of irreparable harm in § 1396a(a)(30)(A) challenge brought under Supremacy Clause where Medicaid providers "would be unable to recover due to the State's Eleventh Amendment immunity") (Pl.'s Reply App. 30a); *Indep. Living Ctr. of S. Cal., Inc. v. Maxwell-Jolly*, No. 09-55692, 2010 WL 737650, at *1 (9th Cir. Mar. 3, 2010) (mem.) (rejecting argument that state legislature complied with § 1396a(a)(30)(A) where agenda to legislative committee meeting merely contained one-sentence reference to private study that found Medicaid payments for certain pharmaceuticals exceeded cost) (Pl.'s Reply App. 35a-36a).

Governor Rell claims that *Independent Living* and its progeny are "an aberration" that this Court should ignore. Def.'s Opp'n at 13. She neglects to point out, however, that this supposed "aberration" is based on Second Circuit precedent. Indeed, the Ninth Circuit's seminal

Independent Living decision relied on several Second Circuit rulings in finding that the right of private parties to seek injunctive relief under the Supremacy Clause exists regardless of whether the allegedly preemptive statute confers any federal "rights" enforceable under 42 U.S.C. § 1983. *See Indep. Living Ctr. of S. Cal., Inc. v. Shewry*, 543 F.3d 1050, 1059 (9th Cir. 2008) ("*Independent Living I*") (citing *Village of Westfield v. Welch's*, 170 F.3d 116, 124 n.4 (2d Cir. 1999), and *Burgio & Campofelice, Inc. v. N.Y. State Dep't of Labor*, 107 F.3d 1000, 1005-07 (2d Cir. 1997)), *cert. denied sub nom. Maxwell-Jolly v. Indep. Living Ctr. of S. Cal., Inc.*, 129 S. Ct. 2828 (2009). Therefore, despite her repeated attempts to do so, Governor Rell cannot marginalize *Independent Living* and its progeny simply by characterizing this line of persuasive authority as the product of some rouge Ninth Circuit panel. To do so is to disregard the fact that *Independent Living* and its progeny are built on a solid foundation of decisions issued by the Supreme Court and the First, Second, Third, Fifth, Seventh, Eighth, Tenth and D.C. Circuits. *See Independent Living I*, 543 F.3d at 1055-64 (canvassing Supreme Court and circuit precedent).

Nor is Governor Rell correct in her suggestion that a 2006 Second Circuit decision precludes CAHCF's Supremacy Clause claims. In *New York Ass'n of Homes & Services for the Aging, Inc. v. DeBuono* ("*NYAHSA II*"), 444 F.3d 147, 148 (2d Cir. 2006) (per curiam), the Second Circuit issued a short opinion adopting the district court's decision. In relevant part, the district court's decision explained that § 1396a(a)(30)(A) "mandates that States provide methods and procedures . . . to assure that any reimbursement rates it pays to providers are consistent with what is needed by facilities to maintain efficient, economic, and quality care." *In re NYAHSA Litig.*, 318 F. Supp. 2d 30, 32 (N.D.N.Y. 2004) ("*NYAHSA I*"). The aspect of *NYAHSA* upon which Governor Rell relies found that § 1396a(a)(30)(A) does not confer federal "rights" on Medicaid providers that are enforceable under § 1983. *See NYAHSA I*, 318 F. Supp. 2d at 39-40.

Importantly, *NYAHSA* did not involve claims for injunctive relief based on the Supremacy Clause. As a result, a long line of Second Circuit precedent demonstrates that *NYAHSA*'s holding with respect to § 1983 has no bearing on CAHCF's Supremacy Clause claims.[4] Rulings from outside the Second Circuit are to the same effect.[5]

4. Governor Rell's Illogical Argument Based On The Repeal Of The Boren Amendment Has Been Rejected By Several Appellate Courts And CMS

According to Governor Rell, one statement in a congressional report demonstrates that Congress intended to foreclose any meaningful enforcement of § 1396a(a)(30)(A) when, in 1997, Congress repealed a different statutory provision commonly known as the Boren Amendment, 42

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[4] *See, e.g.*, *Air Transp. Ass'n of Am., Inc. v. Cuomo*, 520 F.3d 218, 221 (2d Cir. 2008) ("The distinction between a statutory claim and a Supremacy Clause claim, although seemingly without a difference in this particular context, is important and is not a trifling formalism."); *Loyal Tire & Auto Ctrs., Inc. v. Town of Woodbury*, 445 F.3d 136, 149 (2d Cir. 2006) (acknowledging difference between claims for injunctive relief rooted in the Supremacy Clause and § 1983 claims); *Welch's*, 170 F.3d at 124 n.4 (holding that a cause of action under the Supremacy Clause "do[es] not depend on the existence of a private right of action under the [preempting statute]"); *Burgio*, 107 F.3d at 1005-07 (holding that plaintiff could assert preemption claims based on federal statute even though it was "beyond dispute" that plaintiff fell outside the statute's express enforcement provisions); *W. Air Lines, Inc. v. Port Auth. of N.Y. & N.J.*, 817 F.2d 222, 225-26 (2d Cir. 1987) (explaining that Second Circuit's earlier holding that a private party has no implied right of action to enforce the substantive provisions of a federal statute had no bearing on whether a private party could assert claims for injunctive relief under the Supremacy Clause based on the same federal statute).

[5] *See, e.g.*, *Independent Living I*, 543 F.3d at 1063 (rejecting identical argument made by State based on previous circuit precedent under § 1983); *Lankford v. Sherman*, 451 F.3d 496, 509 (8th Cir. 2006) ("Preemption claims are analyzed under a different test than section 1983 claims, affording plaintiffs an alternative theory for relief when a state law conflicts with a federal statute or regulation."); *Minnesota Pharmacists Ass'n*, 2010 WL 561473, at *13 ("Because the [§ 1983] test for enforceable individual rights does not apply in the preemption context, an action under the Supremacy Clause alleging that a State Medicaid plan conflicts with federal law is not precluded by decisions holding that no enforceable individual rights exist under [§ 1396a(a)(30)(A)].").

U.S.C. § 1396a(a)(13)(A) (1996). *See* Def.'s Mem. at 9, 19. As set forth below, Governor Rell's argument is illogical and has been universally rejected.

The Boren Amendment required a State to make various "findings" and "assurances" in order to receive federal approval of any change in the State's Medicaid payment methods and standards. *See* 42 U.S.C. § 1396a(a)(13)(A) (1996).[6] Congress repealed the Boren Amendment in 1997, replacing it with a series of public notice requirements. *See* Balanced Budget Act of 1997, Pub. L. No. 105-33, § 4711(a), 111 Stat. 489, 507-08 (Def.'s Stat. App. Ex. 5).[7]

Although the legislation repealing the Boren Amendment did not alter the language of § 1396a(a)(30)(A), one statement in a committee report that accompanied the 1997 legislation opined that it was the "Committee's intention that, following enactment of this Act, neither this nor any other provision of [42 U.S.C. § 1396a] will be interpreted as establishing a cause of action for hospitals and nursing facilities relative to the adequacy of the rates they receive." H.R. Rep. No. 105-149, at 591 (1997) (Def.'s Stat. App. Ex. 9). This single statement serves as the

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[6] One such "finding" required that a State objectively determine that it paid for services using rates that were "reasonable and adequate to meet the costs that must be incurred by efficiently and economically operated providers to provide services in conformity with applicable State and Federal laws . . . ." 42 U.S.C. § 1396a(a)(13)(A) (1996). In *Wilder v. Virginia Hospital Ass'n*, 496 U.S. 498 (1990), the Supreme Court held that the Boren Amendment created federal "rights" that Medicaid providers could enforce using § 1983. Moreover, the Court held that providers could challenge not only the procedural aspects of the Boren Amendment (i.e., whether the State actually submitted its findings and assurances to the Federal Government), but also the substance of a State's assurances that its payment rates were reasonable and adequate. *See* 496 U.S. at 513-15.

[7] In place of the Boren Amendment, the Medicaid Act now requires that a state plan "provide for a public process for determination of rates of payment under the plan for . . . nursing facility services . . . under which—(i) proposed rates, the methodologies underlying the establishment of such rates, and justifications for the proposed rates are published, (ii) providers, beneficiaries and their representatives, and other concerned State residents are given a reasonable opportunity for review and comment on the proposed rates, methodologies, and justifications, [and] (iii) final rates, the methodologies underlying the establishment of such rates, and justifications for such final rates are published. . . ." 42 U.S.C. § 1396a(a)(13)(A) (2006).

linchpin of Governor Rell's argument regarding the meaning of the statute actually at issue in CAHCF's motion, § 1396a(a)(30)(A). *See* Def.'s Mem. at 9, 19.

There are several fundamental flaws with Governor Rell's argument. First, it is based on one isolated statement in one committee report from a Congress that did not enact or otherwise amend § 1396a(a)(30)(A). The law of this Circuit already instructs that § 1396a(a)(30)(A) "was not affected by repeal of the Boren Amendment." *NYAHSA I*, 318 F. Supp. 2d at 32, *aff'd per curiam*, 444 F.3d at 148. Instead, § 1396a(a)(30)(A) has independent meaning and significance, "mandat[ing] that States provide methods and procedures . . . to assure that any reimbursement rates it pays to providers are consistent with what is needed by facilities to maintain efficient, economic, and quality care." *NYAHSA I*, 318 F. Supp. 2d at 32. Therefore, the intent of unnamed committee staff from 1997 is of no relevance to the legal issues presented by CAHCF's motion. "Even for those disposed to allow the meaning of a statute to be determined by a single committee," the 1997 report is "utterly irrelevant, since it was not prepared in connection with" the legislation giving § 1396a(a)(30)(A) its current form. *Vt. Agency of Natural Res. v. United States ex rel. Stevens*, 529 U.S. 765, 783 n.12 (2000).

Second, even if the Court were inclined to wade into a thicket of legislative history in order to interpret § 1396a(a)(30)(A)'s plain language, the legislative history that is actually relevant to § 1396a(a)(30)(A) cuts against Governor Rell. In 1981, for example, Congress altered the language of § 1396a(a)(30)(A). *See* Omnibus Budget Reconciliation Act of 1981, Pub. L. No. 97-35, § 2174(a), 95 Stat. 483, 809 (Pl.'s Reply App. 2a). A committee report that accompanied that legislation explained that changes to State Plans "that would affect the rights of Medicaid beneficiaries *or participating providers* would be subject to approval by the Secretary, who must confirm that the State's program will continue to be operated in a lawful

manner. *Of course, in instances where the States or the Secretary fail to observe these statutory requirements, the courts would be expected to take appropriate remedial action*." H.R. Rep. No. 97-158, vol. II, at 301 (1981) (emphasis added) (Pl.'s Reply App. 4a). Such "remedial action" is what CAHCF seeks here.

Third, even if it were relevant, the 1997 committee report's offhand comment that no provision of § 1396a should be "interpreted as establishing a cause of action for . . . nursing facilities relative to the adequacy of the rates they receive," H.R. Rep. No. 105-149, at 591, does not affect the validity of CAHCF's Supremacy Clause claims. Those claims do not look to § 1396a(a)(30)(A) to create a "cause of action." Instead, the Supremacy Clause itself serves as the foundation for CAHCF's causes of action for injunctive relief. *Cf. Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 96 n.14 (1983) ("A plaintiff who seeks injunctive relief from state regulation, on the ground that such regulation is preempted by a federal statute which, by virtue of the Supremacy Clause, must prevail, thus presents a federal question which the federal courts have jurisdiction under 28 U.S.C. § 1331 to resolve.").

Fourth, CMS has expressly rejected Governor Rell's argument. In its moving brief (at 25), CAHCF explained that, in addressing the substantial-likelihood-of-success element, a State's interpretation of federal law receives no deference. In response, Governor Rell attempts to give her arguments an air of legitimacy by citing a 13-year-old *amicus* brief filed by the Solicitor General of the United States following the Ninth Circuit's decision in *Orthopaedic Hospital v. Belshe*, 103 F.3d 1491 (9th Cir. 1997). Governor Rell suggests that the 13-year-old *amicus* brief contains the definitive interpretation of § 1396a(a)(30)(A), to which this Court owes a heightened level of deference. *See* Def.'s Mem. at 12-13. Her argument should be rejected, as it already has been by the Ninth Circuit. *See Indep. Living Ctr. of S. Cal., Inc. v. Maxwell-Jolly*,

572 F.3d 644, 654 (9th Cir. 2009) ("*Independent Living II*"), *petition for cert. filed*, 78 U.S.L.W. 3500 (U.S. Feb. 16, 2010) (No. 09-958).

Contrary to Governor Rell's suggestion (Def.'s Mem. at 13 n.4), the law of this Circuit instructs that a legal position advanced in a federal agency's *amicus* brief does not deserve a heightened level of deference. *See Conn. Office of Protection & Advocacy For Persons With Disabilities v. Hartford Bd. of Educ.*, 464 F.3d 229, 239-40 (2d Cir. 2006) ("Where, as here, an agency advances a statutory interpretation in an *amicus* brief that has not been articulated before in a rule or regulation, we do not apply the high level of deference due under [*Chevron, U.S.A., Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837 (1984)]."). Instead, whatever weight a court chooses to give an agency's views expressed in an *amicus* brief is based on "'all those factors which give it power to persuade, if lacking power to control,'" including "'its consistency with earlier and later pronouncements.'" *Id.* (quoting *Skidmore v. Swift & Co.*, 323 U.S. 134, 140 (1944)); *see also N.Y. State Rest. Ass'n v. N.Y. City Bd. of Health*, 556 F.3d 114, 130 (2d Cir. 2009) (explaining that views expressed in federal agency's *amicus* brief are viewed under *Skidmore* standard, not *Chevron* standard). The 13-year-old *amicus* brief on which Governor Rell relies was filed in a different case in a much different procedural posture that did not assert claims for injunctive relief based on the Supremacy Clause.[8]

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[8] *Orthopaedic Hospital* was based solely on § 1983 claims. *See* 103 F.3d at 1495. The Supreme Court invited the Solicitor General to file a brief expressing the views of the United States as to whether the Court should grant plenary review of the Ninth Circuit's decision. *See* 521 U.S. 1116 (1997). The Solicitor General expressed disagreement with certain aspects of the Ninth Circuit's ruling, particularly language in the lower court's decision that the Solicitor General believed suggested that § 1396a(a)(30)(A) required payment rates that reimbursed providers for their *full* costs regardless of efficiency and economy (an interpretation of § 1396a(a)(30)(A) not advocated by CAHCF). *See* Br. for United States as *Amicus Curiae* at 3, 6-8, *Belshe v. Orthopaedic Hosp.*, No. 96-1742 (U.S. Nov. 26, 1997) (Def.'s Stat. App. Ex. 26).

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Furthermore, the position advocated by CMS as a party in subsequent cases overwhelmingly supports CAHCF, not Governor Rell. For example, Alaska recently appealed a CMS decision denying a proposed state plan amendment on § 1396a(a)(30)(A) grounds. *See Alaska Dep't of Health & Soc. Servs. v. Ctrs. for Medicare & Medicaid Servs.*, 424 F.3d 931 (9th Cir. 2005). In its merits brief, CMS expressly rejected Alaska's argument that Congress's repeal of the Boren Amendment affected the meaning of § 1396a(a)(30)(A). CMS explained that "[n]owhere in any of the cases cited by the State, nor in the legislative history, is there a suggestion that the repeal of the Boren Amendment alters the Secretary's responsibilities under [§ 1396a(a)(30)(A)] to ensure that a state's Medicaid rates are consistent with efficiency and economy and quality of care (i.e., the rates are neither too high *nor too low*)." Br. for Resp'ts at 36, *Alaska Dep't of Health & Social Servs. v. Ctrs. for Medicare & Medicaid Servs.*, No. 04-74204 (9th Cir. Dec. 27, 2004) ("CMS *Alaska* Br.") (emphasis added) (Pl.'s Reply App. 110a). "While it is true that in general 'reasonable cost' reimbursement under Medicaid has been largely replaced," CMS explained that state payment methodologies must still "be grounded in some concrete basis with its roots in the efficient and economical provision of care. *An economically-operated system contemplates charges that bear some relationship to the cost of providing the service*." *Id.* at 32 (Pl.'s Reply App. 106a) (emphasis added). The Ninth Circuit rejected Alaska's arguments to the contrary. *See Alaska*, 424 F.3d at 941.

CMS also refuted arguments similar to those advanced by Governor Rell in a recent Eighth Circuit appeal brought by Minnesota, and in so doing further confirmed the interpretation of § 1396a(a)(30)(A) advocated by CAHCF. There, as in *Alaska*, Minnesota appealed a CMS

The Solicitor General nonetheless recommended that the Court deny plenary review, *id.* at 20, which it did, 522 U.S. 1044 (1998).

decision denying a proposed state plan amendment on § 1396a(a)(30)(A) grounds. *See Minnesota v. Ctrs. for Medicare & Medicaid Servs.*, 495 F.3d 991 (8th Cir. 2007). Among other things, Minnesota argued that Congress's repeal of the Boren Amendment gave States near unfettered discretion in setting payment rates. In opposition to Minnesota's argument, CMS explained, as it had in *Alaska*, that "Congress's 1997 repeal of the Boren Amendment . . . affected only [§ 1396a(a)(13)], and thus did not limit the Secretary's oversight responsibilities under [§ 1396a(a)(30)(A)]." Br. for Resp'ts at 17, *Minnesota v. Ctrs. for Medicare & Medicaid Servs.*, No. 06-3263 (8th Cir. Dec. 18, 2006) ("CMS *Minnesota* Br.") (Pl.'s Reply App. 149a); *accord* CMS *Alaska* Br. at 33 ("[T]he repeal of the Boren Amendment, which involves a statutory provision other than [§ 1396a(a)(30)(A)], does not alter or restrict the Secretary's role under [§ 1396a(a)(30)(A)].") (Pl.'s Reply App. 107a).

CMS went on to explain that, although § 1396a(a)(30)(A)'s "criteria of 'efficiency' and 'economy' are not defined in the Medicaid statute or regulations," CMS's interpretation "comports with the natural and ordinary meaning of the statutory standard." CMS *Minnesota* Br. at 35 (internal quotations and citation omitted) (Pl.'s Reply App. 167a). CMS interpreted "efficiency" as meaning "effective operation as measured by a comparison of production *with cost* (as in energy, time, or money)." *Id.* (emphasis added; quotations and citation omitted). "Economy," on the other hand, meant "thrifty and efficient use of material resources: frugality in expenditures." *Id.* (quotations and citation omitted). Therefore, CMS concluded that § 1396a(a)(30)(A) "does not allow a state to limit improperly its Medicaid *outlays* solely for budgetary reasons." *Id.* at 36 (citing *Ark. Med. Soc'y v. Reynolds*, 6 F.3d 519, 531 (8th Cir.

1993)) (Pl.'s Reply App. 168a). The Eighth Circuit agreed with CMS and with the logic of the Ninth Circuit's decision in *Alaska*. *See Minnesota*, 495 F.3d at 997-98.[9]

Accordingly, logic, existing precedent, and CMS's repeatedly stated position demonstrate that Congress's repeal of the Boren Amendment had no effect on the meaning of § 1396a(a)(30)(A). Contrary to Governor Rell's argument, CMS also has made explicit that the actual cost of providing quality care in an efficient and economical manner is essential under § 1396a(a)(30)(A).

5. The Undisputed Factual Record Demonstrates That Section 32 Was Enacted Based Solely On State Budgetary Concerns

All courts of appeals that have addressed the issue have "generally recognized that state Medicaid rate reductions may not be based solely on state budgetary concerns." *Independent Living II*, 572 F.3d at 656; *accord Catholic Med. Ctr. of Brooklyn & Queens, Inc. v. Rockefeller*, 305 F. Supp. 1268, 1264 (E.D.N.Y. 1969) (finding that a State's "[l]ack of funds" is not a recognized ground for disregarding the Medicaid Act's requirements), *aff'd per curiam*, 430 F.2d at 1298; *Rite Aid of Pa., Inc. v. Houstoun*, 171 F.3d 842, 856 (3d Cir. 1999) (finding that "budgetary considerations may not be the sole basis for a rate revision"); *Arkansas Medical Society*, 6 F.3d at 531 ("Abundant persuasive precedent supports the proposition that budgetary considerations cannot be the conclusive factor in decisions regarding Medicaid."). CMS's interpretation of § 1396a(a)(30)(A) is to the same effect. *See* CMS *Minnesota* Br. at 36 (explain-

[9] CMS's interpretation of the words "efficiency" and "economy" is consistent with the expert economic testimony submitted by CAHCF, which Governor Rell makes no effort to refute. *See, e.g.*, Harris Decl. ¶ 12 ("[A]n economically efficient system minimizes the costs of production and avoids waste in producing goods. A regulatory system that for the majority of producers systematically and consistently causes Medicaid reimbursement to be less than the cost of serving its Medicaid patients is not an efficient and economic system.") (Pl.'s App. 4:895a).

ing that § 1396a(a)(30)(A) "does not allow a state to limit improperly its Medicaid *outlays* solely for budgetary reasons") (Pl.'s Reply App. 168a).

As explained in detail by CAHCF's moving brief (at 14-22), the legislative record demonstrates beyond any doubt that Section 32 was enacted based solely on state budgetary concerns. Governor Rell admits as much. "[T]he Stop Gain," she explains, is the "principal means of assuring that rates do not grow at a faster pace than the State can afford." Def.'s Opp'n at 8. "[F]acing an unprecedented budget shortfall," she claims that "the State could not afford to increase nursing facility rates, and the Stop Gain was set at zero" by Section 32. *Id.*

The affidavits and other evidentiary materials filed by Governor Rell provide further confirmation that Section 32 was enacted based solely on state budgetary concerns. On July 25, 2008, Governor Rell sent a memorandum to all agency heads asserting that the State's "financial situation will require considerable belt-tightening this year and in the upcoming biennium." Mem. from M. Jodi Rell, Conn. Governor, to All Agency Heads at 1 (July 25, 2008) (Pl.'s Reply App. 196a). "The challenge of this next biennial budget," she explained, was "to maintain our progress while not requiring the taxpayers of the state to carry a heavier tax burden." *Id.* In a follow-up memorandum to all agency heads, the Secretary of Connecticut's Office of Policy and Management ("OPM"), Robert L. Genuario, asserted that state revenues could no longer be expected to cover state expenditures. *See* Mem. from Robert L. Genuario, Sec'y, Conn. Office of Pol'y & Mgmt., to All Agency Heads at 2 (Sept. 5, 2008) (Pl.'s Reply App. 199a). Secretary Genuario therefore instructed all agency heads that they were "required to submit reduction options totaling **10%** of their 2009-10 current services budget request." *Id.* (emphasis in original). These "reduction options" were to be submitted no later than October 14, 2008. *Id.* at 3 (Pl.'s Reply App. 200a).

However, when Commissioner Starkowski submitted his reduction options two months after the October 14, 2008 deadline, he did not propose a statutory amendment to the Stop Gain to preclude the rebasing of Medicaid payment rates that was otherwise required by state law. *See* Letter from Michael P. Starkowski, Comm'r, Conn. Dep't of Soc. Servs., to Robert L. Genuario, Sec'y, Conn. Office of Pol'y & Mgmt. (Dec. 15, 2008) (Def.'s App. 158A-61A). Instead, the idea for enacting Section 32 later came from the agency responsible for the state budget, OPM. *See* Starkowski Aff. ¶¶ 11-13 (Def.'s App. 154A) (explaining that what became Section 32 was the brainchild of OPM, not DSS); Genuario Aff. ¶ 7 (Def.'s App. 164A) (explaining that what became Section 32 was proposed by OPM because of the "compelling need to achieve budget savings"). It is hard to imagine stronger evidence that Section 32 was enacted solely because of state budgetary concerns.[10]

Therefore, existing precedent and CMS's interpretation of § 1396a(a)(30)(A) overwhelmingly demonstrate that, on this basis alone, CAHCF possesses a substantial likelihood of success on the merits of its Supremacy Clause claims. *Cf. Campbell v. Bysiewicz*, 213 F. Supp. 2d 152, 157 (D. Conn. 2002) (finding that plaintiffs had "satisfied their burden to show a substantial likelihood of success on the merits" because of precedent invalidating a similar state statute).

6. The Undisputed Factual Record Demonstrates That The State's Payment System Bears No Reasonable Relationship To Efficient And Economical Nursing Faculties' Costs Of Providing Quality Care

To comply with § 1396a(a)(30)(A), a State must set Medicaid payment rates that bear a reasonable relationship to efficient and economical providers' costs of providing quality care.

[10] Contrary to Governor Rell's suggestion (Def.'s Mem. at 31-32), CAHCF has never argued that state budgetary concerns can *never* be considered when setting payment rates. Instead, overwhelming precedent demonstrates that they cannot serve as the sole basis for setting payment rates, which is what happened here.

Independent Living II, 572 F.3d at 651. As CMS explained in *Alaska*, § 1396a(a)(30)(A) requires that state payment systems "be grounded in some concrete basis with its roots in the efficient and economical provision of care," such that "[a]n economically-operated system contemplates charges that bear some relationship to the cost of providing the service." CMS *Alaska* Br. at 32 (Pl.'s Reply App. 106a); *accord* CMS *Minnesota* Br. at 35 (explaining that § 1396a(a)(30)(A)'s use of the word "efficiency" means "effective operation as measured by a comparison of production with cost") (Pl.'s Reply App. 167a).

The undisputed factual record demonstrates that, following Section 32's recent amendment of the Stop Gain, Connecticut law does not set payment rates that bear a reasonable relationship to efficient and economical providers' costs of providing quality services. For example, Governor Rell makes no attempt to refute the multiple state studies that make this conclusion undeniable. *See, e.g.*, LPRI Rep. at 25-26 (explaining that the Stop Gain "has eliminated the relationship between facilities' allowed costs and the Medicaid rate ultimately issued") (Pl.'s App. 2:319a-20a); Task Force Rep. at 8 (concluding that Connecticut's payment system "does ***not*** adequately reflect the actual costs of wages, benefits and staffing") (emphasis in original) (Pl.'s App. 2:368a); OLR Nursing Homes Rep. at 6 (explaining that, "[w]hile the structure for limiting the costs the state will allow remains in statute," the Stop Gain has rendered that structure "moot") (Pl.'s App. 2:394a); *see also* Gary M. Richter, Dir., Office of Certificate of Need & Rate Setting, Conn. Dep't of Soc. Servs., *Nursing Home Funding: Rate Setting Process* at 6 (May 18, 2009) (explaining that the LPRI Report, which Governor Rell makes no effort to address, provides an "[e]xcellent overview/analysis") (Pl.'s App. 1:154a).

Governor Rell also makes no attempt to refute the expert testimony submitted by CAHCF, which demonstrated that Connecticut law does not set payment rates that bear a

reasonable relationship to efficient and economical providers' costs of providing quality services. *See, e.g.*, Harris Decl. ¶ 13 ("A regulatory system that for the majority of producers systematically and consistently causes Medicaid reimbursement to be less than the cost of serving its Medicaid patients is not an efficient and economic system.") (Pl.'s App. 4:895a). Nor does Governor Rell provide any real response to the fact that, even when judged against the State's own historical standard for determining "efficiency," the State's current system is woefully deficient. *See* Pl.'s Mem. at 34-35; Lubarsky Decl. ¶ 33 (explaining that, even for the approximately 116 Medicaid-participating nursing facilities in Connecticut whose Medicaid-allowable costs are at or below the median of all providers—the State's own historical standard for judging "efficiency"—Section 32 causes an astounding 81 percent to be paid less than their Medicaid-allowable costs) (Pl.'s App. 4:879a).

By the State's own admission, the actual cost of what is required to provide quality care in an efficient and economical manner only becomes a relevant factor for rate-setting purposes *after* a provider is near bankruptcy or is in state receivership, when the facility is forced to plead for interim rate relief. *See* Richter Aff. ¶ 11 (explaining that "DSS's evaluation of a request for an interim rate increase includes a review of the reasonableness of facility costs in comparison with state-wide averages") (Def.'s App. 4A). Commonsense teaches that a rate-setting system conflicts with § 1396a(a)(30)(A) if it only considers how much it actually costs to provide quality care in an efficient and economical manner *after* a provider is pushed to the brink of bankruptcy or is in state receivership.

Accordingly, *Independent Living* and its progeny, as well CMS's interpretation of § 1396a(a)(30)(A) as expressed in *Alaska* and *Minnesota*, demonstrate that, on this basis alone,

CAHCF possesses a substantial likelihood of success on the merits of its Supremacy Clause claims.

7. The Undisputed Factual Record Demonstrates That The State Did Not Rely On Responsible Cost Studies Prior To Enacting Section 32

As the Ninth Circuit explained in *Orthopaedic Hospital*, § 1396a(a)(30)(A) "provides that *payments* for services must be consistent with efficiency, economy, and quality of care, and that those *payments* must be sufficient to enlist enough providers to provide access to Medicaid recipients. The [State] cannot know that it is setting rates that are consistent with efficiency, economy, quality of care and access without considering the costs of providing such services." 103 F.3d at 1496. Therefore, to comply with § 1396a(a)(30)(A), a State must "rely on responsible cost studies, its own or others', that provide reliable data as a basis for its rate setting." *Id.*; *cf. Arkansas Medical Society*, 6 F.3d at 530 (holding that § 1396a(a)(30)(A) requires States to "consider the relevant factors of equal access, efficiency, economy, and quality of care as designated in the statute when setting reimbursement rates"); CMS *Alaska* Br. at 32 ("An economically-operated system contemplates charges that bear some relationship to the cost of providing the service.") (Pl.'s Reply App. 106a); CMS *Minnesota* Br. at 35 (explaining that § 1396a(a)(30)(A)'s use of the word "efficiency" means "effective operation as measured by a comparison of production with cost") (Pl.'s Reply App. 167a).

In its moving brief (at 14-22), CAHCF explained in detail how the legislative record unambiguously demonstrates that the General Assembly failed to consider the § 1396a(a)(30)(A) factors prior to enacting Section 32. In particular, 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 must incur to deliver quality care; (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.[11]

By providing no argument to the contrary, Governor Rell concedes that the State did not rely on responsible costs studies prior to enacting Section 32. Accordingly, *Orthopaedic Hospital* and in its progeny demonstrate that, on this basis alone, CAHCF possesses a substantial likelihood of success on the merits of its Supremacy Clause claims.[12]

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[11] Secretary Genuario asserts that he had "discussions" with unidentified "legislative leadership" at unspecified times "concerning the financial viability of nursing facilities and the potential impact of the Governor's Recommended Budget on nursing facilities and on patient access to care." Genuario Aff. ¶ 10 (Def.'s App. 166A). He claims that these "discussions" with unidentified "legislative leadership" at unspecified times were "mindful of the need to fund nursing facility care sufficiently to afford access to quality care for Medicaid-assisted individuals who need nursing facility services." *Id.* However, Secretary Genuario points to nothing in the legislative record or any other tangible evidence that reflects these "discussions" actually took place, when they took place, what was said, or whether the subject of these "discussions" was shared with other members of the General Assembly. Therefore, assuming for purposes of argument that these "discussions" actually took place, such informal "discussions" with select members of the General Assembly fall well short of the formal consideration of the § 1396a(a)(30)(A) factors required of the General Assembly by federal law. *See, e.g.*, *California Pharmacists II*, 596 F.3d at 1108-09 (rejecting State's assertion that legislature considered § 1396a(a)(30)(A) factors when, among other things, declaration asserted that agency staff provided "information, technical assistance, and responses to numerous inquiries to legislative staff members concerning" proposed rate reductions) (Pl.'s Reply App. 13a-14a).

[12] Governor Rell argues that this Court should simply disregard the Ninth Circuit's well-reasoned opinion in *Orthopaedic Hospital*. *See* Def.'s Mem. at 28-29.

8. Governor Rell's Equality-Of-Access Argument Is Fundamentally Flawed

According to Governor Rell, "the State's reimbursement rates comply with section 1396a(a)(30)(A) because Connecticut's Medicaid recipients in fact enjoy ample access to quality nursing facility care." Def.'s Opp'n at 12. There are at least two problems with this contention.

First, assuming for the sake of argument that Governor Rell is correct in her assertion that "Connecticut's Medicaid recipients in fact enjoy ample access to quality nursing facility care," that fact alone does not demonstrate compliance with § 1396a(a)(30)(A). The plain language of the statute instructs that the State must "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." § 1396a(a)(30)(A) (emphasis added). As set forth above, Section 32 assures that payments are *not* consistent with efficiency, economy and quality of care.

Second, as best reflected by a statement contained in the affidavit submitted by DSS's chief rate-setting official, Governor Rell's conclusion that "Connecticut's Medicaid recipients in fact enjoy ample access to quality nursing facility care" is based on pure speculation. That affidavit states, in relevant part: "The high proportion of Medicaid occupancy in Connecticut nursing facilities, the ample vacancy rate in Connecticut nursing facilities, and the high level of available beds per capita demonstrate that the State's Medicaid rates for nursing facilities are sufficient to enlist enough providers so that services under the State Plan are available to recipients at least to the extent that those services are available to the general population." Richter Aff. ¶ 18 (Def.'s App. 8A).

However, the overall occupancy rate says nothing about whether *Medicaid beneficiaries* have the same level of access to nursing facility services as do non-Medicaid beneficiaries, which is the standard required by § 1396a(a)(30)(A). As Mr. Richter admitted in testimony before the General Assembly, the State has no way of knowing whether Medicaid beneficiaries actually have the same level of access to nursing facility services as do non-Medicaid beneficiaries. According to Mr. Richter, DSS does not keep track of waiting lists reflecting how long it takes Medicaid beneficiaries and non-Medicaid beneficiaries to gain access to nursing facility services. *See* Mar. 3, 2009 Hr'g Tr. at 64 (Pl.'s App. 1:101a); *see also* Richter Aff. ¶ 14 (Def.'s App. 6A) (recounting admission). Accordingly, the Court should reject Governor Rell's equality-of-access argument.

9. That Connecticut's Rates Are Higher On Average Than Other States Says Nothing About Whether Connecticut's Payment System Satisfies § 1396a(a)(30)(A)

Governor Rell repeatedly claims that the State's payment methodology does not conflict with § 1396a(a)(30)(A) because the State's rates are "among the highest in the nation." Def.'s Opp'n at 6, 9, 17. The Eighth Circuit rightly rejected the exact same argument in *Arkansas Medical Society*. There, the state Medicaid agency claimed that it "considered reimbursement rates for providers in other states" as a means to comply with § 1396a(a)(30)(A). 6 F.3d at 530. That fact, the appellate court explained, was legally irrelevant. The state agency had failed to show "how such a comparison has any bearing on equal access, efficiency, economy, and quality of care *in Arkansas*." *Id.* (emphasis added).

The logic of *Arkansas Medical Society* applies with equal force here. The rates paid by other States have no bearing on equal access, efficiency, economy, and quality of care *in Connecticut*. In fact, Connecticut's rates should be among the highest in the nation since, as the

LPRI Committee specifically found, the cost of providing quality care in this State is higher than in most other States. In addressing this issue, the LPRI Committee explained that the reason Connecticut's Medicaid rates are generally higher when compared to other States "can be explained by wage differences between Connecticut and the other Northeastern and Mid-Atlantic States." LPRI Rep. at 16 (Pl.'s App. 2:310a). For example, in comparing Connecticut's rates with those paid by Massachusetts, the LPRI Committee determined that, based on wage differences, "direct care salaries alone (not benefits) make Connecticut facilities $57 million a year more expensive than Massachusetts) homes. This does not compare the added costs of wages paid for indirect care, like housekeeping and dietary workers (which [an American Association of Homes and Services for the Aging] survey indicates are also higher in Connecticut)." *Id.* at 16-17 (Pl.'s App. 2:310a-11a).

The UConn Study made similar findings. While Connecticut's Medicaid rates may be higher compared to certain other States, the UConn Study also concluded that the "average Medicaid per diem rate [in Connecticut] is substantially less than the other primary payers (Medicare and private pay). The Medicaid rate is nearly $100 a day less than Medicare and $75 less than the average private pay rate . . . ." UConn Study at 31 (Pl.'s App. 2:388a). Furthermore, "[d]espite the fact that Connecticut's average per diem rates are higher than in most states," the UConn Study concluded that "shortfalls in Medicaid funding for nursing home care persist." *Id.* In 2003, for example, the UConn Study explained that "Connecticut experienced a $14.30 per patient day shortfall in Medicaid funding." *Id.*

Accordingly, that Connecticut's Medicaid rates are "among the highest in the nation" does nothing to refute the fact that Section 32 conflicts with § 1396a(a)(30)(A).

10. Second Circuit Primary Jurisdiction Precedent Counsels Against Delaying Action On CAHCF's Motion

Governor Rell also makes a half-hearted primary jurisdiction argument that should be rejected. According to Governor Rell, this Court should refuse to grant preliminary injunctive relief because Congress has vested the Secretary of Health and Human Services with the "responsibility to review state Medicaid plans" and to determine whether their payment standards "produce outcomes that are consistent with" § 1396a(a)(30)(A). Def.'s Opp'n at 19. However, Governor Rell makes no effort to demonstrate that this matter satisfies the four-factor test required by Second Circuit precedent.

For example, in *Schiller v. Tower Semiconductor Ltd.*, 449 F.3d 286 (2d Cir. 2006), the Second Circuit refused to delay judicial action because the question to be decided—whether an agency complied with federal law—did not "involve technical or policy considerations within the agency's particular field of expertise," but instead required the court "to engage in an activity—statutory interpretation—that is the daily fare of federal judges." *Id.* at 295. "For obvious reasons," the Second Circuit explained that "whether an agency has ignored its statutory mandate is a question for the judiciary, not the agency, to address." *Id.*

The same "obvious reasons" counsel that the doctrine of primary jurisdiction has no application here. Whether CAHCF has demonstrated a substantial likelihood of success on the merits of its claims that Section 32 conflicts with § 1396a(a)(30)(A) presents a question of statutory interpretation "that is the daily fare of federal judges." *Schiller*, 449 F.3d at 295. Importantly, the law of this Circuit also provides that a court must "balance the advantages of applying the [primary jurisdiction] doctrine against the potential costs resulting from complications and delay in the administrative proceedings." *Ellis v. Tribune Television Co.*, 443 F.3d 71, 83 (2d Cir. 2006) (internal quotations omitted). The "potential costs" at issue here are signifi-

cant. CAHCF's members lose tens of thousands of dollars each day Section 32 is allowed to operate—money that cannot be compensated by a later money damages award.

As for the "complications and delay in the administrative proceedings," they too will prove significant. When issues are raised regarding a State's compliance with § 1396a(a)(30)(A), it is not unusual for CMS to take many *years* to finally decide whether to approve or disapprove a proposed state plan amendment ("SPA"). *See, e.g.*, CMS *Minnesota* Br. at 8-14 (recounting three-year process for completion of CMS administrative proceedings addressing SPA's compliance with § 1396a(a)(30)(A)) (Pl.'s Reply App. 140a-46a); CMS *Alaska* Br. at 13-17 (same) (Pl.'s Reply App. 87a-91a). Even those SPAs raising few, relatively straightforward legal issues can take years to resolve. *See, e.g.*, Notice of Hearing: Reconsideration of Disapproval of Connecticut's Medicaid State Plan Amendment 03-002A, 69 Fed. Reg. 28,895 (May 19, 2004) (reflecting that CMS took over one year to issue its initial disapproval of SPA raising discrete effective-date issue).

CMS has already refused to rubberstamp the 2009 SPA, which DSS submitted on September 30, 2009. *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) (Pl.'s App. 3:560a). In a letter dated November 19, 2009, CMS instructed DSS to provide additional information after finding that DSS's initial submission provided an inadequate basis on which to determine whether the 2009 SPA satisfied § 1396a(a)(30)(A). *See* Letter from Novena James-Hailey, Ctrs. for Medicare & Medicaid Servs., to Michael P. Starkowski, Comm'r, Conn. Dep't of Soc. Servs. (Nov. 19, 2009) (Def.'s App. 76A). Because CMS concluded that the 2009 SPA reduced payments otherwise due nursing facilities, CMS specifically asked DSS to confirm whether the State had complied with § 1396a(a)(30)(A). *Id.* CMS

also pointedly asked DSS another question CMS had not asked the previous year: "What impact, if any, does the proposed SPA have on the availability and access to long term care services for Medicaid clients in Connecticut?" *Id.*; *see also* Richter Aff. ¶ 24 ("In addition to the Standard Questions, CMS asked DSS what impact, if any, the [2009 SPA] would have on the availability of and access to long term care services for Connecticut Medicaid clients.") (Def.'s App. 5A).

In a letter to CMS submitted a few weeks after CAHCF initiated this action, DSS cited many of the same arguments it makes here, but in so doing used language giving the mistaken impression that serious financial crisis (imminent bankruptcy, state receivership, etc.) is not a condition precedent to the granting of interim rate relief under state law, nor did DSS mention that the funds available for interim rate relief are limited. *See* Letter from Michael P. Starkowski, Comm'r, Conn. Dep't of Soc. Servs., to Mark Cooley, Ctrs. for Medicare & Medicaid Servs. at 2-3 (Feb. 16, 2010) (asserting that Connecticut law "provides a mechanism whereby a facility may apply to [DSS] and [DSS] may provide an interim rate increase in order to avoid harm to residents and maintain bed availability in the area in cases of a transfer to new ownership, change in bed capacity or if the facility faces financial distress") (Def.'s App. 80A-81A). As it does here, DSS's letter to CMS also pointed to overall occupancy levels as supposed proof that Medicaid beneficiaries' access to nursing facility services in Connecticut equaled that of non-Medicaid beneficiaries. *See id.* at 3 (Def.'s App. 81A).

It remains to be seen how CMS will respond to DSS's February 16, 2010 submission. For its part, CAHCF has made sure that CMS has a complete factual understanding when reviewing the 2009 SPA. *See* Letter from James F. Segroves, Proskauer Rose LLP, to Janet G. Freeze, Ctrs. for Medicare & Medicaid Servs. (Feb. 22, 2010) (forwarding copy of materials from this case, including all of CAHCF's February 16, 2010 preliminary injunction materials)

(Pl.'s Reply App. 194a-95a). Therefore, whatever theoretical advantage there might be for applying the primary jurisdiction doctrine in this case is substantially outweighed by the potential costs resulting from complications and delay in CMS's administrative proceedings. Whatever CMS does, this case still has to be decided. *See* H.R. Rep. No. 97-158, vol. II, at 301 (1981) (explaining that, "in instances where the States or the Secretary fail to observe these statutory requirements, the courts would be expected to take appropriate remedial action") (Pl.'s Reply App. 4a).

11. CMS's Approval Of A Previous Year's State Plan Amendment Is Irrelevant To The Issues Presented By CAHCF's Motion

Finally, Governor Rell argues that the State is simply continuing to do something that CMS has already condoned by its approval of the 2008 SPA. *See* Def.'s Opp'n at 17-18. However, as reflected by the foregoing discussion of CMS's proceedings thus far in reviewing the 2009 SPA, CMS has addressed the 2009 SPA differently from the 2008 SPA.

Contrary to Governor Rell's suggestion (Def.'s Opp'n at 18), *Perry v. Dowling*, 95 F.3d 237 (2d Cir. 1996), does not support her argument. There, the court applied *Chevron* deference only because (1) the State had "received prior federal-agency approval to implement" the exact state plan provision being challenged, (2) the "federal agency expressly concurred" in the State's interpretation of federal law by filing a declaration from a senior federal official, and (3) the State's interpretation was a permissible construction of the statute. *Id.* at 236-37. None of these three circumstances apply to this case. Accordingly, the Court should reject Governor Rell's attempt to bootstrap *Chevron* deference using CMS's approval of something that is altogether different from what is at issue here.

* * * * *

As set forth above and in CAHCF's moving brief, CAHCF has demonstrated a substantial likelihood of success on the merits of its Supremacy Clause claims.

B. CAHCF Members Will Continue To Suffer Irreparable Harm In The Absence Of Preliminary Injunctive Relief

The law of this Circuit provides that where, as here, the Eleventh Amendment precludes a federal court from awarding retroactive money damages should the movant ultimately succeed on the merits of its legal claims, the risk of pecuniary harm to the movant constitutes irreparable harm. *See United States v. New York*, 708 F.2d at 93. Therefore, in its moving brief (at 36-39), CAHCF used a sample of seven member-facilities to demonstrate that many CAHCF members have suffered and will continue to suffer irreparable harm because: (1) Section 32 causes many Medicaid-participating nursing facilities to receive less payment than they would have received had Section 32 not been enacted; and (2) the Eleventh Amendment precludes this Court from awarding those facilities retroactive money damages should the Court ultimately conclude that Section 32 is null and void because it conflicts with § 1396a(a)(30)(A).

In opposing CAHCF's motion, Governor Rell never even cites, let alone distinguishes, *United States v. New York*. Instead, she cites Tenth Circuit authority for the proposition that the "Eleventh Amendment is not sufficient to satisfy the irreparable harm standard; [CAHCF] must otherwise prove that actual and imminent injury will result but for the issuance of a preliminary injunction." Def.'s Opp'n at 26 (citing *Kan. Health Care Ass'n v. Kan. Dep't of Soc. & Rehab. Servs.*, 31 F.3d 1536, 1543 (10th Cir. 1994)). This is nothing more than saying that CAHCF must demonstrate a causal connection between the complained-of conduct—here, the enactment and implementation of Section 32—and the harm suffered by CAHCF members. CAHCF's moving brief clearly demonstrated such a causal connection.

Governor Rell also raises certain additional arguments on the question of irreparable harm. As set forth below, those additional arguments are without merit.

1. CAHCF's Assertion Of Irreparable Harm Is Not Speculative

Governor Rell contends that CAHCF has not demonstrated the "possibility of additional bankruptcies in the nursing facility industry." Def.'s Opp'n at 20. Assuming for the sake of argument that Governor Rell is correct, she disregards binding Second Circuit precedent in arguing that, in order to demonstrate irreparable harm, CAHCF must identify specific member-facilities who will go out of business unless CAHCF's motion is granted. *United States v. New York* imposes no such requirement. Moreover, the Tenth Circuit expressly rejected the exact same argument in a case similar to this one. *See Kansas Health Care Ass'n*, 31 F.3d at 1544 (holding that the "plaintiffs do not, nor need they, assert that they are on the verge of going out of business in order to establish that they are suffering imminent and irreparable harm").

Governor Rell also attempts to make much of the fact that the seven member-facilities are able to generate an overall profit and that the forever-lost amounts are relatively small, she claims, in comparison to the facilities' overall revenues. *See* Def.'s Opp'n at 22-24. Not only is this contention completely irrelevant under the legal standard established by *United States v. New York*, yet again, Governor Rell's argument was expressly rejected by the Tenth Circuit.

In *Kansas Health Care Ass'n*, the court of appeals explained that it did not believe "the fact that many facilities can subsidize Medicaid underreimbursement should undermine plaintiffs' claim of injury from such underreimbursement." 31 F.3d at 1544 n.15. "Under that analysis," the appellate court explained, "a wealthy individual would never be able to prove monetary injury, on the theory that such an individual could always in fact subsidize any such injury through his or her other sources of wealth." *Id.* The logic of *Kansas Health Care Ass'n*

applies with equal force here. Accordingly, the Court should reject Governor Rell's suggestion that overall profit somehow makes the harm caused by Medicaid underreimbursement any less irreparable in light of the State's Eleventh Amendment protection.

In its moving brief (at 24), CAHCF explained that Section 32 causes the sample of seven member-facilities to lose $385,180.38 a month that cannot be compensated by a later money damages award. Governor Rell does not challenge the accuracy of this assertion. Instead, in what appears to be a ploy designed to generate a factual dispute, Governor Rell makes an *ad hominem* attack based on the seven facilities' cost reports, which she suggests contain "questionable" expenses. Def.'s Opp'n at 22. What Governor Rell neglects to point out, however, is that even if the expenses she identifies are, in fact, "questionable"—CAHCF has no reason to believe that they are, nor will it waste valuable briefing space debunking Governor Rell's innuendo—the underlying payment methodology that is rendered moot by Section 32 contains mechanisms that would allow DSS to adjust those costs if it believed they were somehow improper, which process would also allow the facilities to defend themselves against the type of allegations leveled in Governor Rell's brief. *See* Conn. Gen. Stat. § 17b-238; Conn. Agencies Regs. § 17-311-52; Richter Aff. ¶ 30 (Def.'s App. 12A) ("While a facility may also incur whatever costs it wishes, Connecticut only reimburses certain of these costs in accordance with its statutes and regulations."). Therefore, Governor Rell's suggestion that granting the relief requested by CAHCF will allow "questionable" expenses to go unchecked has no basis in law or fact.

2. Governor Rell's Administrative Remedies Argument Ignores Second Circuit Precedent

The Court should also reject Governor Rell's contention that none of the seven facilities have "availed themselves of multiple state-law processes by which providers may appeal DSS rate decisions." Def.'s Opp'n at 24. *United States v. New York* instructs that CAHCF members

need not resort to state-law remedies before seeking preliminary injunctive relief in this Court. There, the Second Circuit expressly rejected New York's argument that the lower court erred in granting the requested injunction because the private plaintiff "could have sued New York in the New York Court of Claims." 708 F.2d at 93. The Second Circuit explained in no uncertain terms: "New York's argument . . . simply misses the mark; 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." *Id.* (emphasis in original). In like fashion, Governor Rell's argument in this case "simply misses the mark."

The Second Circuit's later decision in *Connecticut Hospital Ass'n v. Weicker*, 46 F.3d 211 (2d Cir. 1995), is not to the contrary. Governor Rell cites *Connecticut Hospital Ass'n* in arguing that, because CAHCF's seven member-facilities who submitted declarations have not resorted to the state administrative remedies she claims are available to them, that fact counsels against granting the requested injunction. *See* Def.'s Opp'n at 25-26. According to Governor Rell, the Second Circuit in *Connecticut Hospital Ass'n* "explicitly rejected the [trade association's] attempt to obtain an injunction in federal court when none of the individual plaintiff hospitals had attempted to exhaust available state remedies for rate relief." *Id.* at 25. The Second Circuit did no such thing. Instead, the court of appeals simply noted that the plaintiff hospitals were seeking the exact same relief—an adjustment of the base year used to calculate their Medicaid reimbursement—that they could have obtained had they utilized the state administrative process specifically designed to provide that exact form of relief. *See* 46 F.3d at 219. Even after pointing this out, however, the Second Circuit was careful to explain that the failure to use the state administrative process did not preclude the association's claims for injunctive relief. *See id.* at 220.

Not only does *Connecticut Hospital Ass'n* not stand for the legal proposition claimed by Governor Rell, the facts of *Connecticut Hospital Ass'n* are readily distinguishable from this case. The relief that CAHCF seeks here on behalf of its members—a preliminary injunction barring the implementation of Section 32—is relief the state administrative processes Governor Rell cites cannot provide because Commissioner Starkowski is legally obligated to follow state law, which includes Section 32. *See* Conn. Gen. Stat. § 17b-238 (instructing that nursing facilities may appeal the Commissioner's annual, facility-specific determination regarding "the cost of services for which payment is to be made," which cost-based calculation is the very calculation rendered moot by Section 32); Pub. Act No. 09-3, 2009 Gen. Assem., June Spec. Sess. § 54 (Conn. Sept. 8, 2009) (authorizing the Commissioner to provide advance payment for two months but only with the OPM Secretary's approval and only after the Commissioner "take[s] prudent measures to assure that such advance payments are not provided to any nursing facility that is at risk of bankruptcy or insolvency"). Nor should CAHCF's members be forced to the brink of bankruptcy or state receivership in order to seek the inadequate and highly discretionary form of relief provided by the State's interim rate process. *See* Conn. Gen. Stat. § 17b-340(a) (instructing that, "within available appropriations," the Commissioner may grant a nursing facility's request for an interim rate only if the rate increase is necessary to avoid a nursing facility filing a petition for bankruptcy, the facility has been placed in state receivership, or 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).

Therefore, Governor Rell's administrative remedies argument completely ignores relevant Second Circuit precedent (*United States v. New York*), misstates the holding of an otherwise irrelevant Second Circuit decision (*Connecticut Hospital Ass'n*), and disregards the fact that the

state administrative remedies she claims are available to CAHCF's members cannot provide the relief CAHCF seeks here.

3. Governor Rell's Delay Argument Is Without Merit

Governor Rell also claims that the relatively short delay between Section 32's enactment and the filing of CAHCF's motion somehow suggests that the harm to CAHCF's members is not really irreparable. *See* Def.'s Mem. at 25. Rather than rush into this Court with an ill-advised and ill-planned motion for a preliminary injunction, CAHCF thoroughly researched its legal arguments and the factual underpinnings of its motion, carefully assembling a four-volume, 894-page appendix in support of its motion during a period of time that included the year-end holiday season. Among other things, CAHCF's submission contained two expert declarations (neither of which are challenged by Governor Rell), five factual declarations, several studies performed by the State itself, and the legislative history of Section 32's enactment. Recognizing that the State would likely do all it could to defend the legality of Section 32—a prediction that has proven accurate—CAHCF was well within its rights to make sure that its initial submission was thorough.

Governor Rell nonetheless seeks to use the relatively short delay against CAHCF, although she stops short of claiming any prejudice. Contrary to Governor Rell's suggestion (Def.'s Opp'n at 25), however, the logic of *New Jersey Ass'n of Health Care Facilities, Inc. v. Gibbs*, 838 F. Supp. 881 (D.N.J. 1993), does not support her argument. There, the plaintiff waited one whole year after filing suit to file its motion for a preliminary injunction. *See id.* at 928. Here, in contrast, CAHCF filed its motion less than one month after commencing this action.

Kansas Health Care Ass'n also demonstrates that Governor Rell's delay argument should be rejected. There, the Tenth Circuit rejected the state officials' argument that an eight-month delay between the implementation of a change in the State's payment methodology and the filing of litigation counseled against a finding of irreparable harm. *See* 31 F.3d at 1543-44. In affirming the district court's order preliminarily enjoining the State's change in payment methodology, the appellate court noted that, among other things, the plaintiffs had delayed filing suit in order to obtain an empirical analysis of the change in methodology. *See id.* at 1544. The Tenth Circuit explained that it was "reluctant to criticize plaintiffs for awaiting specific and concrete documentation of the adequacy of their Medicaid reimbursement rates" because, "[w]ithout such documentation, they run the risk of having their claimed injury be deemed speculative." *Id.* The same logic applies to this case. Accordingly, Governor Rell's delay argument should be rejected.

4. Governor Rell's Administrative Deference Argument With Respect To Irreparable Harm Should Be Rejected

Governor Rell claims that, "in light of the deference this Court must accord to CMS's approval of State Medicaid plans," CAHCF's Eleventh Amendment argument is a "red herring." Def.'s Opp'n at 27. If CMS approves the 2009 SPA, Governor Rell asserts that the State "would not owe rate increases to [CAHCF's] members." *Id.* If CMS disapproves the 2009 SPA, however, the lowering of rates caused by Section 32 "would not be effective under the State plan." *Id.* "Therefore," Governor Rell claims that CAHCF's members "will not suffer irreparable harm even though the Eleventh Amendment prevents this Court from awarding retrospective damages." *Id.*

What CMS decides to do months, if not years, from now with respect to the 2009 SPA has no bearing on the fact that CAHCF's members are *currently* suffering financial harm that can

never be compensated by a later money damages award. At this time, Governor Rell's arguments as to what CMS will or will not do are based on pure speculation.

* * * * *

In sum, CAHCF has overwhelmingly demonstrated that its members have suffered and will continue to suffer irreparable harm in the absence of preliminary injunctive relief.

C. The Balance Of Equities And Public Interest Weigh In Favor Of Confirming The Supremacy Of Federal Law

History teaches that more than 40 years ago, another district court in this Circuit faced issues nearly identical to those presently facing this Court. There, as here, state officials complained that they would have to make difficult policy choices if the court issued an order confirming that federal law was, in fact, the supreme law of the land, such that the state statute in question was null and void because it conflicted with the Medicaid Act. As the district court there explained, the State "point[ed] to the extreme burdens beyond original expectations, which the Medicaid program ha[d] placed on the state budget." *Catholic Med. Ctr. of Brooklyn & Queens, Inc. v. Rockefeller*, 305 F. Supp. 1256, 1264 (E.D.N.Y. 1969). However, the district court also explained that "[l]ack of funds" was not a recognized ground for disregarding the Medicaid Act's requirements. *Id.* Only because state officials had taken remedial action following the court's interim ruling—the governor ordered $30 million in retroactive payments to providers before the district court issued its final decision—did the district court question whether an injunction was necessary. *See Catholic Medical Center II*, 305 F. Supp. at 1270. Since the State had "shown a desire to comply with applicable federal requirements," the district court assumed that the State would "abide by a judicial declaration of rights without having to be compelled to do so by injunction." *Id.* at 1271. The Second Circuit later affirmed the district court's well-reasoned judgment. *See* 430 F.2d at 1298.

In contrast to the situation that faced the district court in *Catholic Medical Center*, Governor Rell's actions in response to this suit reflect that she has no desire to comply with federal law. Instead, her agents have done everything possible to assassinate the character of CAHCF's members, accusing them of greed and questioning some of their accounting practices. According to Governor Rell, CAHCF "claims that its member facilities are entitled to more, when everyone else is being asked to get by with less." Def.'s Opp'n at 4. "At most," Governor Rell asserts that CAHCF has "established that there is some dissatisfaction with how the current reimbursement system operates" and that "some facilities will make less money." *Id.* at 3.

Governor Rell's effort to trivialize the issues of fundamental importance presented by this case insults those nursing facilities, and their thousands of employees, who provide life-sustaining care to Connecticut's most frail and elderly citizens. CAHCF, CANPFA and SEIU have done far more in this case than express "some dissatisfaction with how the current reimbursement system operates" and complain that "some facilities will make less money." CAHCF, CANPFA and SEIU have demonstrated that Connecticut's payment system for Medicaid-participating nursing facilities conflicts with federal law.

Governor Rell contends that nursing facilities in this State have made a voluntary business decision to participate in Connecticut's Medicaid program, suggesting that, with a flip of a switch, they can easily withdraw from the program. Def.'s Opp'n at 3. Not only is the ability to exit the Medicaid program a point of serious contention between the parties, only two decisions are legally relevant with respect to CAHCF's motion.

First, Connecticut has voluntarily chosen to participate in the Medicaid program, thereby agreeing to comply with the Medicaid Act's requirements in return for billions of dollars in federal funds. As the Ninth Circuit recently reminded California: "As we have stated many

times, it is the states that choose whether to participate in Medicaid. Should a state choose to participate in the Medicaid program, it must comply with federal Medicaid law." *California Pharmacists II*, 596 F.3d at 1102; *see also Planned Parenthood of Houston*, 403 F.3d at 337 (explaining that, in the context of conflict preemption, "State participation in federal funding programs is voluntary, but once a state has accepted federal funds, it is bound by the strings that accompany them").

Second, Connecticut has voluntarily chosen to cover a host of optional services under its Medicaid program that, unlike nursing facility services, are *not* required by federal law. As DSS's chief rate-setting official admitting during recent testimony before the General Assembly: "I don't envy your job. . . . 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. . . . And this is what's, uh, you've been able to do in the nursing home area." Video Recording of May 18, 2009 Forum at 02:00:55-02:01:34 (testimony of Mr. Richter). As the record in this case demonstrates, what Connecticut has "been able to do in the nursing home area" conflicts with federal law.

According to Governor Rell, "granting [CAHCF]'s Motion would force the state to offset up to $281 million over two years by cutting spending elsewhere, raising taxes, or both, none of which furthers the public interest." Def.'s Opp'n at 28. This case, however, is not about Governor Rell's view of what is or is not in the public interest. Congress has made the relevant public interest determination, and Congress has instructed that States "must" assure that Medicaid payments are consistent with efficiency, economy, quality of care and equality of access.

Moreover, this Court is not free to disregard Second Circuit precedent simply because the relief requested by CAHCF would require Governor Rell and the General Assembly to make decisions that they find difficult or at odds with their current view of appropriate public policy in order to bring the State into compliance with federal law. As reflected by *Catholic Medical Center*, *Independent Living*, *California Pharmacists Ass'n* and other cases cited by CAHCF, Connecticut is not the first State to allow budgetary considerations to take precedence over complying with federal law, nor will it be the last State to do so.

A rule of law that allows States to disregard federal requirements when compliance is made more difficult by a financial downturn creates a strong incentive for more States to do what Connecticut has done here. Connecticut has promised the Federal Government that it will comply with the requirements of § 1396a(a)(30)(A) in order to receive billions of dollars in federal funds. That promise remains unfulfilled. As this Court explained in *Campbell*, 213 F. Supp. 2d at 157, a court "cannot leave unaffected [state] statutes with a substantial likelihood of being found to fail to meet constitutional muster." That is exactly what Governor Rell asks this Court to do in this case.

As demonstrated by the multiple other courts that have preliminarily enjoined state statutes similar to Section 32, the balance of the equities and the public interest counsel that the Court should reaffirm the supremacy of federal law by issuing the preliminary injunction requested by CAHCF. *See 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 I*, 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"); *California Pharmacists II*, 596 F.3d at 1114 (rejecting State's argument that, in light of State's "deepening fiscal crisis, a preliminary injunction should not issue" despite the fact that "injunctions against payment reductions have forced the State to eliminate many optional [Medicaid] services").

D. CAHCF's Motion For A Preliminary Injunction Is Ripe For Decision

Governor Rell contends that an evidentiary hearing is necessary before this Court grants CAHCF's motion because "essential facts" are in dispute. Def.'s Opp'n at 28. The only factual dispute she asserts is whether CAHCF's members are "likely to suffer any irreparable harm." *Id.* As explained above, Governor Rell has not challenged the fact that the Eleventh Amendment precludes this Court from awarding CAHCF members money damages if the Court finally concludes that Section 32 conflicts with § 1396a(a)(30)(A). Nor has Governor Rell challenged the accuracy of the financial figures contained in CAHCF's moving brief and supporting declarations, which demonstrate that many CAHCF members have suffered and will continue to suffer financial harm as a direct result of Section 32 that cannot be compensated by a later money damages award. Therefore, *United States v. New York* instructs that there are no "essential facts" in dispute on the question of irreparable harm. As a result, an evidentiary hearing is completely unnecessary and will only serve to delay a ruling on CAHCF's motion. *See Moore v. Consol. Edison Co. of N.Y.*, 409 F.3d 506, 512 (2d Cir. 2005) (affirming district court's denial of request for evidentiary hearing under similar circumstances).[13]

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[13] Because she makes no argument to the contrary, Governor Rell has waived any argument that CAHCF should be required to post security under Rule 65(a). *See* Pl.'s Mem. at 39. Similarly, because she has failed to raise any objection, Governor Rell has waived any challenge to the form of the preliminary injunction requested by CAHCF. *See id.* at 39-40.

CAHCF's Motion for a Preliminary Injunction has now been fully briefed. After studying Governor Rell's response, CAHCF now believes that the issues raised by CAHCF's motion can be resolved without oral argument. Of course, if the Court believes that oral argument will be helpful, CAHCF will gladly provide oral argument. Otherwise, CAHCF respectfully requests that the Court proceed to decide CAHCF's motion.

II. THE COURT SHOULD DENY GOVERNOR RELL'S MOTION TO DISMISS

The function of a motion to dismiss under Rule 12(b)(6) is "merely to assess the legal feasibility of the complaint, not to assay the weight of the evidence which might be offered in support thereof." *Ryder Energy Distrib. v. Merrill Lynch Commodities, Inc.*, 748 F.2d 774, 779 (2d Cir. 1984). Therefore, in deciding a motion to dismiss under Rule 12(b)(6), the Court must accept as true all factual allegations in the complaint and must draw inferences in a light most favorable to the plaintiff. *Scheuer v. Rhodes*, 416 U.S. 232, 236 (1974). Factual allegations need only "be enough to raise a right to relief above the speculative level, on the assumption that all allegations in the complaint are true (even if doubtful in fact)." *Ashcroft v. Iqbal*, 129 S. Ct. 1937, 1949 (2009) (citations omitted).

A. CAHCF's Supremacy Clause Claims State Claims Upon Which Relief Can Be Granted

For the reasons set forth above in discussing the fact that CAHCF possesses a substantial likelihood of success on the merits of its Supremacy Clause claims, Governor Rell's arguments for why the Court should dismiss CAHCF's Supremacy Clause claims are without merit.

B. CAHCF's Takings Claims State Claims Upon Which Relief Can Be Granted

The Fifth Amendment's Takings Clause instructs: "nor shall private property be taken for public use, without just compensation." U.S. Const. amend. V, cl. 5. The purpose of the Takings Clause, which applies to the States via the Fourteenth Amendment, *Kelo v. New London*,

545 U.S. 469, 472 n.1 (2005), is to "prevent the government from 'forcing some people alone to bear public burdens which, in all fairness and justice, should be borne by the public as a whole,'" *Palazzolo v. Rhode Island*, 533 U.S. 606, 617 (2001) (quoting *Armstrong v. United States*, 364 U.S. 40, 49 (1960)).[14]

1. The Complaint Adequately Pleads Protected Property Interests

The threshold legal question in any takings case is whether the plaintiff has a protected property interest. *Ruckelshaus v. Monsanto Co.*, 467 U.S. 986, 1000 (1983). Governor Rell claims that CAHCF has failed to identify a property right that has been taken by the State. Def.'s Mem. at 34. Unless CAHCF "is able to identify some feature of Connecticut law that would give its members a right in future reimbursement (which it has not done and cannot do)," she asserts that "the lack of a protected property interest is fatal to [CAHCF's] takings claim." *Id.*

Governor Rell's argument disregards the plain language of the complaint. The complaint never alleges that CAHCF's members have a property interest in future Medicaid reimbursement. Instead, the complaint alleges that "CAHCF's members have a legally cognizable property interest in receiving a reasonable return on the value of their property, which includes their nursing facilities and the services provided therein." Compl. ¶¶ 197, 202. Governor Rell provides no argument for the proposition that CAHCF's members do *not* have a legally cognizable property interest in receiving a reasonable return on the value of their property.

[14] The Connecticut Constitution also provides that the "property of no person shall be taken for public use, without just compensation therefor." Conn. Const. art. I, § 11. Connecticut's courts interpret the state constitution's takings provision consistent with the Takings Clause of the Fifth Amendment and look to federal decisions for guidance. *See, e.g.*, *Bauer v. Waste Mgmt. of Conn.*, 662 A.2d 1179, 1195 n.16 (Conn. 1995) ("[W]e have never interpreted the two provisions to require different analysis.").

The complaint also alleges that "Connecticut law effects a *per se* taking of CAHCF members' private property" by "granting Medicaid beneficiaries an irrevocable license to physically occupy member-facilities" and "precluding those facilities from exiting the Medicaid program or leaving the business altogether." Compl. ¶¶ 199, 204. Governor Rell does not contend that these allegations fail to allege a protected property interest, nor can she.[15] Instead, Governor Rell asserts that these allegations are "inaccurate." Def.'s Mem. at 33. The accuracy of these assertions, however, is not the proper subject of a Rule 12(b)(6) motion to dismiss. *See Iqbal*, 129 S. Ct. at 1949.

Accordingly, the complaint pleads protected property interests that are legally cognizable.

2. The Court Should Reject Governor Rell's Voluntariness Argument

If the plaintiff has a protected property interest, the next question is whether there has been a government "taking." *See Monsanto*, 467 U.S. at 1000. CAHCF dedicated several paragraphs of its complaint describing some of the ways in which participation in the Medicaid program is not voluntary because Connecticut law erects various barriers that preclude or substantially inhibit a nursing facility from exiting the State's Medicaid program or leaving the business altogether. *See* Compl. ¶¶ 69-76; *see also* CANPFA Br. at 5-6 (describing "significant penalties for withdrawing from the Medicaid program"). Governor Rell nonetheless argues that "voluntary provision of nursing facility services and voluntary participation in Connecticut's Medicaid program defeat [CAHCF's] takings claim." Def.'s Mem. at 34. However, the case on

[15] *See, e.g.*, *Loretto v. Teleprompter Manhattan CATV Corp.*, 458 U.S. 419, 435 (1981) ("The power to exclude has traditionally been considered one of the most treasured strands in an owner's bundle of property rights."); *Cablevision Sys. Corp. v. FCC*, 570 F.3d 83, 98 (2d Cir. 2009) (explaining that the "touchstone [of the *per se* takings rule] is required acquiescence to the occupation of the property by an uninvited stranger *or* an interloper with a government license") (emphasis added and internal quotations omitted), *petition for cert. filed*, 78 U.S.L.W. 3454 (U.S. Jan. 27, 2010) (No. 09-901).

which she principally relies, *Garelick v. Sullivan*, 987 F.2d 913 (2d Cir. 1993), is easily distinguishable from this case.

In *Garelick*, the Second Circuit addressed a takings challenge brought by anesthesiologists who claimed that certain federal statutory provisions, which limited the amount of money the anesthesiologists could charge Medicare beneficiaries, effected an uncompensated taking of private property. *Id.* at 915. The court of appeals rejected the anesthesiologists' challenge, stating:

> The anesthesiologists, . . . unlike public utilities, are under no legal duty to provide services to the public and to submit to price regulations. The [federal statutory provisions limiting charges to Medicare beneficiaries] do not require anesthesiologists, or any other physicians, to provide services to Medicare beneficiaries. The challenged provisions simply limit the amounts [certain] physicians, anesthesiologists in this case, may charge those Medicare beneficiaries whom they choose to serve. They retain the right to provide medical services to non-Medicare patients free of price regulations.

Id. at 916-17. Thus, because the anesthesiologists "voluntarily choose to provide services in the price-regulated [Medicare] program," the Second Circuit ruled that they could not assert a viable takings claim. *Id.*[16]

Unlike the federal statutes at issue in *Garelick*, however, Connecticut statutes erect a multitude of barriers to exit and create financial penalties for leaving the Medicaid program that, when considered in their totality, distinguish this case from *Garelick*. For example, Connecticut

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[16] The Second Circuit also rejected the anesthesiologists' reliance on a dissenting opinion authored by Justice Scalia in *Pennell v. San Jose*, 485 U.S. 1 (1988). *See* 987 F.2d at 918. In his dissent, Justice Scalia argued that where a price regulation is designed to ameliorate or cure a social ill that the regulated property-owner has neither contributed to nor created, the regulation gives rise to a taking. *Pennell*, 485 U.S. at 18-24 (Scalia, J., dissenting). CAHCF respectfully submits that Justice Scalia was correct, and that under the standard he articulated in *Pennell*, a taking would be found under the circumstances presented by this case. *Cf. St. Joseph's Living Ctr., Inc. v. Town of Windham*, 966 A.2d 188, 211 (Conn. 2009) (finding that Connecticut's Medicaid rates are so inadequate that they "relieve[] the state of having to shoulder the entire financial burden of caring for the indigent elderly").

law provides that a nursing facility that terminates its Medicaid participation "shall be responsible for any loss of federal [matching funds] arising from such termination." Conn. Gen. Stat. § 17b-347(a). As explained by CANPFA's *amicus* brief (at 5 n.6), this statutory provision creates an enormous financial penalty for any facility that dares leave the Medicaid program.

A nursing facility wishing to leave Connecticut's Medicaid program can do so only if it applies for and receives a certificate of need, which the State is under no obligation to grant. *See* § 17b-352(b)(3). In doing so, the facility must provide a detailed written notice

> to all patients, guardians or conservators, if any, or legally liable relatives or other responsible parties, if known, and shall post such notice in a conspicuous location at the facility. The notice shall state the following: (A) The projected date the facility will be submitting its certificate of need application, (B) that only [DSS] has the authority to either grant, modify or deny the application, (C) that [DSS] has up to ninety days to grant, modify or deny the certificate of need application, (D) a brief description of the reason or reasons for submitting a request for permission, (E) that no patient shall be involuntarily transferred or discharged within or from a facility pursuant to state and federal law because of the filing of the certificate of need application, (F) that all patients have a right to appeal any proposed transfer or discharge, and (G) the name, mailing address and telephone number of the Office of the Long-Term Care Ombudsman and local legal aid office.

§ 17b-352(d).

Connecticut law also provides that, so long as a nursing facility remains a nursing facility, its residents have an irrevocable license to physically occupy a portion of the facility. *See* § 19a-535(b) ("A facility shall not transfer or discharge a patient from the facility except to meet the welfare of the patient which cannot be met in the facility, or unless the patient no longer needs the services of the facility due to improved health, or the health or safety of individuals in the facility is endangered, or . . . the facility ceases to operate."). In effect, state law provides that residents may stay in the nursing facility for as long as they want, and the facility must

continue to accept whatever payment the State provides without looking to the resident for additional compensation. *See* § 17b-340(c).[17]

In addition, the Second Circuit in *Garelick* found it particularly important that the anesthesiologists "retain[ed] the right to provide medical services to non-Medicare patients free of price regulations." 987 F.2d at 916-17. The same cannot be said of nursing facilities in Connecticut. Connecticut law expressly provides that if a nursing facility leaves the Medicaid program, the State will regulate how much the provider may charge so-called "self-pay patients," broadly defined as patients who are "not receiving state or municipal assistance to pay for the cost of care." Conn. Gen. Stat. § 17b-341(a)(1).

The clear impact of these provisions is to substantially impede, if not outright prevent, most nursing facilities from leaving the Medicaid program unless they declare bankruptcy. The district court in *Georgia Nursing Home Ass'n v. Georgia*, No. 1:97-CV-2250-RCF, 1997 WL 820966 (N.D. Ga. Oct. 29, 1997) (Pl.'s Reply App. 32a-34a), faced a similar situation, albeit one with far fewer and less onerous barriers to exit. Georgia passed a statute providing that any nursing facility wishing to withdraw from the Medicaid program would have to enter into a "limited provider agreement," whereby the nursing facility would have to continue serving its current Medicaid beneficiaries until such time as those Medicaid beneficiaries either requested a transfer to another facility or were no longer entitled to receive Medicaid benefits. *Id.* at *2 (Pl.'s Reply App. 33a). In addition, the Georgia statute limited the amount of Medicaid reimbursement a terminating facility could receive, such that instead of receiving its usual facility-

[17] Section 17b-347(a) states that a nursing facility departing the Medicaid program must "transfer all patients who receive [Medicaid] benefits to another facility which participates in the Medicaid program within thirty days of the date of such termination." However, that requirement conflicts with § 19a-535(b) and with 42 U.S.C. § 1396r(c)(2), thereby making it inoperative.

specific rate, the facility would receive the "state-wide average medical assistance rate paid to the class of facilities under the state plan to which the terminating facility belongs." *Id.*

The Georgia Nursing Home Association and certain individual nursing facilities filed suit against state authorities. Among other things, the plaintiffs argued that the state statute effected an uncompensated taking of private property. *See id.* at *1 (Pl.'s Reply App. 33a). The defendants moved to dismiss the case, arguing that it was foreclosed by the plaintiffs' voluntary participation in the Medicaid program. *See id.* at *2 (Pl.'s Reply App. 33a). In its decision denying the defendants' motion to dismiss, the district court explained that the defendants were "correct in their contention that government price regulation does not constitute a taking of property where the regulated group is not required to participate in the regulated industry." *Id.* at *3 (Pl.'s Reply App. 34a). However, the plaintiffs alleged that they were "legally compelled under Georgia law to house certain Medicaid recipients even if they choose to opt out of the Medicaid program. If this allegation proves to be true, plaintiffs may have a viable takings claim." *Id.* Therefore, the court declined to dismiss the plaintiffs' takings claims. *Id.*

The same is true here. Although Connecticut law does not expressly state that Medicaid participation is mandatory, the State has enacted a mosaic of laws that make exit from the State's "voluntary" Medicaid program so onerous as to constitute a taking. At a minimum, Governor Rell's voluntariness argument depends on factual assertions that are outside the four corners of the complaint, thereby making dismissal under Rule 12(b)(6) inappropriate. *See Methodist Hosps., Inc. v. Ind. Family & Soc. Servs. Admin.*, 860 F. Supp. 1309, 1336 (N.D. Ind. 1994) (refusing to dismiss Medicaid providers' takings claim after concluding that factual questions existed as to whether Medicaid rates for mandatory emergency treatment effected a taking

because they were so deficient). Accordingly, the Court should deny Governor Rell's Motion to Dismiss CAHCF's takings claims.[18]

C. CAHCF's § 1983 Claims State Claims Upon Which Relief Can Be Granted

Governor Rell has moved to dismiss the § 1983 counts of CAHCF's complaint (¶¶ 185-93) on the basis of *NYAHSA*, which held that §§ 1396a(a)(13)(A) and 1396a(a)(30)(A) do not confer federal "rights" on nursing facilities that are enforceable under § 1983. *See* Def.'s Mem. at 15. CAHCF respectfully submits that *NYAHSA* wrongly decided the § 1983 question. Among other things, the Second Circuit's decision cannot be reconciled with the Supreme Court's decision in *Wilder*, which was not overruled by the later Supreme Court decision on which *NYAHSA* relies, *Gonzaga University v. Doe*, 536 U.S. 273 (2002). *NYAHSA* also failed to address the central importance of 42 U.S.C. § 1320a-2, which specifically instructs that, "[i]n an action brought to enforce a provision of [the Social Security Act, of which the Medicaid Act is a part], such provision is not to be deemed unenforceable because of its inclusion in a section of [the Social Security Act] requiring a State plan or specifying the required contents of a State plan." Also missing from *NYAHSA* is any discussion of § 1396a(a)(30)(A)'s relevant legislative history. *See* H.R. Rep. No. 97-158, vol. II, at 301 (explaining that changes to State Plans "that would affect the rights of . . . participating providers would be subject to approval by the Secretary . . . . Of course, in instances where the States or the Secretary fail to observe these

[18] CAHCF acknowledges that existing Supreme Court precedent counsels that CAHCF's state-law takings claim (Compl. ¶¶ 200-04) is barred by the Eleventh Amendment and should be dismissed without prejudice under Rule 12(b)(1). *See* Def.'s Mem. at 38 (citing *Pennhurst State Sch. & Hosp. v. Halderman*, 465 U.S. 89 (1984)). CAHCF included its state-law takings claim in its complaint to preserve that issue for further appellate review, if necessary. Furthermore, because the other counts of CAHCF's complaint state claims upon which relief can be granted, CAHCF's claim under the Declaratory Judgment Act is not subject to dismissal.

statutory requirements, the courts would be expected to take appropriate remedial action.") (Pl.'s Reply App. 4a).

Accordingly, CAHCF included the § 1983 counts of its complaint in order to preserve these and other issues related to *NYAHSA* for further appellate review, if necessary.

CONCLUSION

For the foregoing reasons and those stated in CAHCF's moving brief, the Court should grant CAHCF's Motion for a Preliminary Injunction [Doc. No. 15] and deny Governor Rell's Motion to Dismiss [Doc. No. 39].

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Respectfully submitted,

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CERTIFICATE OF SERVICE

I hereby certify that on April 9, 2010, a copy of the foregoing **Consolidated Reply in Support of Plaintiff's Motion for a Preliminary Injunction and Opposition to Defendant's Motion to Dismiss** was filed electronically and served by mail on anyone unable to accept electronic filing. Notice of this filing will be sent by e-mail to all parties by operation of the Court's electronic filing system or by mail to anyone unable to accept electronic filing as indicated on the Notice of Electronic Filing. Parties may access this filing through the Court's CM/ECF System.

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