

# 10-2237-CV

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**In the United States Court of Appeals for the Second Circuit**

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CONNECTICUT ASSOCIATION OF HEALTH CARE FACILITIES, INC.,

*Plaintiff-Appellant,*

v.

M. JODI RELL, Governor, State of Connecticut; and MICHAEL P.  
STARKOWSKI, Commissioner of Social Services,

*Defendants-Appellees.*

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ON APPEAL FROM THE UNITED STATES DISTRICT COURT  
FOR THE DISTRICT OF CONNECTICUT

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**DEFENDANTS-APPELLEES' OPPOSITION TO PLAINTIFF-APPELLANT'S  
EMERGENCY MOTION FOR AN INJUNCTION PENDING APPEAL**

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## **INTRODUCTION**

In the past year, virtually every business has contended with declining revenues; many employees have been laid off, furloughed, or asked to take pay cuts; and the State of Connecticut has wrestled with unprecedented budget deficits. Against that background, and after several days of hearings, the General Assembly determined *not* to cut the rates that Connecticut pays to nursing facilities that care for Medicaid beneficiaries, but not to increase those rates either. The Centers for Medicare and Medicaid Services (“CMS”), the federal agency which is tasked with oversight of the Medicaid program, reviewed the State’s action for compliance with federal law and approved it.

The Connecticut Association of Health Care Facilities (“Plaintiff”) now asks this Court to disregard the considered judgment of state and federal officials and to order the State to increase Medicaid nursing home rates (by over \$100 million per year) while its appeal from the denial of a preliminary injunction is pending. In other words, Plaintiff insists that its member facilities are entitled to more, when everyone else is being asked to get by with less.

Plaintiff’s emergency motion should be denied for the reasons given by the district court. After a careful review of the language, legislative history, and case law relating to the statute under which Plaintiff brings suit, Judge Dorsey correctly held that no injunction was warranted because Plaintiff “has a difficult

case to prove” and it was “against the public interest” to override “the legislature’s expertise in fiscal and budgetary arenas.”

In its emergency motion to this Court, Plaintiff focuses less on the merits of its cause than on the “irreparable harm” its members allegedly will suffer as a result of the State’s Eleventh Amendment immunity from money damages. But, as the district court found, the State has a process in place to provide interim rate relief to any facility that is in financial distress. In addition, an injunction to increase nursing home rates pending appeal will harm the State (and the citizens who need the other services it provides) just as irreparably. The funds to pay higher rates have to come from somewhere, and if other programs or benefits are cut to put more money in the hands of the nursing homes, those programs or benefits cannot be retroactively reinstated.

Moreover, if the State prevails on appeal, as is likely, any attempt to recover overpaid funds will result in net payments to nursing homes that are substantially lower than the rates they challenge here. Accordingly, the balance of harms, and the other factors to be considered before granting the extraordinary remedy of an injunction pending appeal, counsel that Plaintiff’s motion be denied.

**STANDARD FOR INJUNCTION PENDING APPEAL**

A party seeking a stay or injunction pending appeal “bears a difficult burden.” *United States v. Private Sanitation Indus. Ass’n of Nassau/Suffolk, Inc.*,

44 F.3d 1082, 1084 (2d Cir. 1995). This Court weighs four factors in determining whether to grant an injunction pending appeal: (1) whether the movant will suffer irreparable injury absent an injunction; (2) whether the opposing party will suffer substantial injury if an injunction is issued; (3) whether the movant has shown a substantial possibility of success on appeal; and (4) the public interests that may be affected. *E.g.*, *Hirschfeld v. Bd. of Elections*, 984 F.2d 35, 39 (2d Cir. 1993). These factors weigh strongly against granting Plaintiff’s emergency motion.

### **ARGUMENT**

#### **I. PLAINTIFF’S MOTION FOR AN INJUNCTION PENDING APPEAL SHOULD BE DENIED**

##### **A. Plaintiff Cannot Demonstrate a Substantial Possibility of Success On Appeal.**

Although Plaintiff asserted six claims for relief in its Complaint, it relied on only two of them in pursuit of its motion for a preliminary injunction. Both of those claims asserted that Section 32 of Connecticut Public Act 09-5 (“Section 32”), the state legislation holding the nursing home rates in check, was preempted under the Supremacy Clause by 42 U.S.C. § 1396a(a)(30)(A), the “equal access” provision of the Medicaid Act.<sup>1</sup> Count I alleged that Section 32

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<sup>1</sup> That section provides: “A State plan for medical assistance must . . . provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan . . . as may be necessary to safeguard against unnecessary utilization of such care and services and to assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist (continued...)”

was preempted by Section (a)(30)(A)'s "procedural" requirements. (Plaintiff contended that the word "assure" in Section (a)(30)(A) required the State to take certain actions in setting rates, and that the State failed to take them). Count II alleged that Section 32 was preempted by Section (a)(30)(A)'s "substantive" requirements. (Plaintiff asserted that Section (a)(30)(A) required that rates bear a reasonable relationship to providers' costs).

In arguing that Section (a)(30)(A) has procedural and substantive requirements that can serve as the basis of a preemption challenge, Plaintiff relied almost exclusively on a series of recent cases from the Ninth Circuit,<sup>2</sup> which in turn relied on a 1997 decision from that Circuit that has been expressly disavowed by the United States, as explained below.

Contrary to Plaintiff's assertion, the fact that another Court of Appeals has case law favorable to its position is not sufficient to establish a substantial possibility of success on appeal in this Circuit. The Ninth Circuit decisions are

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enough procedures 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." 42 U.S.C. § 1396a(a)(30)(A).

<sup>2</sup> E.g., *Indep. Living Ctr. of S. Cal., Inc. v. Maxwell-Jolly*, 572 F.3d 644 (9th Cir. 2009), *pet. for cert. filed*, 78 U.S.L.W. 3500 (U.S. Feb. 16, 2010) (No. 09-958); *see also Cal. Pharmacists Ass'n v. Maxwell-Jolly*, 596 F.3d 1098 (9th Cir. 2010); *Dominguez v. Schwarzenegger*, 596 F.3d 1087 (9th Cir. 2010); *Indep. Living Ctr. of S. Cal., Inc. v. Shewry*, 543 F.3d 1050 (9th Cir. 2008). A petition for certiorari from the initial Ninth Circuit rulings is currently pending before the Supreme Court, which has called for the views of the Solicitor General as to whether it should grant the petition. *See Maxwell-Jolly v. Indep. Living Ctr. of S. Cal.*, 2010 WL 2025135 (U.S. May 24, 2010).

aberrations and cannot be reconciled with case law from this Circuit and others. In order to fully understand why this Court is unlikely to follow the Ninth Circuit, it is important to understand the development of the Medicaid laws governing reimbursement to institutional providers such as nursing facilities, and how this Circuit has interpreted those laws. The path that Plaintiff advocates is a sharp and unwarranted departure from established precedent in this Circuit that is highly unlikely to succeed on appeal.

**1. Plaintiff's Suit Is Premised On an Interpretation of the Statute That Congress Has Dismantled and the Executive Branch Has Repudiated.**

Although one would not know it from reading Plaintiff's motion, there is a specific provision in the Medicaid statute governing reimbursement to nursing facilities. That section, 42 § U.S.C. 1396a(a)(13), provides that a state plan for medical assistance must have "a public process for determination of rates of payment for . . . nursing facilities" under which – (i) proposed rates, the methodologies underlying the establishment of such rates, and justifications for the proposed rates are published; (ii) providers and others are given a reasonable opportunity for review and comment; and (iii) the final rates are published. Although Plaintiff asserts a violation of this section in Count IV of its Complaint, plaintiff does not rely on any alleged violation of Section (a)(13) as grounds for a preliminary injunction, presumably because this Court and others have concluded

that it does not confer enforceable rights on participating providers. *See N.Y. Ass'n of Homes & Servs. for the Aging, Inc. v. DeBuono*, 444 F.3d 147, 148 (2d Cir. 2006) (per curiam), *aff'g sub nom. In re NYAHSA Litig.*, 318 F. Supp. 2d 30 (N.D.N.Y. 2004); *Children's Seashore House v. Waldman*, 197 F.3d 654, 659 (3rd Cir. 1999); *Evergreen Presbyterian Ministries v. Hood*, 235 F.3d 908, 919, n.12 (5th Cir. 2000), *overruled in part on other grounds, Equal Access for El Paso v. Hawkins*, 509 F.3d 697 (5th Cir. 2007).

This was not always the case. The language in Section (a)(13) was formerly much more prescriptive. From 1980 to 1997, this statutory provision (known as the Boren Amendment) required state Medicaid agencies to provide for the “filing of uniform cost reports” by facilities, and to make “findings” and “assurances” that a State’s reimbursement rates were “reasonable and adequate.” Pub. L. No. 96-499, § 962(a), 94 Stat. 2599, 2650-51 (1980). A number of courts interpreted this language to embody a “procedural” requirement that States must study facilities’ costs in establishing reimbursement rates. *See, e.g., Wilder v. Virginia Hosp. Ass’n*, 496 U.S. 498 (1990); *Conn. Hosp. Ass’n v. Weicker*, 46 F.3d 211 (2d Cir. 1995); *Pinnacle Nursing Home v. Axelrod*, 928 F.2d 1306, 1313-14 (2d Cir. 1991). Courts, including this one, also found a “substantive” component that rates must be sufficient “to meet the costs” which “must be incurred” by “efficiently and economically operated facilities” in order to provide care and

services. *See, e.g., Wilder*, 496 U.S. at 510; *Pinnacle Nursing Home*, 928 F.2d at 1316; *Friedman v. Perales*, 841 F.2d. 47 (2d Cir. 1988).

After more than a decade of rate-setting litigation against States across the country, Congress acted decisively in 1997 by repealing the Boren Amendment to stop the flood of litigation. *See* Balanced Budget Act of 1997, Pub. L. No. 105-33, § 4711(a)(1), 111 Stat. 251, 507-08 (1997) (“BBA”). In the legislative history of the BBA, Congress noted that the repeal was necessary because “Federal courts have ruled that State [payment] systems failed to meet the test of ‘reasonableness’ and some States have had to increase payments to these providers as a result of these judicial interpretations.” H.R. Rep. No. 105-149, at 590 (1997). The congressional committee in charge of the legislation stated, “It is the Committee’s intention that, following enactment of this Act, neither this *nor any other provision of Section 1902* [codified at 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.” *Id.* at 591 (emphasis added).

Despite this statement of intent, some institutional rate challenges, like this case filed by Plaintiff, have turned to 42 U.S.C. § 1396a(a)(30)(A) as an alternative to the Boren Amendment. Unlike Section (a)(13), Section (a)(30)(A) applies broadly to payments for all covered services, including non-institutional community-based services (such as physician services) that are not typically or

readily subject to “cost-based” reimbursement. Like Section (a)(13), however, the history of Section (a)(30)(A) also belies any congressional intent to require States to take specific steps or achieve specific outcomes when they determine Medicaid payments.

As originally enacted, Section (a)(30)(A) required States to ensure that payments did not exceed Medicare-prescribed “reasonable charge” levels. *See* Pub. L. No. 90-248, § 237, 81 Stat. 821, 911 (1968). While the statute by its terms only imposed a ceiling on payments, the Secretary in the implementing regulations construed the statute as also embodying a requirement that States make payments designed to enlist sufficient provider participation so that Medicaid beneficiaries would have access to state plan services at least to the extent that those services were available to the general population. *See* 36 Fed. Reg. 21591 (Nov. 11, 1971) (adopting 45 C.F.R. § 250.30(a)(5)). That regulation has remained in effect to this day (though moved to a different title of the Code of Federal Regulations) in essentially the form of its original adoption. *See* 42 C.F.R. § 447.204.

Congress amended Section (a)(30)(A) in 1989 to add the “equal access” standard to the statute itself. *See* Pub. L. No. 101-239, § 6402(a), 103 Stat. 2260 (1989). As demonstrated by the committee reports, the intent was to embody in the statute the equal access standard that had been imposed in the Secretary’s regulations (then contained in 42 C.F.R. §447.204). *See* H.R. Rep. No. 101-247, at

389-90 (1989); H.R. Rep. No. 101-386, at 448 (1989) (Conf. Rep.). The reports explain that the “sufficien[cy]” of Medicaid payments was to be measured by recipients’ ability to access care. They do not mention provider costs, and in no way suggest any intent to require that payments be predicated on any factor other than beneficiary access. In interpreting Section (a)(30)(A), the Department of Health and Human Services has not adopted any regulation that requires States to make any findings or assurances in determining payments for Medicaid services.

Despite the limited nature of this statutory provision, in 1997, the Ninth Circuit concluded that Section (a)(30)(A), like the Boren Amendment, contained certain “procedural” and “substantive” elements that had to be satisfied when a State determined payments for providers, including institutional providers. *See Orthopaedic Hosp. v. Belshe*, 103 F.3d 1491, 1496-99 (9th Cir. 1997). The federal government roundly rejected the Ninth Circuit’s interpretation when the Solicitor General, at the request of the Supreme Court, filed a brief *amicus curiae* with respect to a petition for certiorari seeking review of that case. *See* Brief for the United States as Amicus Curiae, *Belshe v. Orthopaedic Hosp.*, No. 96-1742, 1997 WL 33561790 (Nov. 26, 1997). The Solicitor General concluded that the Ninth Circuit erred in finding that Section (a)(30)(A) contains a procedural requirement that States “consider” a provider’s costs in determining Medicaid payments and a substantive requirement that payments bear a reasonable

relationship to those costs. On the procedural issue, the Solicitor General's brief states that "the Secretary has not required States to adopt any particular methodology or rate-making procedures to provide for payments for services under the Act. The Secretary has, instead, sought to preserve maximum flexibility for the States to set Medicaid payment rates." *Id.* at \*2. "Nor does the Secretary require the States to adopt any particular procedure or methodology for determining whether payments are 'necessary' to meet the general criteria in [Section (a)(30)(A)], or require that the payments be made at rates that will enable providers to recover their full costs of furnishing covered services." *Id.* at \*3. "Rather, the Secretary requires States to achieve the desired outcomes of equal access and quality of care." *Id.*

With respect to the substantive claim that Section (a)(30)(A) requires a State to reimburse a provider's costs, the Solicitor General stated the federal government's interpretation that the "focus of the Section is [] on the availability of services generally," and "does not require States to set rates that reimburse [providers] . . . for their costs." *Id.* at \*7. The Ninth Circuit's "contrary holding that States must reimburse providers at rates that essentially ensure recovery of their costs is therefore incorrect. Indeed, when Congress has intended to require States to base Medicaid reimbursement rates on the costs incurred in providing a particular service, it has said so expressly in the text of the Act." *Id.* at \*7-8. The

Solicitor General also discussed the significant textual differences between Section (a)(30)(A) and the Boren Amendment, and concluded that “by contrast [to the Boren Amendment], Section 1396a(a)(30)(A) does not set forth any requirement that a State consider costs in making payments for . . . services, much less that a State fully reimburse a [provider’s] higher costs in furnishing such services. That omission is persuasive evidence that Section 1396a(a)(30)(A) does not require a State to do so.” *Id.* at \*8 (citation omitted).<sup>3</sup>

Because the Solicitor General’s brief expresses the views of the federal Secretary of Health and Human Services, *id.* at \*20, this Court should defer to the views expressed therein. *See Cmty. Health Ctr. v. Wilson-Coker*, 311 F.3d 132, 137 n.8 (2d Cir. 2002) (noting “that any interpretation of the Medicaid regulations in an amicus brief from the Secretary [of HHS] is entitled to some deference from this court” (citing *Auer v. Robbins*, 519 U.S. 452, 462 (1997))); *see also United States v. Mead Corp.*, 533 U.S. 218, 253 (2001) (Scalia, J., dissenting) (noting that, in a prior case, the Court accorded *Chevron* deference to the Pension Benefit Guaranty Corporation’s interpretation of ERISA, even though the

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<sup>3</sup> Despite the Solicitor General’s views on the Ninth Circuit’s incorrect interpretation of Section 1396a(a)(30)(A), the Solicitor General took the position that the Supreme Court should deny certiorari for a variety of reasons, including the plaintiff’s failure to preserve certain issues on appeal, new case law, and the repeal of the Boren Amendment. U.S. Amicus Brief, 1997 WL 33561790, at \*15-\*20. The Supreme Court denied certiorari. 522 U.S. 1044 (1998).

interpretation “was reflected only in an amicus brief to this Court and in several Opinion Letters”); *Chevron USA, Inc. v. NRDC, Inc.*, 467 U.S. 837, 842-43 (1984).

**2. This Circuit Has Held That Section (a)(30)(A) Does Not Confer Enforceable Rights on Providers.**

Although Count III of Plaintiff’s complaint alleged a violation of Section (a)(30)(A) enforceable under 42 U.S.C. § 1983, it did not make that claim a basis for its preliminary injunction motion, presumably because the question has already been decided against it by this Circuit.

For a cause of action to be available under Section 1983, the “text and structure” of the underlying statutory provision must “unambiguously” demonstrate that Congress intends to confer “individual rights” directly on the party who is bringing the action. *Gonzaga Univ. v. Doe*, 536 U.S. 273, 286 (2002); *see also Blessing v. Freestone*, 520 U.S. 329 (1997). The text of the statute must be “individually focused” and employ “rights creating” language. *Gonzaga*, 536 U.S. at 287. Conversely, “statutes that focus on the person regulated rather than the individuals protected create[] no implication of an intent to confer rights on a particular class of persons.” *Id.* (internal quotation omitted).

Consistent with the text and legislative history described above, this Circuit has conclusively ruled that neither Section (a)(13) nor Section (a)(30) confer enforceable legal rights under the *Gonzaga* standard. *DeBuono*, 444 F.3d at 148, *aff’g sub nom. In re NYAHS A Litig.*, 318 F. Supp. 2d 30. In that case, this

Court specifically endorsed the district court's finding, after reviewing the case law, that "health care providers had no enforceable federal rights under sections 1396a(a)(13)(A) and 1396a(a)(30)(A)." 444 F.3d at 148. Many other courts agree. *E.g.*, *Hawkins*, 509 F.3d at 702-03; *Mandy R. v. Owens*, 464 F.3d 1139 (10th Cir. 2006); *Westside Mothers v. Olszewski*, 454 F.3d 532, 542-43 (6th Cir. 2006); *Sanchez v. Johnson*, 416 F.3d 1051, 1059 (9th Cir. 2005); *Long Term Pharmacy Alliance v. Ferguson*, 362 F.3d 50, 57 (1st Cir. 2004).

**3. This Court Is Unlikely To Follow The Ninth Circuit In Finding That Section (a)(30)(A) Imposes Procedural or Substantive Requirements That Can Preempt State Law.**

In light of the plain language of the statute, which does not set forth any specific procedures that a State must follow in determining payments; the repeal of the Boren Amendment and Congress's intent to remove rate-setting litigation from federal court; and the federal government's disavowal of the *Orthopaedic Hospital* decision that is the backbone of the recent spate of Ninth Circuit cases, Plaintiff has no likelihood in prevailing on its argument that this Court should follow the Ninth Circuit and find that Section (a)(30)(A) imposes procedural and substantive requirements that can preempt state law. As Judge Dorsey correctly noted in rejecting the Ninth Circuit's reasoning, "[p]roviders formerly had the [] rights Plaintiff now claims, but they were specifically repealed by Congress. It is illogical to argue that the [] requirements survived in another

provision focused on a different concern.” *Conn. Assoc. of Health Care Facilities, Inc. v. Rell*, No. 3:10-cv-136, 2010 WL 2232693, at \*8 (D. Conn. June 3, 2010) (“*CAHCF I*”). Indeed, “[i]t is highly unlikely that . . . Congress intended the courts to assume a robust role in rate setting.” *Id.* at \*9.

#### **4. Plaintiff Cannot Show That Section 32 Conflicts With Federal Law.**

As shown above, the principal focus of Section (a)(30(A) is to ensure adequate access to quality care for Medicaid recipients. Plaintiff has failed to demonstrate – or even allege – that the State’s nursing home rates are insufficient to afford Medicaid beneficiaries with equal access to quality care. Plaintiff’s “hundreds of pages” of studies and expert testimony focus solely on providers’ costs, not on Medicaid recipients’ access to quality care. Connecticut’s nursing facility rates are among the highest in the nation, and the State’s Department of Public Health has certified that all nursing facilities that participate in Medicaid meet federal quality-of-care standards. (*See Richter Aff.* ¶¶ 23, 27 Mar. 19, 2010, Ex. 1 at 9A; *Starkowski Aff.* ¶ 5 Mar. 19, 2010, Ex. 2 at 152A.) Further, a recent Department of Social Services (“DSS”) survey of Connecticut’s nursing homes revealed a relatively high overall vacancy rate, a high level of available beds per capita, and a high proportion of Medicaid occupancy. (*See Richter Aff.* ¶¶ 21-22, Ex. 1 at 9A.) Finally, the State has granted, and will continue to grant as necessary, interim rate increases to nursing homes facing serious financial

difficulty. (*See id.* ¶¶ 15-16, Ex. 1 at 6-7A; Starkowski Aff. ¶ 8, Ex. 2 at 153A.) As Judge Dorsey recognized, such increases may be used to prevent any closures that would affect access to quality nursing home care. *CAHCF I*, 2010 WL 2232693, at \*12.

**5. CMS’s Approval of Connecticut’s Nursing Home Rates Is Entitled To Deference.**

On May 17, 2010, CMS approved Connecticut State Plan Amendment 09-012, which implemented the nursing home rates established in Section 32 by providing that rates in effect during state fiscal year 2009 “shall remain in effect” for state fiscal years 2010 and 2011. (CMS Approval, Ex. 3 at 1, 3.) CMS has therefore determined that the rates at issue in this case comply with federal law, including the requirements set forth in Section (a)(30)(A). (*See id.* at 1.) Judge Dorsey properly acknowledged that courts in this Circuit accord “considerable deference to CMS’s expert determination that Connecticut’s amended state plan complies (and therefore could not conflict) with federal law.” *CAHCF I*, 2010 WL 2232693, at \*10; *accord Wilson-Coker*, 311 F.3d at 138; *Perry v. Dowling*, 95 F.3d 231, 237 (2d Cir. 1996). Under this deferential standard, Plaintiff cannot demonstrate a substantial possibility of success on appeal.<sup>4</sup>

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<sup>4</sup> If Plaintiff wishes to challenge CMS’s approval of Connecticut’s state plan amendment, it must do so by seeking judicial review under the Administrative (continued...)

**B. The Balance of Hardships Weighs In Favor of Defendants.**

If Section 32 is enjoined pending appeal, the State faces imminent, substantial injury that greatly outweighs Plaintiff's speculative and conclusory allegations of irreparable harm. "Irreparable harm is an injury that is not remote or speculative but actual and imminent." *Tom Doherty Assocs., Inc. v. Saban Entm't, Inc.*, 60 F.3d 27, 37 (2d Cir. 1995). "Issuing a preliminary injunction based only on a possibility of irreparable harm is inconsistent with [the Supreme Court's] characterization of injunctive relief as an extraordinary remedy . . . ." *Winter v. NRDC, Inc.*, 129 S. Ct. 365, 375-76 (2008).

Granting an injunction would force the State to expend over \$100 million in additional funds during fiscal year 2011, when the State already faces a projected budget deficit of \$3 billion. (*See* Genuario Aff. ¶ 8 Mar. 18, 2010, Ex. 4 at 165A.) Because the State is projected to run a massive deficit, enjoining Section 32 would require not just a change to Medicaid rates, but also a reallocation of the entire state budget. *See CAHCF I*, 2010 WL 2232693, at \*10. The transfer of finite state funding to Plaintiff's member nursing facilities will necessarily deprive other state programs (and their beneficiaries) of millions of dollars.

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Procedure Act, *see* 5 U.S.C. § 702, not by bringing suit under the Supremacy Clause, which can only preempt *state* action, not *federal* agency action.

Contrary to Plaintiff's simplistic assertions, if this Court later affirms Judge Dorsey's decision, the State cannot easily recoup any overpayments to CAHCF members during the pendency of the appeal. Such large recoupments are difficult to implement because they can deprive facilities of the funds they need to operate. Indeed, the dissolution of a one-year injunction would not only reduce nursing home rates to their current levels, it would further slash annual revenue to all nursing homes by nearly ten percent (assuming the State takes one year to recoup overpayments and does not recover interest). Plaintiff's members would, by their own assertions, be in extreme financial jeopardy, and Medicaid recipients would be at risk of losing access to quality nursing home care.

Though Plaintiff hypothesizes that "the survival of [the] entire [nursing home] industry" hangs in the balance, Plaintiff fails to allege that any particular facility will go bankrupt absent an injunction. To the contrary, each of the seven "representative" facilities that submitted declarations in the district court showed a profit in its 2009 cost report, despite making substantial payments to facility owners and related entities that were completely unrelated to the provision of services. (*See Richter Aff.* ¶ 29, Ex. 1 at 11-12A.)

Even if a facility were to allege that it needed additional funding to avoid bankruptcy, the existing methodology affords individual facilities the opportunity to seek interim rate relief. *See Conn. Gen. Stat. § 17b-340(a)*. Upon a

showing of proper need, the State has the authority to increase payment rates to avoid irreparable harm. *See id.* However, none of the seven “representative” facilities – and few of Plaintiff’s other members – has applied for an interim rate increase. (Richter Aff. ¶ 29, Ex. 1 at 11-12A.) “Where administrative options exist to obtain relief, the election instead to litigate a matter is at best questionable.” *Weicker*, 46 F.3d at 219-20 (citation omitted).

Rather than allege with particularity that any of its member facilities faces imminent, irreparable harm, Plaintiff relies on the Eleventh Amendment bar of retrospective money damages. Merely invoking the Eleventh Amendment is not sufficient to satisfy the irreparable harm standard; Plaintiff must otherwise prove that actual and imminent injury will result but for the issuance of a preliminary injunction. *Kan. Health Care Ass’n v. Kan. Dep’t of Soc. & Rehab. Servs.*, 31 F.3d 1536, 1543 (10th Cir. 1994). In *United States v. New York*, cited by Plaintiff, this Circuit did *not* hold that the Eleventh Amendment always warrants a finding of irreparable harm. 708 F.2d 92 (2d Cir. 1983) (per curiam). Instead, this Court merely affirmed the district court’s discretionary finding on the issue. *Id.* at 93.

Balanced against the imminent, substantial harm faced by the State if Section 32 is enjoined, Plaintiff’s speculative and conclusory allegations of irreparable harm do not warrant the extraordinary relief of an injunction pending appeal.

**C. An Injunction Pending Appeal Is Against the Public Interest.**

As previously noted, enjoining Section 32 would require the State to expend over \$100 million it does not have, reallocate the entire state budget, and deprive other state programs of millions of dollars, all during these challenging economic times. By contrast, denying Plaintiff's motion would merely maintain the status quo, which has been in place since Medicaid rates were initially frozen on July 1, 2008, and has caused only modest decreases in revenue for individual nursing homes. (*See Richter Aff.* ¶ 29, Ex. 1 at 11-12A.)

Plaintiff argues that Judge Dorsey should not have focused on the “difficult economic times” and the General Assembly’s “expertise in fiscal and budgetary arenas” in finding that the public interest weighs against an injunction pending appeal, because budgetary concerns cannot be taken into account under the Medicaid statute. Similar arguments were made in the *NYAHS*A litigation, when the plaintiffs claimed that the use of budgetary measures to set rates of reimbursement was arbitrary and unreasonable because fiscal concerns were not related to legitimate governmental objectives of the Medicaid Act, including Section (a)(30)(A). The district court rejected the plaintiffs’ claims, reasoning that “[t]he avowed purpose of enacting the measures was to balance the budget by, *inter alia*, control of Medicaid costs. Such a purpose is indeed a legitimate and laudable objective of the State[.]” *In re NYAHS*A Litig., 318 F. Supp. 2d at 41.

This Court affirmed “for the reasons set forth in the district court’s well-reasoned Memorandum Decision and Order.” 444 F.3d at 148.

**II. DEFENDANTS TAKE NO POSITION ON WHETHER THE APPEAL SHOULD BE EXPEDITED**

In addition to filing an emergency motion for an injunction pending appeal, Plaintiff also moved to expedite briefing and oral argument on the merits. Defendants take no position concerning whether this appeal should be expedited.

**CONCLUSION**

For the foregoing reasons, Plaintiff’s motion for an injunction pending appeal should be DENIED.

July 2, 2010

Respectfully submitted,

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**CERTIFICATE OF COMPLIANCE**

Pursuant to Fed. R. App. P. 27(d)(1)(E), the undersigned certifies that **Defendants-Appellees' Opposition to Plaintiff-Appellant's Emergency Motion for an Injunction Pending Appeal** complies with the typeface requirements of Fed. R. App. P. 32(a)(5) and the type-style requirements of Fed. R. App. P. 32(a)(6) because it has been prepared in a proportionally spaced typeface using Microsoft Word 2003 in 14-point Times New Roman font.

/s/ Jonathan G. Hardin

Jonathan G. Hardin

**CERTIFICATE OF SERVICE**

The undersigned certifies that on July 2, 2010, a copy of the foregoing **Defendants-Appellees' Opposition to Plaintiff-Appellant's Emergency Motion for an Injunction Pending Appeal** was filed electronically with the Court using the Case Management/Electronic Case Filing ("CM/ECF") system, which will automatically serve notice of same upon the following counsel for Plaintiff-Appellant Connecticut Association of Health Care Facilities, Inc. via electronic mail:

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